STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 02/26/2020 through 02/28/2020. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. 3 complaints were investigated during the survey. The census in this 138 certified bed facility was 97 at the time of the survey. The survey sample consisted of 4 current Resident reviews (Residents #1, #3, #4 and #6) and 2 closed record reviews (Residents #2 and #5).	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		4/13/20

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

Electronically Signed | 03/26/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure one of six sampled residents, Resident #3, had the right to make choices regarding staff preferences during ADL (activities of daily living) care. The findings included: Resident #3 was admitted to the facility on 4/2/19 with diagnoses that included but were not limited to, high blood pressure, post traumatic stress disorder, and severe intellectual disabilities. Resident #3's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/8/2020. Resident #3 was coded as being cognitively intact scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from one staff member with personal hygiene, and dressing; and total dependence on staff with bathing. On 2/26/20 at 4:08 p.m., an interview was conducted with OSM (other staff member) #5, the facility social worker. OSM #5 had mentioned an incident involving Resident #3 and the night shift CNA (certified nursing assistant) #1 on 9/8/19. OSM #5 stated that Resident #3 had reported to	F 561	1. Resident #3 interviewed regarding her preferences. 2. All residents have the potential to be affected. 3. Staff Development Coordinator will in-service nursing staff regarding residents having the right to make their choices regarding staff preferences during ADL care. Social Worker will interview residents regarding their choices and complete audit daily for 1 week M-F, then weekly X 4, then monthly X 2. 4. The reported results of the audits will be reviewed to the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

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	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 561	Continued From page 2	F 561		

her that this nursing aide had called her "nasty" and would state that she wasn't going to change her if she smelled. OSM #5 also stated it was alleged that this CNA would flinch or jump at the resident acting as if she was going to hurt her. OSM #5 stated that she reported this allegation to APS (adult protective services) and not the facility administrator because per OSM #5, she has reported allegations of abuse to the executive director in the past and nothing has been done.

Review of Resident #3's investigation file revealed a grievance with a report date of 9/9/2019. The following was documented by the former DON (Director of Nursing) RN (Registered Nurse) #1:

"Resident (Name of Resident #3) is a 69-year-old female that was admitted to (Name of facility) on April 4th, 2019 with medical diagnosis of primary hypertension (high blood pressure), post-traumatic stress disorder, anemia, Vitamin D Deficiency, other obesity, Hyperlipidemia, other specified depressive episodes, severe intellectual disabilities, chronic obstructive pulmonary disease, gastro-esophageal reflux without esophagitis. (Name of Resident #3 BIMS score noted 99 on 7/8/19, BIMS score reassessed at 10 on 9/19/19.

On September 9, 2019 a grievance was reported via (Name of Resident #3) to social worker (OSM #5). (Name of Resident #3) reported that her assigned CNA who she described in detail was rude to her last night when she was washing her in bed and changing her. (Name of Resident #3) reported that CNA told her she could put (Name of Resident #3) out of the nursing home. (Name of Resident #3) further disclosed that she thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 561	Continued From page 3	F 561		

CNA had "called me nasty" looked like I ain't been changed in 8 hours." (Name of Resident #3) further disclosed not liking the CNA and no longer wants her to give ADL (activities of daily living) care. (Name of Resident #3) expressed "I feel she doesn't want to work with me." SW (social work) reviewed with SDC case assignment ledger book which was assigned C.NA (sic) for last three consecutive nights as: (Name of CNA #1).

During the investigation the following was noted:

1. Alleged incident occurred 9/8/19 during 11 (PM) to 7 (AM) shift approximately 6 a.m.
2. On the following dates, resident was assigned to the following CNAs on 11 pm to 7 am shift:
9/9/19 (Name of CNA #1)
9/8/19 (Name of different CNA (CNA #8))...
3. (Name of CNA #1) stated she was called into room via another CNA (Name of CNA #8), to assist in changing resident. Resident was unhappy about being awakened, both (Name of CNA #8 and CNA #1) provided incontinence care, and per (Name of CNA #8), (Name of CNA #1) did not say anything to resident."

A witness statement dated 9/10/19 from CNA #1 documented the following: "I don't know what happen when I went to halpe (sic) the aide (sic) She was upset she don't won't (sic) be changed but, we need to chang (sic) her because she she was very weat (sic). She doesn't want to be change in the morning because she won't sleep but I can't live (sic) her weat (sic). I (unidentifiable word) for her and change her every morrning (sic)."

A witness statement taken via phone interview from CNA #8 by RN #1 dated 9-11-19,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 561	Continued From page 4	F 561		

documented the following:
"9-11-19 phone interview with (Name of CNA #8)
Q: Pease tell me what happened with (Name of Resident #3) the night of 9-8-19.
A: Nothing happened. What do you mean?
Q: (Name of Resident #3) has stated that a CNA called her nasty and threatened to put her out of the building. She has described (Name of CNA #1). Please tell me what happened. Who was assigned to care for her?
A: I had her. I asked (Name of CNA #1) to help me. She didn't want us to change her but she was very wet. We told her we had to change her . She was unhappy we wake her up.
Q: Did either of you say anything else?
A: We were polite. Just told her we needed to do our job and get her cleaned up.
Q: Did either one of you say she was nasty?
A: We would never do that."

A written witness statement not obtained until 9/19/19 from CNA #8 documented the following: " When we go to room (Resident #3's room) we ask her (with CNA #1 besides me) if she wants to be changed she said no. We are very polite to explain to her and convince her to be changed under wear. She said ok. So I change her. the only words that I said its going to be a quick change, she said again ok and she look at me I ask her are you comfortable? She said yes!! (Name of CNA #1) don't say any words."

Further review of Resident #3's investigation file revealed that CNA #1 had worked with Resident #3 for a second time on 9/16/19. The following statement was written by the nurse on shift: "On Monday September 16, 19 CNA (Name of CNA #1) came and asked me to go with her at (sic) room (Name of Resident #3's) room. She need to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 561	Continued From page 5	F 561		

work with (Name of Resident #3). I asked her: "Why do you change/switch with any CNA because I knew that you can't go to this room." She state that (Name of CNA #8) can't go to this room either. (Name of another CNA) didn't want to switch because she said she didn't know people. And (Name of another CNA), she can't find her- and (Name of CNA #1) said: DON told her she can come to (Resident #3's room) with somebody with her. I told her - ok. So we come to the room together. I stand next to her. When (Name of Resident #3) saw me, she just smiling, I guess (Name of Resident #3) knew me, so she trust me and was very mood (sic) at this time. Very pleasant. I observed and heard (Name of CNA #1) was very polite, always said "please!" (Can you move to this side, please can I change your brief, please!...) The statement I write that base on the true (sic) I observed- "

On 2/27/20 at 4:00 p.m., an interview was conducted with Resident #3. When asked if any staff have ever been mean to her, Resident #3 stated that a CNA one time had called her nasty because she was wet but could not recall when this occurred. When asked if this CNA had ever worked with her after this incident, Resident #3 stated that she couldn't recall. Resident #3 then stated that she didn't think so.

