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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED	
		49G075	B. WING			11/15/2022	
NAME OF PROVIDER OR SUPPLIER ABERDEEN GARDENS				STREET ADDRESS, CITY, STATE, ZIP CODE 1421 ABERDEEN ROAD HAMPTON, VA 23666			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 000	An announced Life Sa conducted 11/15/22 i of Federal Regulation 480: Requirements fo Facilities for Persons The facility was surve the LSC 2012 Existin The facility was in cor	are: One Story V(000) y Sprinkled afety Code survey was n accordance with 42 Code , Part 483.150 and 410 to r Intermediate Care with Mental Retardation. yed for compliance using g regulations.	K				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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

Facility ID: VAICFID87