STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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 survey was conducted on 2/6/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced	E 009		3/25/18

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

Electronically Signed | 02/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 009	Continued From page 1 by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The findings include: On 2/6/18 at 1:30 p.m., an interview was conducted with ASM #1 (Administrative Staff Member), the Administrator, and a review of the facility's emergency preparedness plan was conducted. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for including a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. ASM # 1 stated that the facility did not have the documentation to evidence collaboration. ASM #1 stated that he in on the town council with the Mayor and is frequently in contact with the Fire Marshal, Police, etc.; and that local state representatives including the current Governor, has visited the facility. Through these measures,	E 009	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	

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E 009	Continued From page 2 he felt the collaboration existed. No further information was obtained prior to exit.	E 009		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set	E 013		3/25/18

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E 013	Continued From page 3 forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence the Emergency Preparedness policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 2/6/18 at 1:36 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. . ASM # 1 stated the facility did not have the documentation. No further information was obtained prior to exit.	E 013	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 024	Policies/Procedures-Volunteers and Staffing	E 024		3/25/18

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E 024 SS=C	Continued From page 4 CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop and ensure policies and procedures for the use of volunteers and other staffing strategies in the emergency preparedness plan. The findings include: On 2/6/18 at 2:01 p.m. during a review and	E 024	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by	

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E 024	Continued From page 5 interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures for the use of volunteers and other staffing strategies in the emergency preparedness plan. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 024	the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced	E 026		3/25/18

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E 026	Continued From page 6 by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 2/6/18 at 2:14 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 026	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan.	E 029	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan	3/25/18

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E 029	Continued From page 7 The facility staff failed to develop policies and procedures for a written communication plan. The findings include: On 2/6/18 at 2:18 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan for a written communication plan and all the necessary components of a written communication plan. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 029	development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the	E 030		3/25/18

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E 030	Continued From page 8	E 030		

following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Next of kin, guardian, or custodian.
(iv) Other RNHCIs.
(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Hospice employees.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Other hospices.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Volunteers.
(iv) Other OPOs.
(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

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	495339	A. BUILDING _____ B. WING _____	02/08/2018

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E 030	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a written communication plan. Therefore the facility also failed to include that all required facility contacts are included in the communication plan. The findings include: On 2/6/18 at 2:21 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan for a written communication plan and all the necessary components of a written communication plan. Therefore the facility also failed to include that all required facility contacts are included in the communication plan. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 030	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 031		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 031	Continued From page 10 (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a written communication plan. Therefore the facility also failed to include all required Emergency Officials contacts are included in the communication. The findings include: On 2/6/18 at 2:28 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's	E 031	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	

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E 031	Continued From page 11 emergency preparedness plan failed to evidence policies and procedures in the emergency plan for a written communication plan and all the necessary components of a written communication plan. Therefore the facility also failed to include all required Emergency Officials contacts are included in the communication. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 031		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a written communication plan.	E 032	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the	3/25/18

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E 032	Continued From page 12 Therefore the facility also failed to include and ensure the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. The findings include: On 2/6/18 at 2:30 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan for a written communication plan and all the necessary components of a written communication plan. Therefore the facility also failed to include and ensure the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 032	facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to	E 033		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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 033	Continued From page 13 maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a written communication plan. Therefore the facility also failed to include and ensure the communication plan includes 1) a method for sharing information and medical documentation for patients under the facility's	E 033	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

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E 033	Continued From page 14 care, as necessary, with other health providers to maintain the continuity of care in the written communication plan; and 2) policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients in the written communication plan. The findings include: On 2/6/18 at 2:31 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan for a written communication plan and all the necessary components of a written communication plan. Therefore the facility also failed to include and ensure the communication plan includes 1) a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care in the written communication plan; and 2) policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients in the written communication plan. ASM #1 stated the facility maintains the electronic health records on an onsite server and an offsite server. Regarding the documentation of this as part of the written communication plan, ASM # 1 stated the facility did not have it. No further information was obtained prior to exit.	E 033	4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7)	E 034		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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E 034	Continued From page 15 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a written communication plan. Therefore the facility also failed to include 1) that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident	E 034	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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E 034	Continued From page 16 Command Center, or designee; and 2) that the communication plan includes a means of providing information about their occupancy. The findings include: On 2/6/18 at 2:35 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan for a written communication plan and all the necessary components of a written communication plan. Therefore the facility also failed to include 1) that the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; and 2) that the communication plan includes a means of providing information about their occupancy. ASM # 1 stated the facility did not have it. No further information was obtained prior to exit.	E 034	Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their	E 035		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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E 035	Continued From page 17 families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for a written communication plan. Therefore the facility also failed to include that the communication plan includes a method for sharing information from the emergency plan with residents or clients and their families or representatives. The findings include: On 2/6/18 at 2:39 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures in the emergency plan for a written communication plan and all the necessary components of a written communication plan. ASM #1 evidenced from the facility admission packet, what emergency preparedness information is disseminated to the residents and/or families and representatives, but without a written communication plan, this requirement was therefore also not included in the plan. ASM # 1 stated that the facility did not have it. No further information was obtained prior to exit.	E 035	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)	E 041		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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 041	Continued From page 18 (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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E 041	Continued From page 19	E 041		