On 2/27/20 at approximately 5:00 p.m., an interview was conducted with RN #1, the former DON. When asked the process if she received an allegation of abuse between a staff member and a resident at the facility, RN #1 that she would suspend the accused staff member immediately until the investigation was completed. RN #1 stated that she would initiate an investigation and obtain witness statements. When asked if CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 561	Continued From page 6	F 561		

#1 had worked with Resident #3 after the incident on 9/8/19, RN #1 stated that she did but after the investigation was completed. RN #1 stated that abuse was not founded. When asked if CNA #1 should be working with Resident #3 if Resident #3 voiced that she did not want her to provide ADL care, RN #1 stated, "More than likely she (CNA #1) was probably stuck on that assignment and she just needed to switch that room with another nursing aide." When asked if it was the CNA's responsibility to find a nursing aide to switch rooms with her, RN #1 stated that the nurse should have removed CNA #1 from Resident #3's at the beginning of the shift. When asked if she approved CNA #1 to work with Resident #3 if another staff member was present, RN #1 stated that she did. When asked why she allowed CNA #1 to provide ADL care to Resident #3 on 9/16/19, RN #1 stated that staffing was limited and Resident #3 was known to fabricate things/incidents about the staff. RN #1 stated that CNA #1 had not worked with Resident #3 since the APS investigation that took place on 9/17/19.

On 2/27/20 at 5:26 p.m., an interview was conducted with ASM #2, the DON (Director of Nursing). When asked if a nursing aide should continue to work with a resident if the resident has already voiced that they do not want that particular aide working with them, ASM #2 stated, "No, they should not work with the resident. The resident is already uncomfortable." ASM #2 stated that it was a resident right for the resident to be comfortable with the care provided to them. The above concerns were addressed with ASM #2. ASM #2 stated that CNA #1 should not have been put back on the assignment to work with Resident #3 on 9/16/19.

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	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 561	Continued From page 7 On 2/28/20 at 11:13 a.m., an interview was conducted with CNA #1. CNA #1 stated that she knew that she was not supposed to work with Resident #3 after the incident (she could not recall the date) but that she was put on the schedule to work with Resident #3 (she could not recall the date). CNA #1 stated that she asked every aide to switch rooms with her and no one was willing to take Resident #3. CNA #1 stated that she finally asked the nurse to come in with her as a witness while she provided care. CNA #1 stated that she could not leave Resident #3 wet all shift. CNA #1 also stated that the DON at the time gave her permission to provide care with the nurse present. On 2/28/20 at 2:30 p.m., ASM #1, the Executive Director and ASM #2 the DON were made aware of the above concerns. Facility policy titled, "Resident Rights" documents in part, the following: "Federal and State laws guarantee certain basic rights to all resident of this facility. These rights include the residents right to: a. A dignified existence; b. be treated with respect, kindness and dignity c. be free from abuse, neglect and exploitation...e. self determination..."	F 561		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a	F 567		4/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 567	Continued From page 8 resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and in the course of a complaint investigation, it was determined that facility staff failed to manage, safeguard and account for one of six sampled resident's personal funds (Resident #1), deposited with the facility.	F 567	1. Resident #1 had her personal funds deposited in her account on 11/22/19. 2. All residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 567	Continued From page 9 The findings included: Resident #1 was admitted to the facility on 9/21/18 with diagnoses that included but were not limited to multiple sclerosis, epilepsy, schizophrenia with periods of hypomanic episodes. Resident #1's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 12/4/19. Resident #1 was coded as being cognitively intact in the ability to make decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of a Facility Reported Incident (FRI) revealed an incident dated 11-18-19 (report date) that documented the following: "Notified on 11-18-19 by APS (Adult Protective Services) of anonymous allegation of misappropriation of resident funds." The five day follow up investigation documented the following: "(Name of Resident #1) is alert and oriented with a BIM (sic) score of 13. (Name of Resident #1) is capable of verbally expressing her wants and needs to staff members. (Name of Resident #1) has an established resident fund account with the facility; she knows how and where to obtain her funds from her account. On November 13 th, 2019, resident, facility social worker, and resident sister were at the receptionist window for resident to withdraw funds from her account. Resident was informed of her balance by receptionist. As soon as this happened, immediately resident's sister who's visit was being supervised by facility social worker became belligerent and demanded $80.00 from resident's account. Resident's sister had made a deposit to resident's account via money order, a receipt was written on 10/18/19	F 567	3. Business Office Manager will in-service administrative staff regarding managing and safeguarding residents' personal funds deposited with the facility. Admissions Director will audit personal funds daily for 1 week M-F, then weekly X 4, then monthly X 2. 4. The reported results of the audits will be reviewed at the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

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F 567	Continued From page 10	F 567		

for the 40.00 money order which didn't include the resident's name on it. The facility social worker advised resident's sister that receptionist would follow up with resident and JFS (Jewish Family Services), legal guardian for resident. On November 13 th, 2019 the facility receptionist sent appropriate documentation; copies of receipt (receipt number documented) and money order to corporate office to have the $40.00 money order with no name on it, credited to (Resident #1's) account."

Review of a witness statement by the OSM (other staff member) #3, accounts payable; documented the events on 11/13/19 differently from the submitted FRI. The following was documented: "11-13-19 On this day (Name of Resident #1's) daughter (sic) was being loud, cussing and accusing me of embezzling her sister's money. Yelled at a resident (Name of another resident) to go get her sister from dining room. I explained to (Name of other resident) that (Name of Resident #1) was playing Bingo and to not get her and she continued to yell. (Name of other resident) just went outside. I paged (Name of facility social worker OSM #5) several times and when she came up she helped difuse (sic) for a bit. (Name of Resident #1's) sister went to dining room were Bingo was going on. (Name of facility social worker (OSM #5)) called the front desk to tell me the sister had to leave by 3 p.m. and asked if I could remind the sister. I told (Name of OSM #5) I felt uneasy but she explained the sister knows. At 3 p.m. I went to the dining room and whispered in the sisters ears (So no one else could hear) that her scheduled visit was over and she had to leave the building. The sister started cussing and causing a scene in Dining rm (room). I kept telling her she needed to leave I walked her to the front

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 567	Continued From page 11	F 567		

lobby, where she again started yelling and wanted my name so she could report me to the state and stated she was going to call the police because we were embezzling her sister's money. The sister went outside and stayed on the porch for awhile. I continued with my work. I look up again and there were police officers outside talking with her. I had called OSM #5 several times to come to front lobby to no prevail. The police came in and and (sic) started asking me questions. I answered what I could then finaly (sic) (Name of OSM #5) came up and answered the police questions."

