STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495398	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DINWIDDIE HEALTH AND REHAB CENTER	46 DIAMOND DRIVE PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted 4/28/20 through 4/30/20 and 6/17/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 04/28/20 through 04/29/20 and 06/17/2020. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and had implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. On 06/17/2020, the census in this 60 bed certified facility was 54. At the time of the survey 52 residents had been tested with 2 positive results. Two residents declined to be tested. All staff have been tested with 2 results being positive. No other staff or residents had been tested at the time of the survey.	F 000		

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