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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41449 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to submit a demand bill, as requested on the SNF ABN notice (Skilled Nursing Facility Advance Beneficiary Notice) issued to 2 Residents (Resident #4- R4 and Resident #36- R36) in a survey sample of 3 Residents, reviewed for such notices. The findings included: For R4 and R36, the facility staff failed to continue skilled therapy services and submit a claim to Medicare for a coverage decision, as the resident and/or their representatives requested on the SNF ABN form. On 2/5/24, the facility administration was asked to provide the NOMNC (notice of Medicare non-coverage) and SNF ABN forms provided to R4 and R36. These notices were received and reviewed. Review of the forms and clinical record of each resident revealed the following: 1. According to the clinical record, R4 was receiving skilled therapy services from 11/29/23-12/21/23. On 12/19/23, R4 was issued a NOMNC and SNF ABN. R4 selected option 1 which read, I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN. The care listed on the SNF ABN form that was listed as not being covered read, In patient stay at facility transitioning to LTC [long-term care] in facility. 2. According to the census tab of R36's clinical record, R36 was receiving skilled care with Medicare as the primary payor from 11/22/23-1/10/24. On 1/8/24, R36 was issued a SNF ABN and NOMNC forms. R36 selected option 1 on the SNF ABN which stated, I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN. The care listed on the SNF ABN form that was listed as not being covered read, In patient stay at facility transitioning to LTC [long-term care] in facility. (continued on next page)

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.

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

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/24 at 08:27 a.m., Surveyor #1 met with Employee #4, the business office manager (BOM) who confirmed R4 and R36 were skilled for therapy services on the days noted above. The BOM provided copies of the UB04 [billing document submitted to Medicare for payment] for R4 and R36. The UB was reviewed, and the BOM confirmed that therapy services ended for R4 on 12/21/23 and for R36 they ended on 1/11/24. The BOM was asked if either resident had requested a demand bill and the BOM stated no and confirmed no further charges were submitted to Medicare following the end of the skilled stays. When asked how she is notified if a resident were to request a demand bill, she stated that the Social Worker (SW) would let her know. On 2/6/24 at 8:46 a.m., Surveyor #1 met with Employee #3, the social worker (SW). The SW was asked to explain the SNF ABN form and what the 3 options on the form meant. The SW said, Option 1 is to bill Medicare and if they [the facility] bill Medicare, they [the resident] get a summary. When asked what would be billed to Medicare as indicated on the form, the SW said, If they are coming off of their skilled services and they are going to be private pay, medication and certain wound care could be billed to Medicare first. The SW was asked, does it have anything to do with their skilled services? The SW said, no because their skilled services are needing, this is once their skilled services end. The SW was asked what the process after a resident is selects one of the options on the SNF ABN form and if she has any special steps to take dependent upon the option chosen. The SW said, No, I have to upload it into the system [resident's clinical record] and I notify everyone that the NOMNC and ABN is uploaded in the system. When asked if she has to notify the business office, therapy or nursing of which option was selected and if it changes what care is provided to the resident she stated, No, once I upload it and let them know it is uploaded they can go into the system and look at it, but indicated it had no bearing on the care and services they would receive. On 2/6/24 at approximately 10 AM, the surveyor met with Employee #5, the therapy manager. The therapy manager provided therapy service logs for R4 and R36, which revealed therapy services did not continue after the skilled services ended. When asked what is done if a resident selects that they want a demand bill submitted, the therapy manager said, We continue therapy and Medicare is billed. The therapy manager stated that she is made aware of any requests for a demand bill or appeal by the social worker. The therapy manager also confirmed that R4 and R36 had not requested a demand bill or appeal to her knowledge and therefore services did not continue. The facility policy titled; Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) was reviewed. This policy read in part, .The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility . The facility policy also stated, . Information on the ABN (Form CMS-R-131) can be found on the ABN webpage: http://www.cms.gov/Medicare/Mediare-General-Information/BNI/ABN.html . In the CMS document, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN). This instruction sheet read in part, .There are 3 options listed on the SNFABN with corresponding check boxes. The beneficiary must check only one option box . (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CMS instructions regarding when a resident selects option 1, read in part: .When the beneficiary selects Option 1, the care is provided, and the SNF must submit a claim to Medicare. The SNF must notify the beneficiary when the claim is submitted. This will result in a payment decision, and if Medicare denies payment, the decision can be appealed. SNFs aren't permitted to collect money for Part A services until Medicare makes an official payment decision on the claim . Accessed online at: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-snf-abn On 2/6/24, during an end of day meeting, the above findings were discussed with the facility Administrator, Director of Nursing and Corporate Clinical Specialist. On 2/7/24, the facility Administrator provided the survey team with evidence that the SW had received education on the SNF ABN and NOMNC forms following the end of day meeting with the survey team held on 2/6/24. No further information was provided.