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	09/03/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide a safe transfer using a mechanical lift resulting in a fall with fractures for one of eight residents in the survey sample (Resident #1).The findings include:Facility staff failed to attach a mechanical lift sling according to facility and manufacturer's recommendations during a transfer of Resident #1 from the bed to a wheelchair. Resident #1 slid out of the sling during the transfer causing fracture of the resident's shoulder (proximal left humerus) and left wrist (harm).Resident #1 (R1) was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), left side hemiplegia, hypothyroidism, chronic pain, mood disorder, major depressive disorder, hearing loss, epilepsy, polyneuropathy, insomnia and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R1 as cognitively intact and as totally dependent upon staff for bed mobility and transfers.R1's clinical record documented a nursing note dated 7/9/25 stating, .At approximately 1015 am [10:15 a.m.] CNA [certified nurse's aide] called out to staff that resident and CNA needed assistance that a resident was on the floor .as this writer opened the door resident [R1] noted lying on the floor in front of the door . Resident noted yelling out, when asked where she was hurting at resident told this writer that her left side was hurting .911 was called and EMS arrived shortly after call to transfer resident to the hospital .NP [nurse practitioner] and RP [responsible party] made aware of incident. A nursing note dated 7/10/25 documented on 7/9/25, the nurse arrived at R1's room and observed the resident on the floor. This note documented, .I asked what happened and was told that he [she] slid ot [out] of the hoyer lift onto the CNA .asked resident if she was in pain. She [R1] stated 10 on scale [0= no pain, 10 = worst pain] . (sic)R1's hospital discharge record dated 7/9/25 documented x-ray results diagnosing the resident with an acute minimally displaced fracture of the distal radius [wrist] and an acute displaced fracture of the proximal left humerus [shoulder]. R1 returned to the nursing facility on 7/9/25 with orders for immobilization of the left arm/wrist with a splint and sling, pain medication, ice with elevation of left upper extremity for 20 minutes four times per day and a follow up appointment with orthopedics. R1's clinical record documented pain in the left arm/wrist after the fall/fracture. Pain assessments prior to the fall from 7/1/25 through 7/8/25 documented daily pain ratings ranging from 0 to 2 (on scale of 0 = no pain, 10 = worst pain). Pain ratings after the injury from 7/10/25 through 7/26/25 ranged from 0 to 8 with pain medicine and ice/elevation documented as effective. R1 was assessed on 7/17/25 by an orthopedist. The orthopedist note dated 7/17/25 documented, .for evaluation of an acute left proximal humerus fracture and left distal radius fracture sustained when she fell off of a lift at the nursing home, and landed on the left side . The orthopedist assessed proper alignment of fractured areas and no current pain concerns. The orthopedist ordered continued use of the splint and sling and a 4-week follow-up. R1 was assessed on 8/22/25 by the orthopedist with swelling/bruising still present on left shoulder, proper shoulder alignment and excellent healing of the left wrist. The wrist splint was discontinued with orders to continue use of the left upper arm sling, and a 4-week follow-up appointment.R1's plan of care prior to the 7/9/25 injury (revised 11/1/24) documented the resident required total assistance with activities of daily living including transfers due to stroke with left side hemiplegia. R1's MDS assessment dated [DATE] documented the resident weighed 237 pounds and required total assistance of two people for bed mobility and transfers.The facility's investigation of R1's fall/fracture of 7/9/25 was reviewed. The investigation documented CNA #4 was assigned to R1 on 7/9/25 and was assisted during the lift transfer by CNA #1 and CNA #5. CNA #4's written statement dated 7/9/25 documented, I placed the hoyer lift pad under the resident + I had help to lift her up. As she [R1] was up in the air she said 'something isn't right' as me + the other coworker look at her, she was sliding out . (sic) CNA #4's statement documented that she had been educated on how to use the lift, and that she had the lift straps hooked correctly. CNA #1's written statement dated 7/9/25 documented the lift pad straps were already hooked when she went in to help with the transfer. CNA #1's statement documented, .i was lifting her up she [R1] said i'm not in this right, by the time i asked her whats wrong she fell down. (sic) CNA #5's statement documented that as CNA #1 was pulling the lift back to place the resident in the chair, R1 fell from the sling and that she immediately went to get help.The administrator and DON documented a re-enactment of the incident was conducted on 7/9/25. The administrator documented, .we have concluded that one of the three CNAs involved in the transfer [CNA #4] did not properly connect the sling to the Hoyer lift. [CNA #4] verbalized that she did not connect the sling correctly to the Hoyer lift. [R1] slid out of the Hoyer lift sling