for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.
If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.
(1) National Fire Protection Association, 1 Batterymarch Park,
Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.
(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.
(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.
(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.
(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.
(v) TIA 12-5 to NFPA 99, issued August 1, 2013.
(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.
(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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E 041	Continued From page 20 (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence that the Emergency Preparedness policies and procedures were developed to include a plan for how to keep the generator operational during an emergency, unless they plan to evacuate. The findings include: On 2/6/18 at 3:14 p.m. during a review and interview of the facility's emergency preparedness plan conducted with ASM #1 (Administrative Staff Member), the Administrator, review of the facility's emergency preparedness plan failed to evidence policies and procedures were developed to include a plan for how to keep the generator operational during an emergency, unless they plan to evacuate. ASM # 1 stated that the facility did not have this documented in the plan. No further information was obtained prior to exit.	E 041	1) Identified area of concern recognized. 2) The facility consulted with the Central Va. Healthcare Coalition for a full facility emergency and disaster plan development. 3) CVHC is reviewing and revising the facility Emergency Preparedness plan in accordance with regulatory guidelines. Upon completion plan will be fully implemented. 4) The Emergency Procedure and Procedures will be reviewed annually by the QA Committee and revised accordingly. 5) Complete date: March 25, 2018	
F 000	INITIAL COMMENTS	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 000	Continued From page 21 An unannounced Medicare/Medicaid standard survey was conducted from 2/6/18 through 2/8/18. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census in this 120 certified bed facility was 104 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents #74, 411, 12, 46, 76, 27, 93, 31, 45, 23, 14, 35, 106, 15, 64, 29, 65, 24, 63, 40, 42 and 410) and two closed record reviews (Residents #109 and 110).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 550	Continued From page 22 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview and facility document review, it was determined the facility staff failed to ensure two of 24 residents, Residents #46 and Resident #24, were treated with dignity during dining. 1. On 2/7/18 during the lunch service in the Atkins dining room the facility staff failed to serve Resident #46 her meal until after the residents seated at her table had been served and eaten their meals. Resident #46 waited 35 minutes for her meal to be served. 2. On 2/7/18 during the lunch service in the Atkins dining room the facility staff failed to serve Resident #24 her meal until after the resident seated at her table had been served and eaten his meal. Resident #24 waited 40 minutes for her	F 550	1) Resident #46 and Resident #24, were both provided meals as soon as the delay in meal service was recognize. 2) No other residents were identified to be affected. 3) Training was provided to dining room servers as to restaurant style dining. Orders will be taken as residents are seated at the table and meals served per table. 4) The dining service manager will monitor the meal service process and provide staff education as observations are made of delay in meal service. Ongoing concerns will be reported to the facility QA committee for recommendations. 5) Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 550	Continued From page 23	F 550		

meal to be served.

The findings include:

1. On 2/7/18 during the lunch service in the Atkins dining room the facility staff failed to serve Resident #46 her meal until after the residents seated at her table had been served and eaten their meals. Resident #46 waited 35 minutes for her meal to be served.

Resident #46 was admitted to the facility on 5/3/06 with a readmission on 8/18/17 with diagnoses that included, but were not limited to bronchitis (an infection in the lungs), peripheral vascular disease (poor circulation in the lower limbs), diabetes, acid reflux disease, difficulty with swallowing and chronic kidney disease.

Resident #46's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/17/17, coded Resident #46 as scoring 14 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #46 is cognitively intact to make decisions regarding daily living. Resident #46 was further coded as requiring supervision during eating.

On 2/7/18 at 9:51 a.m., a telephone interview was conducted with a resident's family member. The family member stated staff will take some residents' food orders in the dining room but other residents will sit there and not receive food for two hours.