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41449 Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy for 3 Residents (Resident #18- R18, Resident #210-R210, and Resident #211-R211) in a survey sample of 37 Residents and for 2 employees in a sample of 25 staff records reviewed. The findings included: 1. For R18, R210, and R211, all who reported allegations of abuse, the facility staff failed to report the allegations of abuse to the required agencies, failed to have evidence of an investigation being conducted and for R210 and R211, failed to take measures to protect the residents while an investigation is being conducted. On 2/6/24 and 2/7/24, a review was conducted of facility documents to include allegations of abuse. The documents revealed the following: a. On 3/8/23, R18 reported an allegation of verbal abuse from a staff member, CNA #2. On 3/8/23, the facility administrator notified the state survey agency and the ombudsman, but did not notify adult protective services, of the allegation. Once an investigation was conducted, the administrator again notified the state survey agency and the ombudsman of the findings but didn't report to adult protective services, nor the department of health professions, since the allegation was substantiated, and CNA #2 was terminated for their actions towards R18. b. On 3/3/23, R210 reported an allegation of abuse/mistreatment involving CNA #3. The facility administration permitted CNA #3 to continue to work and took no measures to protect R210, while an investigation was being conducted. The facility also failed to report the allegation and result of their investigation to adult protective services and local law enforcement. The facility had no evidence to indicate that an investigation was conducted with regards to R210's report of abuse/mistreatment. c. On 4/24/23, R211 reported an allegation of abuse involving CNA #3. Following the allegation, the facility permitted CNA #3 to continue to work and had no evidence of any measures taken protect R211 from an alleged perpetrator, while an investigation was conducted. The facility also failed to report the allegation and the result of their investigation to adult protective services and the local law enforcement agency. The facility had no credible evidence to indicate an investigation was conducted. On 2/7/24, a review was conducted of CNA #3's personnel file and payroll/time card punches. The review revealed CNA #3 was no longer employed at the facility at the time of survey. There was no documentation within the personnel file to indicate CNA #3 had been the subject of abuse investigations involving two residents in March and April 2023. The time cards also revealed that CNA #3 was permitted to continue working, which allowed continued access to Residents while the allegations were investigated to determine if they had in fact occurred. (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/24, at 11:03 a.m., Surveyor #1 met with the facility Administrator and Corporate Clinical Specialist (CCS). The Administrator was asked to describe the facility's response and protocol when a Resident reports an allegation of abuse. The Administrator stated, We immediately investigate, I notify my regional consultant who can assist with the investigation. I fill out a FRI [facility reported incident/report] send it to the state [state survey agency]. The administrator was asked to clarify who is notified of the allegation with regards to outside agencies, she stated, The Office of Licensure and Certification [state survey agency], Adult Protective Services (APS) and Ombudsman. If needed DHP [department of health professions/board of nursing]. During the above interview the administrator was asked what they do to protect the resident from any alleged perpetrators. The Administrator said, We suspend the employee(s) pending investigation- if the person was another resident, we separate or relocate them. Then we continue to conduct investigation- if the resident is of sound mind, we interview the resident, interview employees, other residents . When asked if the steps taken and evidence is documented, the administrator said, Yes, I do. The administrator went on to say, Once the investigation is complete, I see if it was substantiated or unsubstantiated and send FRI to OLC, APS, Ombudsman and DHP if needed. Surveyor #1 asked why is it important to notify DHP? The Administrator said, Because if employee has done wrong, they can investigate too. On 2/7/24 at 11:15 a.m., the Administrator and CCS, were made aware of the allegations of abuse involving R18, R210, and R211 and the missing elements to each allegation. They were asked to see if they could find any additional evidence that perhaps the surveyor had missed. On 2/7/24 at approximately 12:15 p.m., the CCS returned to Surveyor #1 and reported that they did not have any of the missing elements noted above. She went on to say that the administrator who was at the facility at the time wasn't following the facility's policy and processes and should have notified APS of each of the allegations and results of the investigations. There should have been evidence of the investigations conducted and CNA #3 should have been suspended during each of the investigations. Review of the facility's policy titled; Abuse Prevention was conducted. The policy read in part, . V. Investigation. A. Designated staff will immediately review and investigate all reported incidents or allegations. B. Investigations will include collecting physical and documentary evidence which may include taking photographs, as necessary, interviewing residents and staff with personal knowledge of the incident or alleged incident, requesting witness statements, collecting relevant evidence, and documenting