On 2/26/20 at 12:52 p.m., an interview was conducted with OSM #3, accounts payable. OSM #3 stated that she took over the accounts payable position at the end of October of 2019. OSM #3 stated that in the beginning of October of 2019, Resident #1's sister had made a deposit of $40.00 into her account. OSM #3 stated the same day another resident had made a deposit of $5.00 into her account. OSM #3 stated that the previous accounts payable staff member did not write the names of the residents on top of the deposit slips. OSM #3 stated that the deposits for these two residents were swapped; five dollars went into Resident #1's account instead. OSM #3 stated that on 11/13/19 Resident #1's sister came up to her window screaming and hollering and stated she wanted her $40.00 that she gave her sister. OSM #3 then stated the sister changed $40.00 to $80.00. OSM #3 stated, "I told her that I could not give her the resident's money." OSM #3 stated that she told the sister that she would investigate to see what had happened with Resident #1's money. OSM #3 stated that it took her a couple of weeks to figure out what had happened but that Resident #1 always money in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 567	Continued From page 12 her account and was not without money during this time. OSM #3 was asked to present her bank statements to support this. On 2/26/20 at 1:37 p.m., OSM #3 presented deposit slips to show that both Resident #1 and the other facility resident had deposited money on 10/18/19. Resident #1's sister had deposited 40.00 into her account on this day. The other resident had deposited $5.00. Both deposits did not reflect into their accounts until 11/1/19. Further review of the bank statements revealed that the error was not corrected until 11/22/19. Further review of Resident #1's bank statement revealed that she was never without money in her account. On 2/28/20 at 2:30 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the Director of Nursing were made aware of the above concern. Facility policy titled, "Deposit of Resident Funds" did not address the above concerns. Complaint deficiency.	F 567		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		4/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 607	Continued From page 13 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to implement abuse policies and report an allegation of abuse to the appropriate state agencies for one of six sampled residents, Resident #3. The findings included: Resident #3 was admitted to the facility on 4/2/19 with diagnoses that included but were not limited to high blood pressure, post traumatic stress disorder, and severe intellectual disabilities. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/8/2020. Resident #3 was coded as being cognitively intact scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from one staff member with personal hygiene, and dressing; and total dependence on staff with bathing. On 2/26/20 at 4:08 p.m., an interview was conducted with OSM (other staff member) #5, the facility social worker. OSM #5 had mentioned an incident involving Resident #3 and the night shift CNA (certified nursing assistant) #1 on 9/8/19. OSM #5 stated that Resident #3 had reported to her that this nursing aide had called her "nasty" and would state that she wasn't going to change her if she smelled. OSM #5 also stated it was alleged that this CNA would flinch or jump at the resident acting as if she was going to hurt her.	F 607	1. Investigative protocol was followed, there was no harm to resident #3. 2. All residents have the potential to be affected. 3. Staff Development Coordinator will in-service department managers and staff on abuse policies and requirements to report allegations of abuse to the appropriate state agency. All grievances will be reviewed by Social Worker for 12 weeks for the potential of being an abuse allegation and reported if such. 4. The reported results of the audits will be reviewed by the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 607	Continued From page 14	F 607		

OSM #5 stated that she reported this allegation to APS (adult protective services) and not the facility administrator because per OSM #5, she has reported allegations of abuse to the executive director in the past and nothing has been done.

Review of Resident #3's investigation file revealed a grievance with a report date of 9/9/2019. The following was documented by the former DON (Director of Nursing) RN (Registered Nurse #1):

"Resident (Name of Resident #3) is a 69-year-old female that was admitted to (Name of facility) on April 4th, 2019 with medical diagnosis of primary hypertension (high blood pressure), post-traumatic stress disorder, anemia, Vitamin D Deficiency, other obesity, Hyperlipidemia, other specified depressive episodes, severe intellectual disabilities, chronic obstructive pulmonary disease, gastro-esophageal reflux without esophagitis. (Name of Resident #3 BIMS score noted 99 on 7/8/19, BIMS score reassessed at 10 on 9/19/19.

On September 9, 2019 a grievance was reported via (Name of Resident #3) to social worker (OSM #5). (Name of Resident #3) reported that her assigned CNA who she described in detail was rude to her last night when she was washing her in bed and changing her. (Name of Resident #3) reported that CNA told her she could put (Name of Resident #3) out of the nursing home. (Name of Resident #3) further disclosed that she thought CNA had "called me nasty" looked like I ain't been changed in 8 hours." (Name of Resident #3) further disclosed not liking the CNA and no longer wants her to give ADL (activities of daily living) care. (Name of Resident #3) expressed "I feel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 607	Continued From page 15	F 607		

she doesn't want to work with me." SW (social work) reviewed with SDC case assignment ledger book which was assigned C.NA (sic) for last three consecutive nights as: (Name of CNA #1).

During the investigation the following was noted:

1. Alleged incident occurred 9/8/19 during 11 (PM) to 7 (AM) shift approximately 6 a.m.
2. On the following dates, resident was assigned to the following CNAs on 11 pm to 7 am shift:
9/9/19 -(Name of CNA #1)
9/8/19 (Name of different CNA (CNA #8))...
3. (Name of CNA #1) stated she was called into room via another CNA (Name of CNA #8), to assist in changing resident. Resident was unhappy about being awakened, both (Name of CNA #8 and CNA #1) provided incontinence care, and per (Name of CNA #8), (Name of CNA #1) did not say anything to resident."

A witness statement dated 9/10/19 from CNA #1 documented the following: "I don't know what happen when I went to halpe (sic) the aide (sic) She was upset she don't won't be changed but, we need to chang (sic) her because she she was very weat (sic). She doesn't want to be change in the morning because she won't sleep but I can't live (sic) her weat (sic). I (not identifiable word) for her and change her every morrning (sic)."

A witness statement given via phone interview from CNA #8 by RN #1 dated 9-11-19, documented the following:
"9-11-19 phone interview with (Name of CNA #8)
Q: Pease tell me what happened with (Name of Resident #3) the night of 9-8-19.
A: Nothing happened. What do you mean?
Q: (Name of Resident #3) has stated that a CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 607	Continued From page 16	F 607		

called her nasty and threatened to put her out of the building. She has described (Name of CNA #1). Please tell me what happened. Who was assigned to care for her?
A: I had her. I asked (Name of CNA #1) to help me. She didn't want us to change her but she was very wet. We told her we had to change her . She was unhappy we wake her up.
Q: Did either of you say anything else?
A: We were polite. Just told her we needed to do our job and get her cleaned up.
Q: Did either one of you say she was nasty?
A: We would never do that."

A written witness statement not obtained until 9/19/19 from CNA #8 documented the following: " When we go to room (Resident #3's room) we ask her (with CNA #1 besides me) if she wants to be changed she said no. We are very polite to explain to her and convince her to be changed under wear. She said ok. So I change her. the only (sic) words that I said its going to be a quick change, she said again ok and she look at me I ask her are you comfortable? She said yes!! (Name of CNA #1) don't say any words."

Review of an APS (adult protective services) report revealed that APS had also investigated this allegation on 9/17/19 with abuse unfounded.

There was no evidence that this allegation of abuse was reported to the appropriate state agencies. A five day working follow up to the investigation was also not submitted to the appropriate state agencies.

Review of CNA #1's employee file revealed that she had no identifiable criminal history.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 607	Continued From page 17	F 607		

Further review of Resident #3's investigation file revealed that CNA #1 was reported to the Department of Health Professions.

On 2/27/20 at approximately 5:00 p.m., an interview was conducted with RN #1, the former DON. When asked the process if she received an allegation of abuse between a staff member and a resident at the facility, RN #1 that she would suspend the accused staff member immediately until the investigation was completed. RN #1 stated that she would initiate an investigation and obtain witness statements. When asked who was responsible for reporting abuse to the appropriate state agencies, RN #1 stated that the Executive Director and/or the DON was responsible for submitting the FRI (Facility Reported Incident). When asked if a FRI was submitted regarding the above incident, RN #1 stated that she didn't think a FRI was submitted. RN #1 stated that she knew the Executive Director was out of town that week so the responsibility would have been on the ADON (Assistant Director of Nursing) at the time. When asked why she wouldn't submit a FRI as the DON, RN #1 stated that she was new a Resident of Virginia and wasn't familiar with the reporting process at that time. When asked why CNA #1 was reported to the Department of Health Professions if abuse was unfounded, RN #1 stated that the social worker (OSM #5) probably reported CNA #1 and that she was always finding ways to undermine the nursing staff.

