

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

PRINTED: 06/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495398	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2020
NAME OF PROVIDER OR SUPPLIER DINWIDDIE HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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

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.