each step taken during the investigation . Also in the facility's policy, the following was read in part, . VI. Protection. A. The center will immediately assess the resident, notify the physician and responsible party, and take steps to protect the resident from further harm or incident . VII. Reporting/Response. A. Allegations of Abuse, Neglect, Misappropriation of Property, Exploitation: The center administrator, DON [director of nursing], or designee, must timely report all alleged incidents of abuse, neglect, exploitation, or mistreatments including injuries of unknown origin, misappropriation of property and unusual occurrences using the Virginia Office of Licensure & Certification Facility Reported Incident form to the (OLC) and to all other required agencies including Adult Protective Services (APS), and local law enforcement . (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/24, during a pre-exit meeting, the facility administrator, director of nursing and CCS, were again made aware of the above findings. No further information was provided. 49371 2. The facility staff failed to obtain criminal background checks for 2 of 25 employee records reviewed. On 2/7/24 at approximately 11: 00 AM, a review of 25 employee files revealed that other staff #6 and LPN #6 did not have criminal background checks in their files. On 2/7/24 at 12:50 PM, the human resource manager (administrative staff #7) was interviewed and verbalized that the background checks had not been done for other staff #6 and LPN #6. Review of the Abuse Prevention Policy (revised 10/7/22) for the facility documented that Criminal background checks will be obtained on all new employees in accordance with Virginia Law. If contract staff is used (i.e., housekeeping, dietary, rehab, etc.) the vendor providing the contracted service will be asked to perform criminal background checks for all staff assigned to the center and to make the criminal background check information available to the center prior to the start of the center assignment. On 2/7/24 at 1:36 PM, during the end of the day meeting, the administrator, DON and clinical nurse consultant were informed of these findings. No further information was provided.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41449 Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to report to Adult Protective Services (APS) for 3 Residents (Resident #18- R18, Resident #210-R210, and Resident #211-R211) in a survey sample of 37 Residents. The findings included: For R18, R210, and R211, all who reported allegations of abuse, the facility staff failed to report the allegations of abuse to APS and the results of an investigation. On 2/6/24 and 2/7/24, a review was conducted of facility documents to include allegations of abuse. The documents revealed the following: a. On 3/8/23, R18 reported an allegation of verbal abuse from a staff member, CNA #2. On 3/8/23, the facility administrator notified the state survey agency and the ombudsman, but did not notify adult protective services, of the allegation. Once an investigation was conducted, the administrator again notified the state survey agency and the ombudsman of the findings but didn't report to adult protective services, nor the department of health professions, since the allegation was substantiated, and CNA #2 was terminated for their actions towards R18. b. On 3/3/23, R210 reported an allegation of abuse/mistreatment involving CNA #3. The facility failed to report the allegation and result of their investigation to adult protective services. c. On 4/24/23, R211 reported an allegation of abuse involving CNA #3. Following the allegation, they failed to report the allegation and the result of their investigation to adult protective services. On 2/7/24, at 11:03 a.m., Surveyor #1 met with the facility Administrator and Corporate Clinical Specialist (CCS). The Administrator was asked to describe the facility's response and protocol when a Resident reports an allegation of abuse. The Administrator stated, We immediately investigate, I notify my regional consultant who can assist with the investigation. I fill out a FRI [facility reported incident/report] send it to the state [state survey agency]. The administrator was asked to clarify who is notified of the allegation with regards to outside agencies, she stated, The Office of Licensure and Certification [state survey agency], Adult Protective Services (APS) and Ombudsman. If needed DHP [department of health professions/board of nursing]. On 2/7/24 at 11:15 a.m., the Administrator and CCS, were made aware of the allegations of abuse involving R18, R210, and R211 and the missing elements to each allegation. They were asked to see if they could find any additional evidence that perhaps the surveyor had missed. On 2/7/24 at approximately 12:15 p.m., the CCS returned to Surveyor #1 and reported that they did not have any evidence that the above allegations had been reported to APS as required. The CCS confirmed that they should have been. (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled; Abuse Prevention was conducted. The policy read in part, . VII. Reporting/Response. A. Allegations of Abuse, Neglect, Misappropriation of Property, Exploitation: The center administrator, DON [director of nursing], or designee, must timely report all alleged incidents of abuse, neglect, exploitation, or mistreatments including injuries of unknown origin, misappropriation of property and unusual occurrences using the Virginia Office of Licensure & Certification Facility Reported Incident form to the (OLC) and to all other required agencies including Adult Protective Services (APS), and local law enforcement . On 2/7/24, during a pre-exit meeting, the facility administrator, director of nursing and CCS, were again made aware of the above findings. No further information was provided.