On 2/27/20 at 5:26 p.m., an interview was conducted with ASM (administrative staff member) #2, the current DON and former ADON. When asked the process for reporting abuse, ASM #2 stated that abuse should be reported to the appropriate state agencies within two hours if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 607	Continued From page 18	F 607		

there was physical contact and 24 hours for everything else. ASM #2 also stated that a follow up to the FRI would be sent to the appropriate state agencies (long term care ombudsman, APS, State Survey Agency) within five working days. When asked what type of abuse the above allegation reflected, ASM #2 stated verbal abuse. When asked why a FRI was not submitted to the appropriate state agencies regarding Resident #3 and CNA #1, ASM #2 stated, "APS was notified because they alerted us they were going to investigate." When asked why a FRI was not submitted to the appropriate state agencies prior to APS coming into the facility on 9/17/19, ASM #2 stated that a FRI should have been submitted.

On 2/28/20 at 2:30 p.m., ASM #1, the Executive Director and ASM #2 the DON were made aware of the above concerns.

Facility policy titled, "Abuse and Neglect" documented in part, the following: " Immediate Reporting Requirement: In the event of situations suggest, or are identified as neglect, misappropriation, or/and exploitation, AND, the situation has resulted in injury to to the resident, notification must be made within two hours and police must be notified.
In non-abuse allegations and if no injury has occurred, the facility has 24 hours to report to the state. All situations where resident or facility property may have been misappropriated also require law enforcement involvement. Should staff in charge be unable to to reach the Administrator or DON, ADON, SDC or Social Worker, the highest level staff present will contact the State Survey Agency using the complaint hotline for the appropriate State."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 609	Continued From page 19	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to report an allegation of abuse to the appropriate state agencies for one of six sampled residents, Resident #3.	F 609	1. Investigative protocol was followed, there was no harm to resident #3. 2. All residents have the potential to be affected.	4/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 609	Continued From page 20 The findings included: Resident #3 was admitted to the facility on 4/2/19 with diagnoses that included but were not limited to high blood pressure, post traumatic stress disorder, and severe intellectual disabilities. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/8/2020. Resident #3 was coded as being cognitively intact scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance from one staff member with personal hygiene, and dressing; and total dependence on staff with bathing. On 2/26/20 at 4:08 p.m., an interview was conducted with OSM (other staff member) #5, the facility social worker. OSM #5 had mentioned an incident involving Resident #3 and the night shift CNA (certified nursing assistant) #1 on 9/8/19. OSM #5 stated that Resident #3 had reported to her that this nursing aide had called her "nasty" and would state that she wasn't going to change her if she smelled. OSM #5 also stated it was alleged that this CNA would flinch or jump at the resident acting as if she was going to hurt her. OSM #5 stated that she reported this allegation to APS (adult protective services) and not the facility administrator because per OSM #5, she has reported allegations of abuse to the executive director in the past and nothing has been done. Review of Resident #3's investigation file revealed a grievance with a report date of 9/9/2019. The following was documented by the former DON (Director of Nursing) RN (Registered Nurse #1) which included:	F 609	3. Staff Development Coordinator will in-service department managers and staff on abuse policies and requirements to report allegations of abuse to the appropriate state agency. All grievances will be reviewed by SW for 12 weeks for the potential for being an abuse allegation and reported if such. 4.The reported results of the audits will be audited by the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 609	Continued From page 21	F 609		

On September 9, 2019 a grievance was reported via (Name of Resident #3) to social worker (OSM #5). (Name of Resident #3) reported that her assigned CNA who she described in detail was rude to her last night when she was washing her in bed and changing her. (Name of Resident #3) reported that CNA told her she could put (Name of Resident #3) out of the nursing home. (Name of Resident #3) further disclosed that she thought CNA had "called me nasty" looked like I ain't been changed in 8 hours." (Name of Resident #3) further disclosed not liking the CNA and no longer wants her to give ADL (activities of daily living) care. (Name of Resident #3) expressed "I feel she doesn't want to work with me." SW (social work) reviewed with SDC case assignment ledger book which was assigned C.NA (sic) for last three consecutive nights as: (Name of CNA #1).

During the investigation the following was noted:

1. Alleged incident occurred 9/8/19 during 11 to 7 shift approximately 6 a.m.
2. On the following dates, resident was assigned to the following CNAs on 11 pm to 7 am shift:
9/9/19 -(Name of CNA #1)
9/8/19 (Name of different CNA (CNA #8))...
3. (Name of CNA #1) stated she was called into room via another CNA (Name of CNA #8), to assist in changing resident. Resident was unhappy about being awakened, both (Name of CNA #8 and CNA #1) provided incontinence care, and per (Name of CNA #8), (Name of CNA #1) did not say anything to resident."

Review of an APS (adult protective services) report revealed that APS had also investigated this allegation on 9/17/19 with abuse unfounded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 609	Continued From page 22	F 609		

This allegation of abuse was not reported to all of the state agencies. A five day working follow up to the investigation was also not submitted to all of the appropriate state agencies.

Further review of Resident #3's investigation file revealed that CNA #1 was reported to the Department of Health Professions.

On 2/27/20 at approximately 5:00 p.m., an interview was conducted with RN #1, the former DON. When asked the process if she received an allegation of abuse between a staff member and a resident at the facility, RN #1 that she would suspend the accused staff member immediately until the investigation was completed. RN #1 stated that she would initiate an investigation and obtain witness statements. When asked who was responsible for reporting abuse to the appropriate state agencies, RN #1 stated that the Executive Director and/or the DON was responsible for submitting the FRI (Facility Reported Incident). When asked if a FRI was submitted regarding the above incident, RN #1 stated that she didn't think a FRI was submitted. RN #1 stated that she knew the Executive Director was out of town that week so the responsibility would have been on the ADON (Assistant Director of Nursing) at the time. When asked why she wouldn't submit a FRI as the DON, RN #1 stated that she was new a Resident of Virginia and wasn't familiar with the reporting process at that time. When asked why CNA #1 was reported to the Department of Health Professions if abuse was unfounded, RN #1 stated that the social worker (OSM #5) probably reported CNA #1 and that she was always finding ways to undermine the nursing staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 609	Continued From page 23	F 609		

On 2/27/20 at 5:26 p.m., an interview was conducted with ASM (administrative staff member) #2, the current DON and former ADON. When asked the process for reporting abuse, ASM #2 stated that abuse should be reported to the appropriate state agencies within two hours if there was physical contact and 24 hours for everything else. ASM #2 also stated that a follow up to the FRI would be sent to the appropriate state agencies (long term care ombudsman, APS, State Survey Agency) within five working days. When asked what type of abuse the above allegation reflected, ASM #2 stated verbal abuse. When asked why a FRI was not submitted to the appropriate state agencies regarding Resident #3 and CNA #1, ASM #2 stated, "APS was notified because they alerted us they were going to investigate." When asked why a FRI was not submitted to the appropriate state agencies prior to APS coming into the facility on 9/17/19, ASM #2 stated that a FRI should have been submitted.

On 2/28/20 at 2:30 p.m., ASM #1, the Executive Director and ASM #2 the DON were made aware of the above concerns.

