## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/12/2020 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495241	B. WING _			C 11/09/2020	
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT RIVER POINTE LLC			STREET ADDRESS, CITY, STATE, ZIP 4142 BONNEY ROAD VIRGINIA BEACH, VA 23452	CODE	11700/2020	
SUMMARY STATEMENT OF DEFICIENCIES  EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
0 Initial Comments		E	000			
An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 11-5-20 and continued with offsite review 11-6-20 and 11-9-20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. INITIAL COMMENTS		F	000			
An unannounced COVID-19 Focused Survey and an abbreviated (complaint) survey were conducted onsite 11-5-20 and continued with offsite review 11-6-20 and 11-9-20. The facility was in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.						
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	Initial Comments  An unannounced Emc COVID-19 Focused Son 11-5-20 and continuing the foliation of the conducted onsite 11-6-20 and 11-9-20.  Compliance with E002 Requirements for Lon INITIAL COMMENTS  An unannounced CO an abbreviated (comp conducted onsite 11-6-20 was in compliance with infection control regul implementation of The Medicaid Services and Control recommended COVID-19.  The census in this 13 79 at the time of survices in the conducted conducted conducted covid in the conducted onsite 11-6-20 was in compliance with infection control regul implementation of The Medicaid Services and Control recommended COVID-19.  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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.