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41449 Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to invetigate allegations of abuse involving 2 Residents (Resident #210-R210, and Resident #211-R211) in a survey sample of 37 Residents. The findings included: 1. For R210, and R211, all who reported allegations of abuse, the facility staff failed to have any credible evidence of an investigation being conducted. On 2/6/24 and 2/7/24, a review was conducted of facility documents to include allegations of abuse. The documents revealed the following: a. On 3/3/23, R210 reported an allegation of abuse/mistreatment involving CNA #3. The facility had no documented evidence to indicate that an investigation was conducted with regards to R210's report of abuse/mistreatment. b. On 4/24/23, R211 reported an allegation of abuse involving CNA #3. The facility had no credible evidence to indicate an investigation was conducted. On 2/7/24, at 11:03 a.m., Surveyor #1 met with the facility Administrator and Corporate Clinical Specialist (CCS). The Administrator was asked to describe the facility's response and protocol when a Resident reports an allegation of abuse. The Administrator stated, We immediately investigate, I notify my regional consultant who can assist with the investigation. I fill out a FRI [facility reported incident/report] send it to the state [state survey agency]. The administrator was asked to clarify who is notified of the allegation with regards to outside agencies, she stated, The Office of Licensure and Certification [state survey agency], Adult Protective Services (APS) and Ombudsman. If needed DHP [department of health professions/board of nursing]. During the above interview the administrator was asked what they do to protect the resident from any alleged perpetrators. The Administrator said, We suspend the employee(s) pending investigation- if the person was another resident, we separate or relocate them. Then we continue to conduct investigation- if the resident is of sound mind, we interview the resident, interview employees, other residents . When asked if the steps taken and evidence is documented, the administrator said, Yes, I do. On 2/7/24 at 11:15 a.m., the Administrator and CCS, were made aware of the allegations of abuse involving R210, and R211 and the lack of evidence of an investigation being conducted. They were asked to see if they could find any additional evidence that perhaps the surveyor had missed. On 2/7/24 at approximately 12:15 p.m., the CCS returned to Surveyor #1 and reported that they did not have any credible evidence to indicate an investigation had been conducted. She went on to say that the administrator who was at the facility at the time wasn't following the facility's policy and processes and should have documented evidence of the investigation. (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled; Abuse Prevention was conducted. The policy read in part, . V. Investigation. A. Designated staff will immediately review and investigate all reported incidents or allegations. B. Investigations will include collecting physical and documentary evidence which may include taking photographs, as necessary, interviewing residents and staff with personal knowledge of the incident or alleged incident, requesting witness statements, collecting relevant evidence, and documenting each step taken during the investigation . On 2/7/24, during a pre-exit meeting, the facility administrator, director of nursing and CCS, were again made aware of the above findings. No further information was provided.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation,staff interview and clinical record review the facility failed to develope a baseline care plan for one resident out of 37. The findings included: The facility failed to complete a baseline care plan in the area of nutrition for Resident #160 (R160). R160 was admitted to the facility on [DATE]. Diagnoses for R160 included but not limited to dementia, urinary track infection with sepsis, and hypertension. R160 due to being a new admission in the facility, no Minimum Data Set Assessment (MDS) had been completed On 2/5/24 at 1:15 p.m., interview was conducted with R160 and family was present in the room. The family member had concerns with lack of communication with the staff to know R160 care needs. The family member was concerned with staff sitting the tray down and walking out and not making sure R160 was able to eat. Certified Nursing Assistant (CNA4) was observed picking up R160's meal tray, the family member asked CNA4 if it had been communicated that R160 needed assistance with meals. CNA#4 stated, I wasn't aware R160 needed help with eating. On 2/6/24 R160's clinical record was reviewed and evidenced a nutrition care plan had not been completed. A Registered Dietitian note (dated 2/3/24) documented that R160 needed assistance with meals. On 2/6/24 at 2:44 p.m., CNA # 1 (CNA1) was interviewed and verbalized I get a report from the charge nurse and then when the resident arrives to the facility will go and speak with the resident and find out their needs. CNA1 verbalized when I serve a meal to the resident I will ask the resident if assistance is needed and if the family is present, I still assist unless the resident or family says they want to help the resident. On 2/6/24 at 3:28 interviewed conducted with MDS coodinator and Nurse consultant. Nurse consultant verbalized that the expectation of the baseline assessment would be to have the nutrition area completed and that the nurse on the unit does the initial assessment and then dietary follows up, based on the informaion provided by the nurse. On 2/6/24 at 4:22 p.m., an interview was conducted with the RD. The RD verbalized that I tell the nurses who needs assistance with meals and the nurses place residents names on a list. RD verbalized that R160 needed assistance with meals from the staff. On 2/7/24 at 8:30 a.m., interview was conducted with CNA4. CNA4 verbalized that each unit has a list of the residents that need assistance with feeding but this unit's list is not here right now. On 2/6/24 at 4:32 at the end of day meeting with Administrator, Nurse consultant and Director of Nursing (DON) were made aware of the above findings. No further information was provided.