Facility policy titled, "Abuse and Neglect" documented in part, the following: " Immediate Reporting Requirement: In the event of situations suggest, or are identified as neglect, misappropriation, or/and exploitation, AND, the situation has resulted in injury to to the resident, notification must be made within two hours and police must be notified.
In non-abuse allegations and if no injury has occurred, the facility has 24 hours to report to the state. All situations where resident or facility property may have been misappropriated also require law enforcement involvement. Should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 609	Continued From page 24 staff in charge be unable to to reach the Administrator or DON, ADON, SDC or Social Worker, the highest level staff present will contact the State Survey Agency using the complaint hotline for the appropriate State."	F 609		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review and in the course of a complaint investigation, the facility staff failed to ensure 1 of 6 residents in the survey sample, Resident #2, was provided treatment and services to prevent the development of, promote the healing of and prevent the decline of a pressure ulcer resulting in harm. The findings include: Resident #2 was originally admitted to the facility on 08/21/2019, discharged to the hospital on 11/06/2019, readmitted to the facility on	F 686	1. Resident #2 discharged form facility on 12/2/19. 2. All residents at risk for skin breakdown have the potential to be affected. 3. Wound Care consultants or Staff Development Coordinator will in-service licensed and certified staff on professional standards of practice to prevent pressure ulcer development, promote the healing of pressure ulcers, and how to prevent the decline of a pressure ulcer. 100% skin audit to be conducted for all residents for	4/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 686	Continued From page 25 11/18/2019 and discharged to the hospital on 12/02/2019. Diagnoses included but were not limited to, Type 2 Diabetes Mellitus and Peripheral Vascular Disease. Resident #2's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 08/28/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #2 as requiring supervision with assistance of 1 for eating, extensive assistance of 1 for bed mobility, dressing, toileting and personal hygiene and total dependence of 1 for bathing and total dependence of 2 for transfer. On 02/28/2020 Resident #2's clinical record was reviewed and revealed the following: Review of "Braden Scale For Predicting Pressure Sore Risk" revealed the following: Effective Date: 08/22/2019 Score: 15 Category: AT RISK; Effective Date: 11/19/2019 Score: 17 Category: AT RISK Review of "Weekly Skin Review" revealed the following: Effective Date: 08/28/2019 SKIN CONDITION: 7b. Pre-existing 8a. Open Area 9. Other: Pt. (Patient) with ongoing tx (treatment) to sacrum and right upper thigh. Effective Date: 10/08/2019 SKIN CONDITION: 8a. Open Area 8b. Pre-existing Site - 49) Right heel 50) Left heel 52) Left toe(s) 53) Sacrum Effective Date: 10/15/2019 SKIN CONDITION: 8a. Open Area 8b. Pre-existing Effective Date: 10/29/2019 SKIN CONDITION: 7b. Pre-existing Site - 49) Right heel 50) Left heel 52) Left toe(s) 53) Sacrum	F 686	skin integrity. Director of Nursing will audit 5 residents with pressure ulcers daily M-F for 4 weeks for current treatment orders, complement of pressure ulcer assessments, plan of care updated, nutritional interventions, utilization of preventative surfaces, Nurse Practitioner visited, weekly measurements and review residents with pressure ulcers at the weekly At Risk meeting; audits will continue bi-weekly X 2 weeks, then weekly x 4. 4.The reported results of the audits will be audited at the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

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	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 686	Continued From page 26	F 686		

Review of Medication Review Report revealed the following: "Pt. (Patient) to be seen by wound care nurse." Order Date: 08/21/2019

Review of "Integrated Wound Care" Progress Notes revealed the following:
Date of Service: 09/10/19 Encounter: #1 right Ankle Arterial Ulcer; #2 great toe
Date of Service: 09/17/19 Encounter: #1 right Ankle Arterial Ulcer; #2 great toe
Date of Service: 09/24/19 Encounter: #1 right Ankle Arterial Ulcer; #2 great toe
Date of Service: 10/01/19 Encounter: #1 right Ankle Arterial Ulcer; #2 left great toe; #3 Toe
Date of Service: 10/08/19 Wound to rt (right) heel; wound to left heel; wound to rt lateral foot; wound to lt (left) hellux; bilateral sacral wounds - unstageable to rt buttocks 5cm (centimeters) x 2 cm x 0.2 cm, 75% slough, 25% pink, needs santyl to wounds, cover with bordered gauze.
Date of Service: 10/18/19 Wound to rt heel; wound to left heel; wound to rt lateral foot; wound to rt lower heel; wound to lt hellux; bilateral sacral wounds-unstageable to sacrum needs santyl to wounds, cover with bordered gauze.
Date of Service: 10/22/19 Wound to rt heel; wound to right outer heel; wound to rt lateral foot; wound to right hellux; bilateral unstageable sacral wounds - 6 x 3cm with 90% whitish yellow, 10% pink wound bed = Santyl to wounds, cover with bordered gauze daily.
Date of Service: 10/29/19 Wound to rt heel; wound to right outer heel; wound to rt lateral foot; wound to right hellux; bilateral unstageable sacral wounds - 5.5 x 4.5 x 0.1m with 90% whitish yellow, 10% pink wound bed = Santyl to wounds, cover with bordered gauze daily. Patient is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 686	Continued From page 27	F 686		

currently receiving IV fluids due to poor po intake and increased BUN (Blood Urea Nitrogen). Discussed care with NP (Nurse Practitioner) from primary care, significant decline in wounds and health in general.

Review of Treatment Administration Record for the period of 08/01/2019 through 08/31/2019 revealed there was no treatment order for the sacral wound. It did contain: Pressure Reducing cushion to chair if needed every shift for pressure ulcer prevention." Start Date: 08/21/2019 D/C Date: 11/07/2019.

Review of Treatment Administration Record for the period of 09/01/2019 through 09/30/2019 revealed there was no treatment order for the sacral wound. It did contain: "Pressure Reducing cushion to chair if needed every shift for pressure ulcer prevention." Start Date: 08/21/2019 D/C Date: 11/07/2019.

Review of Treatment Administration Record for the period of 10/01/2019 through 10/31/2019 revealed the following: "Sacrum: Cleanse with normal saline, apply normal saline moistened gauze with santyl application, skin prep surrounding intact skin, and cover with foam dressing daily every 1 (one) hours as needed for unstageable open area." Start Date: 10/16/2019 D/C Date: 11/07/2019. "Sacrum: Cleanse with normal saline, apply normal saline moistened gauze with santyl application to wound bed, skin prep surrounding intact skin, and cover with foam dressing daily one time a day for unstagable open wound." Start Date: 10/17/2019 D/C Date 11/07/19 "Pressure Reducing cushion to chair if needed every shift for pressure ulcer prevention." Start Date: 08/21/2019 D/C Date: 11/07/2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 686	Continued From page 28	F 686		

"Off-load heels while in bed every shift for wounds to bilateral feet." Start Date: 08/21/2019 D/C Date: 11/07/2019.

Review of "Order Summary Report" for the period as of August 22, 2019 revealed the following: "Barrier cream to affected area(s) after each incontinent episode and PRN (As Needed) for skin care." Order Date: 08/21/2019 Start Date: 08/21/2019; "Pressure Reducing cushion to chair if needed every shift for pressure ulcer prevention." Order Date: 08/21/2019 Start Date: 08/21/2019.

Review of Medication Review Report for period of "On or After Date: 10/01/2019" included the following:
"May have pressure relieving / reducing device on bed every shift for pressure ulcer prevention." Order Date 11/18/2019 Start Date: 11/18/2019.

