STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HARRISONBURG LLC	94 SOUTH AVENUE HARRISONBURG, VA 22801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted 04/14/2020 through 04/16/2020 and on 06/11/2020. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted 04/14/2020 through 04/16/2020 and on 06/11/2020. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and has implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. On 04/14/2020 the census in this 117 certified bed facility was 96 (95 + one resident in the hospital with COVID-19). The facility reported that on 04/14/2020 the local health department came to the facilty and tested 81 residents, 14 residents refused. Results were reported on 04/16/2020 with 78 residents tested postive, the 14 refusals were "presumed" positive per the health department. Three residents tested negative. During the onsite survey on 06/11/2020, the DON (director of nursing) reported that two of the three residents who tested negative later became positive. One resident remained negative. Twenty-eight facility staff were also tested, with 20 testing positive for COVID-19. On 06/11/2020, the facility census was 69. From the end of May until the beginning of June, 70	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

residents were retested for COVID-19 and ALL were negative. A cumulative total of 88 residents were tested for COVID-19 with 87 positives, 1 negative. Seventy-one residents were reported as recovered from the virus.