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 28106 Based on observation, staff interview and clinical record review, the facility failed to meet professional standards of practice for one of 37 residents. The facility failed to accurately implement tube feeding physician order for Resident #7 (R7). The Findings Include: Diagnoses for R7 included Dysphasia, cerebral infarction, dementia, and feeding tube. The most current MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 1/26/24. R7 was assessed with a cognitive score of 3 indicating severely cognitively impaired. On 2/5/24 at 11:15 AM an observation of R7 was made. R7 was lying in bed, feeding tube apparatus (IV pole and feeding tube pump) was noted besides the bed but not being used at this time. When asked about the feeding tube, R7 said that the facility used it but was uncertain how long it had been in use and did not give any other information. Review of R7's physician order dated 1/24/24 documented: Give isosource 1.5 60cc/hr [60 cubic centimeters per hour] over 20 hrs [hours] or until 1200cc is delivered. On 2/5/24 at 4:00 PM R7 was again observed not receiving tube feeding. 02/05/24 04:04 PM license practical nurse (LPN #3, assigned to R7) was interviewed regarding tube feeding. LPN #3 verbalized the tube feeding had been stopped at 8:00 AM and will not start again until 8:00 PM and had received this information during report given by the night nurse. LPN #3 was asked to review R7's order pointing out that the tube feeding was supposed to run for 20 hours for a total of 1200cc's. LPN #3 verbalized unawareness to the time period and said that maybe R7 had received 1200cc's. On 2/05/24 at 4:33 PM the director of nursing (DON) and nurse consultant (administrative staff, AS #6) was provided the above information and it was explained that R7's tube feeding had not been running for the past 9 hours. The DON and AS #6 reviewed R7's order, commenting they would have to take a closer look at the order. On 2/06/24 2:45 PM the DON said that the tube feeding order for R7 was entered with wrong start and stop times resulting in not getting the proper amount of tube feeding ordered and nurses didn't catch the error. On 2/06/24 at 2:46 PM an interview was conducted with the registered dietitian (other staff, OS #1). OS #1 verbalized entering the order and had mistakenly entered the tube feeding to start at 8:00 PM and should have been started at 12:00 PM. (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/06/24 at 4:32 PM the above finding was presented to the administrator, DON, and AS #6 and was asked, what is the process for ensuring accuracy of new orders. AS #6 verbalized the clinical team reviews orders every 24 hours Monday through Friday and reviews any weekend orders on Monday and the night shift should be looking at any new orders to ensure accuracy and felt that this order had been missed. No other information was provided prior to exit conference on 2/7/24.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview and clinical record review, the facility staff failed to change insulin administration times as ordered by physician for one of thirty-seven residents in the survey sample (Resident #33). A provider approved pharmacy recommendation to change Resident #33's Humulin insulin administration times was not implemented for over three months. The findings include: Resident #33 (R33) was admitted to the facility with diagnoses that included cerebral infarction, diabetes, congestive heart failure, gastroesophageal reflux disease, chronic kidney disease and atrial fibrillation. The minimum data set (MDS) dated [DATE] assessed R33 with severely impaired cognitive skills. R33's clinical record documented a physician's order dated 11/21/23 for Humulin 70/30 insulin (100 units/milliliter) with instructions to administer 30 units two times per day for diabetes management. R33's medication administration record (MAR) documented the Humulin was scheduled/administered at 9:00 a.m. and 9:00 p.m. each day. R33's clinical record included a pharmacy recommendation dated 10/5/23 documenting, The resident [R33] has an order for Humulin 70/30. She is receiving a dose at 9:00 am and a dose at 9:00 pm. This is a mixture of insulin with both short-acting and long-acting insulin. The short acting insulin is used to cover a meal. The Humulin 70/30 insulin is typically administered twice a day 30 minutes before breakfast and 30 minutes before dinner. This allows the short acting insulin portion to be used for the mealtime coverage . RECOMMEND changing the administration times to be given before breakfast and before dinner . (sic) The nurse practitioner signed the pharmacy report on 10/13/23 and documented approval to change the Humulin 70/30 administration times to before breakfast and before dinner as recommended by the pharmacist. There was no physician's order entered to change R33's Humulin administration times as recommended/approved by the provider. R33's MARs from 10/14/23 through 2/6/24 documented no change to the Humulin 70/30 insulin administration times with continued administration at 9:00 a.m. and 9:00 p.m. each day. On 2/6/24 at 2:30 p.m., the director of nursing (DON) was interviewed about implementing the approved change to R33's Humulin administration times. The DON stated the pharmacy recommendation was not carried through. The DON stated the nurse practitioner accepted/approved the timing change as recommended by the pharmacist, but no physician's order was entered into the electronic heath record changing the administration times on the MAR. This finding was reviewed with the administrator, DON and nurse consultant during a meeting on 2/6/24 at 4:30 p.m. with no other information provided prior to the end of the survey.