On 02/28/2020 at 1:00 p.m., an interview was conducted with the Director of Nursing and when asked if Resident #2 had a wound on his sacrum when admitted to the facility on 08/21/2019, Director of Nursing stated, "No." When asked when the area on the residents sacrum was identified, Director of Nursing stated, "On 08/28/2019 on the weekly skin review." When asked what was the area identified as, Director of Nursing stated, "Usually areas on the sacral area are from pressure." When asked what was the stage of the wound on the sacrum when identified, Director of Nursing stated that she did not know. When asked what treatment was done for the wound on the sacrum in August 2019, Director of Nursing stated, "Nothing is written on the August treatment kardex." The Director of Nursing stated, "All I see is barrier cream." When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 686	Continued From page 29	F 686		

asked for the wound measurements of the sacrum during that time, Director of Nursing stated, "There are no wound measurements for that time frame." When asked when did they start getting wound measurements of the sacrum, Director of Nursing stated, "There are no measurements." When asked if the resident had a treatment ordered for the wound on the sacrum in September 2019, Director of Nursing stated, "No, there is nothing ordered on the TAR (Treatment Administration Record)." Reviewed "Integrated Wound Care" Progress Note of 10/08/2019 with the Director of Nursing concerning unstageable bilateral sacral wounds and the need for Santyl to wounds. When asked who reviews the progress notes of the Wound Nurse Consultant, Director of Nursing stated, "We have a wound nurse that rounds with the Nurse Practitioner from "Integrated Wound Care" and the orders are put in that day. The Nurse Practitioner makes recommendations, MD (Medical Doctor) is made aware for approval and then entered into the system." When asked why the resident didn't have a treatment started for the sacral wound until 10/17/2019, Director of Nursing stated, "I don't have a reason for you." When asked if Resident #2 should have had a treatment to the sacrum before 10/16/2019, Director of Nursing stated, "Yes it should." The Director of Nursing stated that the facility's current Wound Nurse has resigned and currently training her replacement. When asked if Resident #2 was ordered a pressure relieving mattress, Director of Nursing stated, "Should have ordered a pressure relieving mattress on admission." Reviewed orders with the Director of Nursing. No evidence that Resident #2 had orders for a pressure relieving / reducing device on his bed until 11/18/2019. When asked what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 686	Continued From page 30	F 686		

her expectations are of nurses concerning wound care and prevention of skin breakdown, Director of nursing stated, "Got to fix the system. Moving forward current wound nurse is training replacement. Audits are in place, report is due today."

On 02/28/2020 at approximately 2:30 p.m. reviewed complaint with Administrator, Director of Nursing and Corporate Nurse Consultant at pre-exit meeting and made them aware of the concerns.

On 02/28/2020 at approximately 3:00 p.m., the Director of Nursing was asked if she could provide any further information concerning Resident #2's wound and what was done to prevent the wound from declining.

On 02/28/2020 at approximately 4:15 p.m., the Director of Nursing brought the facility Wound Nurse in to meet with Surveyor. An interview was conducted with Licensed Practical Nurse (LPN) #4, Wound Nurse. LPN #4 stated, " Resident #2 did not have any skin breakdown on sacrum on admission, August 21, 2019, he only had arterial wounds on the feet." LPN #4 stated, "About a week or two later he stopped eating well and was non-compliant with wound care, complained of pain as he had neuropathy, terrible pain in his legs." LPN #4 stated, "Once he started declining the Stage 2 showed up on his buttocks, around 09/17/2019." LPN #4 stated, "I provided treatment, Xeroform." When asked was the treatment documented, LPN #4 stated, "No, I have an issue with documenting in the chart and I have been reprimanded." LPN #4 stated, "I do treatments and I have been working as a medication nurse." When asked if there was an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 686	Continued From page 31	F 686		

treatment order for the Xeroform, LPN #4 stated, "No." LPN #4 stated, "I did the wound treatments on Monday through Friday." When asked how would the nurses know to do the treatment on the weekend with it not being documented on the TAR, LPN #4 stated, "They wouldn't." LPN #4 stated that she reported identifying the wound on the Sacrum at the "Standards of Care Review" on 09/18/2019. When asked if weekly measurements were completed, LPN #4 stated, "Weekly wound observations and assessments were inconsistent and were not entered into the system." When asked if Resident #2 was on a pressure relieving mattress, LPN #4 stated, "He was on a air mattress for the Stage 2." When asked if there was a order for the air mattress, the Director of Nursing stated, "No."

On 02/28/2020 at approximately 5:00 p.m., the Director of Nursing and the facility Medical Director came to the conference room to meet with the Surveyor. The Medical Director stated, "The wounds on (Resident Name) were improving." When asked if he was made aware of the unstageable wound on the residents sacrum, Medical Director stated, "Eventually found out, yes ma'am." The Medical Director stated, "The resident went to (Hospital Name) then returned and started declining." Reviewed dates of discharge with the Medical Director. Reviewed that Resident #2 was discharged to the hospital on 11/06/2019 and readmitted to the facility on 11/18/2019 and the unstageable wound on the sacrum was identified by "Integrated Wound Care" nurse on 10/08/2019 which was before discharge to the hospital. The Medical Director stated, "The resident had weight loss and pocketing his food." The Medical Director said that the resident had co-morbidities that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 686	Continued From page 32 would prevent the would from healing. Reviewed that the area of concern was the pressure ulcer on Resident #2's sacrum. Reviewed with the Medical Director that the resident was admitted on 08/21/2019 and the facility stated that the resident did not have any open areas on his sacrum when admitted. On 08/28/2019 the staff stated that Resident #2 developed a Stage 2 on the Sacrum. On 10/08/2019 the "Integrated Wound Care" nurse identified the areas on Resident #2's sacrum as unstageable. Reviewed with the Medical Director that there was no documented evidence that a treatment was provided to the sacral wound until 10/17/2019. The Medical Director provided the Surveyor with copies of his progress notes, labs, dietary notes to review. On 02/28/2020 at approximately 5:30 p.m. the Administrator and Director of Nursing were informed of the findings at the exit meeting. No further information was provided by the facility staff.	F 686		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own	F 776		4/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 776	Continued From page 33 diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure timely Peripheral Vascular Lab (PVL) studies for 1 of 6 residents in the survey sample, Resident #2. The findings include: Resident #2 was originally admitted to the facility on 08/21/2019, discharged to the hospital on 11/06/2019, readmitted to the facility on 11/18/2019 and discharged to the hospital on 12/02/2019. Diagnoses included but were not limited to, Type 2 Diabetes Mellitus and Peripheral Vascular Disease. Resident #2's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 08/28/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #2 as requiring supervision with assistance of 1 for eating, extensive assistance of 1 for bed mobility, dressing, toileting and personal hygiene and total dependence of 1 for bathing and total dependence of 2 for transfer. On 02/27/2020 at approximately 1:00 p.m., Resident #2's Physician Orders Summary and Medication Review Report was reviewed and revealed the following: Order Summary: "Pt. (Patient) to follow up with	F 776	1. PVL study obtained on 10/17/19. 2. All residents requiring diagnostic testing have the potential to be affected. 3. Director of Nursing or Unit Manager will in-service licensed nursing staff on accurate transcription and scheduling of physician orders. DON or designee will audit 10 physician orders daily for 1 week M-F, then weekly X 4, then monthly X 2. 4. The reported results of the audits will be reviewed at the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 776	Continued From page 34	F 776		

(Name) Vascular Specialists, (Doctor Name) Other #7, S/P (Status Post) angio. Wednesday September 25th, 2019 at 12:30 P.M. for Lab Arterial Study Lower extremity with VTS-VB PVL (Peripheral Vascular Lab) Room 4. (Telephone Number). Call for appointment after PVL study done." Order Date: 08/21/2019.