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 28106 Based on observation, staff interview and clinical record review, the facility failed to maintain nutritional parameters via a feeding tube for one of 37 residents. Resident #7 (R7) was not receiving the proper amount of tube feeding as ordered. The Findings Include: Diagnoses for R7 included Dysphasia, cerebral infarction, dementia, and feeding tube. The most current MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 1/26/24. R7 was assessed with a cognitive score of 3 indicating severely cognitively impaired. On 2/5/24 at 11:15 AM an observation of R7 was made. R7 was lying in bed, feeding tube apparatus (IV pole and feeding tube pump) was noted besides the bed but not being used at this time. When asked about the feeding tube, R7 said that the facility used it but was uncertain how long it had been in use and did not give any other information. Review of R7's physician order dated 1/24/24 documented: Give isosource 1.5 60cc/hr [60 cubic centimeters per hour] over 20 hrs [hours] or until 1200cc is delivered. Review of the clinical record indicated R7 had a feeding tube due to severe dysphagia and esophagitis making it hard to swallow, was on a pleasure foods with pureed diet with thickened liquids along with supplements including Pro-stat. Review of R7's weights indicated fluctuations with weights due to pitting edema which R7 was receiving diuretics. The weight range from beginning and ending date documented was; 12/8/23 171.4 pounds and current weight on 2/5/24 was 182.6 pounds. On 2/5/24 at 4:00 PM R7 was again observed not receiving tube feeding. 02/05/24 4:04 PM license practical nurse (LPN #3, assigned to R7) was interviewed regarding tube feeding. LPN #3 verbalized the tube feeding had been stopped at 8:00 AM and will not start again until 8:00 PM and had received this information during report given by the night nurse. LPN #3 was asked to review R7's order pointing out that the tube feeding was supposed to run for 20 hours for a total of 1200cc's. LPN #3 verbalized unawareness to the time period and said that maybe R7 had received 1200cc's. On 2/05/24 at 4:33 PM the director of nursing (DON) and nurse consultant (administrative staff, AS #6) was provided the above information and it was explained that R7's tube feeding had not been running for the past 8 hours. The DON and AS #6 reviewed R7's order, commenting they would have to take a closer look at the order. On 2/06/24 2:45 PM the DON said that the tube feeding order for R7 was entered with wrong start and stop times resulting in not getting the proper amount of tube feeding ordered and nurses didn't catch the error. (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/06/24 at 2:46 PM an interview was conducted with the registered dietitian (other staff, OS #1). OS #1 verbalized entering the order and had mistakenly entered the tube feeding to start at 8:00 PM and should have been started at 12:00 PM. On 2/06/24 at 4:32 PM the above finding was presented to the administrator, DON, and AS #6 and was asked, what is the process for ensuring accuracy of new orders. AS #6 verbalized the clinical team reviews orders every 24 hours Monday through Friday and reviews any weekend orders on Monday and the night shift should be looking at any new orders to ensure accuracy and felt that this order had been missed. No other information was provided prior to exit conference on 2/7/24.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49371 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the medication error rate was less than 5 %. There were 2 medication errors in 32 opportunities, resulting in an 6.25% error rate. The findings included: On 2/5/24 at 4:03 PM, licensed practical nurse #4 (LPN #4) was observed during the medication administration. LPN #4 pulled pantoprazole 40 mg tablet delayed release from the med cart, crushed it and administered it to resident # 39 (R39). R39's clinical record documented a physician's order dated 1/24/24 for pantoprazole sodium oral tablet delayed release 40 mg, give 1 tablet 2 times a day for treatment of gastroesophageal reflux disease. On 2/5/24 at 4:32 PM, LPN #4 was questioned if pantoprazole should be crushed or taken whole. LPN #4 stated that she crushed the pantoprozole because there was a note to crush all meds for R39, then stated that it should be taken whole due to pantoprozole being delayed release. On 2/6/24 at 10:22 AM, the director of nursing (DON) and the clinical nurse consultant were interviewed, and both stated that pantoprazole should have been given whole due to the medication being delayed release. The DON provided drug information for pantoprazole that was received from the facility pharmacist documenting that pantoprazole oral tablets should be swallowed whole, do not split, crush, or chew. On 2/7/24 at 1:35 PM, during the end of day meeting, the facility administrator, DON and clinical nurse consultant were made aware of the above observations and medication error rate of 6.25%. No further information was provided/received. 49456 2. For Resident # 2 (R2) the facility staff failed to administer a medication per physician order. On 2/6/24 at 8:33 a.m., LPN #7 (LPN7) was observed during the medication administration. LPN7 pulled and prepared the medications for R2. During prepartions of medications, LPN7 noted there were two medications not available in medication cart and will need to pull from the stat box. LPN7 went into R2's room and was observed administering the medications and then returned to the medication cart. LPN7 then went to the medication storage room and pulled Potassuim 20 meq tab, LPN7 verbalized that R2 is to receive two 10 meq Potassium pills equaling 20 meq, but the stat box only has 20 meq of Potassium so I will give one of them. LPN7 returned to R2 and administered the medication. On 2/6/24, during the clinical record review, when comparing the medications administered to the medication administration record it was noted that LPN7 signed off to have administered Potassium 20 meq two tablets by mouth. (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/24 at 9:21 a.m., interview was conducted with the Nurse Consultant and Director of Nursing. Nurse consultant reviewed the Potassium order and verbalized a total of 40 meq should have been given per pychician order. On 2/6/24 at 9:26 a.m., an audit order report was reviewed. On 2/6/24 at 6:30 a.m., an order was completed for Potassium Chloride ER Oral Tablet Extended Release 20 MEQ Give 2 tablets by mouth one time only for Potassium Supplement for 1 day.[NAME] On 2/6/24 at 4:32 p.m., during the end of the day meeting the facility Administrator, Director of Nursing and Nurse Consultant were made aware of the above findings and no more information was provided or received,

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation, facility documentation and staff interview the faciliy failed to remove expired biologicals in one of two medication rooms. Findings were: The facility failed to ensure that expired biologicals were not available for use. During a medication storage room review conducted on [DATE] at 11:12 a.m., the medication room on 100 unit was reviewed with license practical nurse(LPN#5, LPN5). A biological product (Liquid Urine Controls) had expired on [DATE] that was being stored in the refrigerator. LPN5 also reviewed the biololgcial product, expiration date and verbalized that it had expired. LPN5 then removed the biological product from the the medication storage room. A facility policy titled, Medication Storage, read in part Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier . On [DATE] at 4:32 p.m., the above information was presented to the Director of Nusing, Administrator and the Nurse Consultant. No further information was provided.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49456 Based on observation, staff interview and facility documentation review the facility staff failed to store food properly in the main kitchen. The findings included: The dietary staff failied to label food products with an open date and the use by date label. On 2/5/24 at 11:00 a.m., obersavations were made in the main kitchen and a tour of the main kitchen was conducted with the dietary manager (other staff #7, OS7). In the dry ingredient storage there was a package of buttermilk pancake mix that was wrapped in plastic wrap and on the shelf with no open date or used by date label on the item. In the bread storage there were hot dog buns in a ziploc bag without a label showing the open date or use by date on the item. In the stand alone cooler there were 3 cups filled, covered with a lid and on a tray and the items had no labeling to indicate the product, date prepared, date opened or a use by date. OS7 identified the items as a cup of skim milk and 2 cups of whole milk. On 2/5/24 at 11:35 a.m., OS7 was interviewed about the unlabeled items and stated that per policy it should be labeled when opened. Should be label by guidelines with the product, open date and use by date on the item. Review of the facility policy titiled,Safe Food and Supply Storage, read in part .dry goods that are opened must be securely closed and product identified and packaged foods which require refrigeration after opened must have an opened and use by date. On 2/6/24 at 4:32 p.m., during the end of day meeting, the facility Administrator, Nurse consultant and Director of Nursing were made aware of the above observations and concerns. No further information ws provided or received.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview and clinical record review, the facility staff failed to document a complete and accurate clinical record for one of thirty-seven residents in the survey sample (Resident #22). Resident #22's dialysis communication form was incomplete. The findings include: Resident #22 (R22) was admitted to the facility with diagnoses that included end stage renal disease with hemodialysis, anemia, benign prostatic hyperplasia, diabetes, chronic kidney disease, and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed R22 as cognitively intact. On 2/5/24 at 2:45 p.m., R22 was interviewed about quality of life/care in the facility. R22 stated during the interview that he went out to dialysis twice per week. R22 stated he took a communication book with him to/from dialysis at each visit. R22's dialysis communication sheet dated 2/6/24 documented the resident left the dialysis center on 2/6/24 at 12:55 p.m. The facility's portion of this 2/6/24 communication form was incomplete. The entire top section of the form labeled, Facility Completes This Information was blank. Spaces to document pre-treatment and post-treatment vital signs and weights were blank. Sections for pain presence, type of vascular access, any acute problems since last treatment, any medication changes and any needed labs were blank. There was no nurse name and/or signature. The bottom section of the form was completed by the dialysis center and had all sections completed. On 2/6/24 at 1:38 p.m., the licensed practical nurse (LPN #2) caring for R22 was interviewed about the dialysis communication form. LPN #2 stated R22 left on dialysis days prior to 7:00 a.m. and was already gone to dialysis when she reported to work today (2/6/24). LPN #2 stated the top section of the communication form was supposed to be completed prior to the resident leaving for dialysis and again post-dialysis. LPN #2 stated nurses were responsible for assessing the resident and completing the form as listed. LPN #2 stated she did not know why the form was not completed. On 2/6/24 at 2:04 p.m., the director of nursing (DON) was interviewed about R22's incomplete dialysis communication form. The DON stated the dialysis form was supposed to be completed by nursing prior to/after dialysis treatment and the form was used for communication of the resident's status with the dialysis center. R22's plan of care (revised 11/10/23) listed the resident required hemodialysis. Included in interventions to avoid dialysis complications was, .Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes . This finding was reviewed with the administrator, DON and nurse consultant during a meeting on 2/6/24 at 4:30 p.m. with no other information provided prior to the end of the survey.