Order Summary: "schedule PVL study for BLE (Bilateral Lower Extremities) 10/07/2019 for f/u (Follow Up) with surgeon, Other #7, ..." Order Date: 09/23/2019 Start Date: 10/27/2019

Order Summary: "PVL study to bilateral lower extremities r/t (Related To) PVD (Peripheral Vascular Disease) Order Date: 10/17/2019

On 02-27-2020 at approximately 3:30 p.m., an interview was conducted with the Director of Nursing and she stated, "(Resident Name) was admitted on 08/21/2019 and had an appointment already scheduled when admitted to see (Doctor Name) Other #7 on 09/25/2019. The appointment was rescheduled due to transportation and was rescheduled for 10/09/2019. Order for PVL studies and bloodwork were obtained and entered into the EMR (Electronic Medical Record). The PVL studies and bloodwork were to be completed on 10/07/2019 so the results could go with the resident to the appointment on 10/09/2019. The studies were incorrectly scheduled for 10/27/2019, it was a transcription error." When asked who schedules the studies, the Director of Nursing stated, "The Charge Nurses schedule the studies and enter them into the EMR." When asked who was the nurse who scheduled the study, Director of Nursing stated, "(Nurse Name) Licensed Practical Nurse (LPN) #1." The Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 776	Continued From page 35	F 776		

of Nursing provided a copy of the order entry placed in the EMR which reads as follows: "Description: schedule PVL study for BLE 10/7/19 for f/u with surgeon (Doctor Name) Other #7 ....." "Alert: This schedule will appear on the administration record as of the specified start date and will remain until administered or the schedule's end date. Start Date: 10/27/2019 End Date: 10/28/2019." When asked if Resident #2 went to the Vascular Surgeon on 10/09/2019, Director of Nursing stated, "Yes." The Director of Nursing stated, "The staff were unable to send the PVL studies because they were not in the system to be done until 10/27/2019. They had not been done." When asked if the studies were ever done, Director of nursing stated, "Yes the studies were done 10/17/2019 and sent to the vascular surgeon but I have no confirmation." The Director of Nursing provided a copy of the "Doppler Report" for Resident #2 dated 10/17/2019. When asked what her expectations are of Nursing staff when scheduling appointments and studies, Director of Nursing stated, " I expect the nurse to correct the situation, figure out how to make sure it doesn't happen again."

On 02/28/2020 at 11:55 a.m., an interview was conducted with LPN #1. LPN #1 stated, "I put in an order for a PVL study for a wrong date. I scheduled the study to pop up on the MAR (Medication Administration Record) for the wrong date. It was an accident."

On 02/28/2020 at approximately 2:30 p.m. the Administrator, Director of Nursing and Corporate Nurse Consultant was made aware of the findings. The facility staff did not present any further information about the finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 776	Continued From page 36	F 776		
	This is a Complaint Deficiency.			
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791		4/13/20

§483.55 Dental Services
The facility must assist residents in obtaining routine and 24-hour emergency dental care.

§483.55(b) Nursing Facilities.
The facility-

§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:
(i) Routine dental services (to the extent covered under the State plan); and
(ii) Emergency dental services;

§483.55(b)(2) Must, if necessary or if requested, assist the resident-
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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F 791	Continued From page 37 dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that facility staff failed to promptly refer one out of 6 sampled residents (Resident #1), to a dentist within three days of knowing about lost dentures; and failed to provide documentation of extenuating circumstances that led to the delay. The findings included: Resident #1 was admitted to the facility on 9/21/18 with diagnoses that included but were not limited to multiple sclerosis, epilepsy, schizophrenia with periods of hypomanic episodes. Resident #1's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 12/4/19. Resident #1 was coded as being cognitively intact in the ability to make decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #1's clinical record revealed that she was admitted to the facility on 9/21/2018. The following was documented on her admission assessment: "Oral- check all that apply: Check	F 791	1. Resident #1 will have dental appointment scheduled on 3/31/2020 with Dental office once the office re-opens related to COVID-19. 2.All residents requiring dental services have the potential to be affected. 3. Staff Development Coordinator will in-service licensed staff, Social Worker,and administration on timely referring residents for dental services within 3 days of knowing about lost dentures; documentation of extenuating circumstances that lead to a delay. MDS-RN will audit the grievance log for complaints of residents lost dentures; audits will be daily for 1 week M-F, then weekly X 4, then monthly X 2. 4. The reported results of the audits will be reviewed at the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 791	Continued From page 38	F 791		

marks were documented next to the following: "C. Denture Upper Full; e. Denture: Lower Full."

Review of Resident #1's admission MDS dated 9/28/19 documented the following under Section L (Oral/Dental Status):
"Check all that apply:
A. Broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable, or loose)
B. No natural teeth or tooth fragments.
C. Abnormal mouth tissue.
D. Obvious or likely cavity or broken natural teeth.
E. Inflamed or bleeding gums or loose natural teeth.
F. Mouth or facial pain, discomfort or difficulty chewing.
G. Unable to examine.
Z. None of the above"

"None of the above" was documented on her admission MDS.

Review of an admission dietary assessment dated 10/12/2018 documented the following: "B5 Oral Health: "A8. Missing teeth. B1. Does the resident have partial dentures?" A "No" was marked for that question. "Does the patient have full plate dentures?" A "No" was marked for that question. "Does the resident have difficulty or pain with chewing?" A "No" was marked for that question. "Diet Order No alteration in texture."

On 4/14/19 a nurses note was written that documented in part, the following: "...ate all meals without difficulty, sister @(at) bedside, concerned about resident's dentures, ask whether she had them when she arrived here, educated family member about her R/P (responsible party) (social service agency) and that she needed to speak

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	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 791	Continued From page 39	F 791		

with the R/P for that information. Sister stated she fully understood information given. Resident stable @ (at) this time."

Facility staff were able to present a copy of a handwritten note dated 4/17/19 by a unknown staff member that documented the following...missing dentures for month per sister."

There was no evidence of any follow up regarding Resident #1's dentures until September of 2019. There was no evidence that Resident #1 was ever referred to a dentist.

On 9/19/19 the following note was documented in part, by the social worker: "...discussed lastly having to reach out to insurance regarding the ability in covering dental work with an in network provider."

On 9/23/19 the following note was documented: "SW (social work) contacted (Name of managed care insurance company) who confirmed that they do no cover dentures. SW sent an email to (Name of social service agency) departments regarding information provided by (Name of managed care insurance company)."

Review of Resident #1's clinical record revealed that she received Medicaid.

Facility staff could not provide an inventory sheet dated back to her admission date (9/21/18). The only inventory sheet provided was from 8/15/2019. Dentures were not listed on the inventory sheet.

There was no evidence that Resident #1 had any weight loss or other nutritional concerns related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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F 791	Continued From page 40	F 791		

the lack of dentures.

On 2/26/20 at 4:08 p.m., an interview was conducted with OSM (other staff member) #5, the facility social worker who was involved with Resident #1. When asked about what she could remember about Resident #1's dentures, OSM #5 stated that Resident #1 did not arrive to the facility with dentures. When asked how that was determined, OSM #5 stated that administration had told her that. OSM #5 stated that back in September of 2019 she did look into Resident #1's insurance and found that her insurance wouldn't cover dentures. OSM #5 stated that she forwarded this information to (Name of Social Service agency). OSM #5 stated that she looked into dentures for Resident #1 because the sister had concerns that her dentures were missing. OSM #5 stated that the resident also "swears up and down" that she had them upon admission to the facility. OSM #5 stated that the sister would be responsible for paying for the dentures. When asked why the sister would be responsible, if (Name of Social Service Agency) was her case manager and she was receiving Medicaid; OSM #5 stated that it was because (Name of Social Service Agency) would not pay for them because Resident #1 could still eat without them. When asked when Resident #1's sister first had concerns regarding dentures, OSM #5 stated that she could not recall. OSM #5 confirmed that Resident #1 had not been to the dentist after the sister's concern for missing dentures.