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49371 Based on observation, staff interview, and facility documentation review, the facility staff failed to follow infection control practices for hand hygiene on 1 of 3 nursing units, unit 3. The findings included: The facility staff failed to adhere to standard precautions and perform hand hygiene between residents during medication administration. On 2/5/24 at 4:03 PM observations of medication administration and blood glucose testing were conducted with licensed practical nurse #4 (LPN #4). The following was observed: LPN #4 prepared medication for one resident, administered the medication, assisted the resident with water to drink then returned to the medication cart. No hand hygiene was performed. LPN #4 then applied gloves (without performing hand hygiene) went into a different resident room and performed blood glucose testing. After the testing was complete LPN #4 removed gloves and applied alcohol-based hand sanitizer. On 2/5/24 at 4:32 PM, LPN #4 was questioned about hand hygiene between resident contact, LPN #4 stated that she usually uses alcohol hand rub but didn't this time. LPN #4 stated that she is used to having it in the hall outside the residents room. On 2/6/24 at 4:13 PM the DON was interviewed. The DON stated she expected hand hygiene to be completed between every med pass and every resident. Review of the facility Hand Hygiene policy was conducted. Per the facility policy: All employees will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all employees working in all locations within the facility. Hand hygiene includes handwashing with soap and water and the use of alcohol-based hand rubs. Per the facility policy some of the clinical circumstances requiring employees to implement hand hygiene practices include when coming on duty, when hands are visibly soiled, before and after direct resident care/contact, before and after any invasive procedure, before and after eating or handling food, and after handing soiled equipment or utensils. On 2/7/24 at 1:35 PM, during the end of day meeting, the facility administrator, DON, and clinical nurse consultant were made aware of the above observations and concerns. No additional information was provided.

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 41449 Based on observation, Resident interview, facility staff interview, and facility documentation review, the facility staff failed to ensure a call bell which relays the call to a centralized work area was present for one Resident (Resident #3- R3) in a survey sample of 37 Residents. The findings included: For R3, the facility staff failed to ensure the call bell at the bedside was functional. On 2/5/24 at 11:53 a.m., an interview was conducted with R3. R3 was sitting in a wheelchair at the side of the bed in their room. R3 was asked to engage the call bell, which they did. However, observations revealed that when pressed the call bell did not illuminate the light outside of the room door and gave no auditory signal to the staff. The surveyor pressed the call bell with the same result. On 2/5/24 at 3:06 p.m., an interview and observations were conducted with R3 again. R3 was again noted to be sitting in a wheelchair at the bedside. R3 was asked to press the call bell, when this was done the call bell again gave no visual or auditory signal to staff. The surveyor pressed the call bell with the same result. R3 was not aware the call bell was not working when asked. On 2/6/24 at 12:51 p.m., R3 was observed to be sitting in their room, in a wheelchair, at the bedside. R3 pressed the call bell after being asked to do so and this was observed to not give any visual or auditory signal outside of the room nor at the nursing station. On 2/6/24 at 12:55 p.m., an interview was conducted with LPN #5. LPN #5 said call bells are used in case of an emergency or if they [the resident] needs anything. LPN #5 accompanied Surveyor #1 to R3's room. LPN #5 was asked to engage the call bell and when she did, LPN #5 confirmed that the call bell was not working. During the above interview with LPN #5, CNA #1 came to the room. CNA #1 also confirmed that the call bell was not working. CNA #1 was able to change where the call bell cord was plugged in, next to the wall and able to get the call bell working. On 2/6/24, a clinical record review was conducted of R3's chart. According to the most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 11/21/23, R3 required staff's assistance with all ADLs (activities of daily living). According to R3's care plan, the resident was also at risk for falls. One of the interventions on the care plan stated, Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all [sic]. On 2/6/24 at approximately 1:15 p.m., the facility Administrator was made aware of the above findings. The Administrator stated that they are between maintenance directors at the moment, but they conduct audits of the call bells. (continued on next page)

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	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dinwiddie Health and Rehab Center	46 Diamond Drive Petersburg, VA 23803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/24 at 2:54 p.m., the Administrator provided Surveyor #1 with evidence that a call bell audit was last conducted 11/29/23. The administrator also provided evidence that they had conducted a 100% audit of all call bells after Surveyor #1 brought it to their attention and found no additional problems. The facility policy titled, Call Lights: Accessibility and Timely Response was provided and reviewed. The policy in part read, The purpose of this policy is to ensure the Center is adequately equipped with a call light at each patients' bedside, toilet, and bathing area to allow patients to call for assistance. Call lights will directly relay assistance is needed to an employee(s) or centralized location to facilitate prompt response/intervention for the patient . No further information was received.