On 2/27/20 at 11:35 a.m., an interview was conducted with OSM (other staff member) #7, the Social Service Agency case manager. When asked what was going on with Resident #1's dentures, OSM #7 stated that she was told the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

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ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 791	Continued From page 41	F 791		

resident did not lose her dentures at the facility and that her insurance wouldn't cover the dentures. OSM #7 stated that she left it at that because the resident had no problems with eating related to the lack of dentures.

On 2/27/20 at approximately 6:13 p.m., an interview was conducted with the Executive Director (ASM (administrative staff member) #1) . When asked the process if a resident is missing dentures, ASM #1 stated that the facility does not do reimbursement for dentures. ASM #1 stated that they will set up a dental appointment and check for the last time the resident had dentures. ASM #1 then stated the business office will send a MAP adjustment downtown for reimbursement. When asked if this process was done for Resident #1, ASM #1 stated that her insurance wouldn't cover dentures. When asked if Resident #1 was Medicaid, ASM #1 stated that she was. ASM #1 also stated that Resident #1 did not lose her dentures at the facility and that she did not have them upon arrival to the facility. When asked how she determined that Resident #1 did not lose her dentures at the facility when her admission assessment documented that she had dentures, ASM #1 stated it must have been a misdocumentation. ASM #1 stated that the nurse who did the assessment was no longer employed with the facility. ASM #1 stated that the long term care ombudsman had all the information on Resident #1's dentures.

On 2/27/20 at 11:08 a.m., an interview was attempted with the long term care ombudsman. He could not be reached prior to exit.

On 2/28/20 at 11:30 a.m., an interview was conducted with Resident #1. Resident #1 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 791	Continued From page 42	F 791		

that she knows she had her dentures when she arrived to the facility. Resident #1 could not recall when she had lost them. Resident #1 stated that she was not sure if she brought this concern up to any staff but knows her sister did. Resident #1 stated that her lack of dentures does not interfere with eating her regular diet but that she would like to have a new pair of dentures. When asked if it bothered her that she didn't have teeth, Resident #1 stated that she never really thought about her appearance, but then stated "When I stop to think about it, it does bother me a little bit."

On 2/28/20 at 11:37 a.m., an interview was conducted with OSM (other staff member) #2, a second facility social worker. When asked the process if a resident is missing dentures, OSM #2 stated that if the dentures were lost at the facility; he would put in a grievance for the lost dentures and begin looking for the dentures. When asked if the facility would help the resident obtain new dentures, OSM #2 stated, "Possibly, if it is causing problems with eating." OSM #2 stated that administration would take over if it was determined the dentures were lost at the facility. When asked how it would be determined if dentures were lost at the facility if they are not on an inventory sheet, OSM #2 stated that dentures are not usually documented on the inventory sheet but are documented on the admission assessment. When asked the process if a resident wants a new pair of dentures, OSM #2 stated that he would check the resident's insurance to see if dentures are covered or not. OSM #2 stated that insurance companies will not cover dentures if there are no health care concerns related to the lack of dentures. When asked the process if a resident has Medicaid, OSM #2 stated that it would be the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 791	Continued From page 43 process. When asked if the facility would send a MAP adjustment downtown for dentures, OSM #2 stated that they did not do MAP adjustments for dentures. OSM #2 could recall Resident #1's sister saying she lost her dentures at the facility and the facility had to fix it. OSM #2 stated OSM #5 mostly handled the concerns about the dentures. On 2/28/20 at 1:00 p.m., an interview was conducted with OSM #8, the business office manager. When asked if a MAP adjustment had ever been sent for Resident #1, OSM #8 looked through her files and stated that the facility never sent one, that (Name of Social Service Agency) was responsible for handling that process for Resident #1. On 2/28/20 at 2:30 p.m., Administrative staff; ASM #1, the Executive Director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Availability of Services, Dental" documented in part, the following: "Nursing/Social Services will be responsible for making necessary dental appointments. All requests for routine or emergency dental services should be directed to Nursing/Social Services to assure that appointments can be made in a timely manner. Inquiries concerning the availability of dental services should be referred to social services or to the Director of Nursing. Resident with lost or damaged dentures will be promptly referred to a dentist." Complaint deficiency.	F 791		
F 880 SS=D	Infection Prevention & Control	F 880		4/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 880	Continued From page 44 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 880	Continued From page 45 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to maintain infection control practices during incontinence care observation for one of six residents in the survey sample, Resident #1. The findings included: Resident #1 was admitted to the facility on 9/21/18 with diagnoses that included but were not	F 880	1. C.N.A.#5 was in-serviced on proper infection control practices during incontinent care. 2. All residents requiring staff assistance for incontinent care have the potential to be affected. 3. Staff Development Coordinator will in-service certified nursing assistants on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 46 limited to multiple sclerosis, epilepsy, schizophrenia with periods of hypomanic episodes. Resident #1's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 12/4/19. Resident #1 was coded as being cognitively intact in the ability to make decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as being totally dependent on one staff members with bed mobility, locomotion on and off the unit, dressing, toileting, personal hygiene and bathing; and total dependence on two or more staff with transfers. Resident #1 was coded in Section H (Bowel and Bladder) as always being incontinent of bowel and bladder. On 2/27/20 at 8:54 a.m., CNA (certified nursing assistant) #4, CNA #5 and CNA #7 were observed entering Resident #1's room to provide morning ADL (activities of daily living) care and to get her up for the day. Incontinence care was observed with permission from Resident #1. Resident #1 removed her gown and CNA #5 kept Resident #1's bottom half covered. CNA #5 with gloves in place washed Resident #1's chest area. CNA #5 then dried her chest area with a towel and left the towel on her chest to cover up Resident #1. CNA #5 then put on new gloves and washed Resident #1's perineal area. CNA #5 then took a towel and dried her perineal area. CNA #5 left the towel on her perineal area to cover the resident up. Using the same gloves used to wash Resident #1's perineal area, CNA #5 opened Resident #1's closet to look for a bra. CNA #5 rummaged through her closet using the same gloves. CNA #5 then opened a bed side table drawer using the same gloves to look for a bra. CNA #5 stated that she could not find a bra and	F 880	proper infection control practices during incontinent care. Staff Development Coordinator will observe 5 C.N.A.s daily for 1 week M-F, provide incontinent care for residents, then weekly for 4 weeks, and monthly X 2. 4. The reported results of the audits will be audited at the QAPI committee monthly. The QAPI committee is responsible for monitoring of the ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

(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
F 880	Continued From page 47	F 880		

that it must have been in the laundry at that time. CNA #5 then assisted CNA #4 with putting Resident #1's shirt on using the same gloves. CNA #5 then turned Resident #1 using the same gloves to put a brief in place. CNA #5 was then observed using the same gloves to help pull up Resident #1's pants. CNA #5 was then observed using the same gloves to place the hoyer lift pad underneath Resident #1. CNA #5 then removed her gloves, tied up the garbage and linen bags and washed her hands.

On 2/27/20 at 9:24 a.m., an interview was conducted with CNA #5. When asked how to maintain infection control while providing incontinence care, CNA #5 stated that she should wash her hands and put on gloves. When asked when she should wash her hands, CNA #5 stated that she did wash her hands after care. CNA #5 was made aware of the above observations, CNA #5 stated that she did change her gloves and wash her hands after drying Resident #1's perineal area. CNA #5 was again told about the above observations. CNA #5 stated, "Okay."

On 2/28/20 at 2:30 p.m., ASM (administrative staff member) #1, the Executive Director and ASM #2, the Director of Nursing were made aware of the above concerns.