On 2/7/18, Resident #46 was observed seated at a table in the Atkins dining hall at 11:05 a.m. Resident #46 was seated with two other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 550	Continued From page 24	F 550		

residents. At 11:15 a.m., the facility staff was observed starting to serve meals. Lunch plates were plated in the kitchen and a server took the individual plate to each resident.

Between 11:17 a.m. and 11:22 a.m., the two residents seated with Resident #46 were served their meals.

At 11:35 a.m., 11 of 30 residents seated in the dining room had not received their food, and staff had started to hand out desert to residents in the process of finishing their main course. This writer did not observe facility staff checking on the residents who had not been served their meal.

At 11:46 a.m., Resident #46 was observed watching the residents seated at her table as they finished their meals. Resident #46 crossed her arms and was observed staring at a server who was cleaning off tables around Resident #46. The servers did not ask Resident #46 about receiving her meal.

At 11:50 a.m., Resident #46 was served her meal.

On 02/08/18 at 08:55 a.m., an interview was conducted with OSM (other staff member) #8, a dietary server. OSM #8 was asked to describe the process for the resident's dining experience. OSM #8 stated, "We greet them, we have their tickets, we take their ticket to the table and ask them what they want to drink and then tell them selections of meals on the ticket and ask what they want." OSM #8 was asked if the residents had assigned seating. OSM #8 stated, "Residents choose to sit wherever they like. When residents are seated, we do a first come first serve basis. If

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 550	Continued From page 25	F 550		

people are seated at a table around the same time then we try to make sure that all the residents on one table have their food at the same time." OSM #8 was asked why they tried to serve people at the same table at the same time. OSM #8 stated, "It is good customer service, I don't want someone to have to wait too long and watch others eat and not get their food. We don't want them upset or mad at all." OSM #8 was asked what she did when she noticed someone had not been served. OSM #8 stated, "I walk up to the lady and make sure she gets her food and apologize for the wait. Normally that never happens. Food can be so slow coming out." When asked about the delay, OSM #8 stated the kitchen wants to make sure it (the food) is perfect and the tickets can change. OSM #8 was asked how the kitchen is made aware of what each resident wanted for lunch. OSM #8 stated, "We just take the tickets to the kitchen as the residents are seated." OSM #8 was asked if there is a process for handling tickets to ensure a table is served at the same time. OSM #8 stated the tickets are submitted on a first come, first served basis. OSM #8 was asked how it would make her feel if she were at a restaurant with her family and food was served to everyone else except her. OSM #8 stated, "I would be upset." OSM #8 was asked if she remembered Resident #46 seated at the table with two other residents, OSM #8 stated that she did. OSM #8 was asked if she noticed that Resident #46 did not have her food, OSM #8 stated, "I didn't catch that otherwise I would have done something. I must have thought she had already ate." OSM #8 was asked whether she asked Resident #46 about her food. OSM #8 stated she did not.

On 02/08/18 at 09:28 a.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 550	Continued From page 26	F 550		

conducted with OSM #7, the cook. OSM #7 was asked to describe the dining room / kitchen process. OSM #7 stated, "The servers bring the tickets to me with the choices already checked off as to what the residents want." OSM #7 were asked if the tickets are presented in any kind of order. OSM #7 stated, "They bring them in first come first served." OSM #7 was asked how the kitchen staff make sure the residents get their food at the same time as other residents seated at their table. OSM #7 stated, "When the CNAs (certified nursing assistants) bring the residents into the dining room they will try to seat them together so they can be served together. The servers let me know and we have a dietary aide in the kitchen who makes sure who gets the food first." OSM #7 was asked, in reference to the lunch service observation on 2/7/18, why people did not get their food served at the same time as others seated at their tables. OSM #7 stated, "I wasn't here yesterday. The aide that makes sure who gets the food when the residents are seated was not here yesterday either." OSM #7 was asked how she would feel if she were out with her family and they got their food and she did not. OSM #7 stated, "I would feel insulted, and I would complain."

On 02/08/18 at 09:39 a.m., an interview was conducted with OSM #2, the director of dining services. OSM #2 was asked whether he observed the lunch service on 2/7/18 in Atkins dining room. OSM #2 stated, "Yes I popped in." OSM #2 was asked to state the process to ensure residents were served their meals timely. OSM #2 stated, "We have restaurant seating, the servers get the tickets and fill them out with the resident and then bring the tickets to the kitchen. If the residents choose the main meal then the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

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HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 550	Continued From page 27	F 550		

service is quick because it is pre-prepared. If the residents have a specialty request it takes a little longer." OSM #2 was asked how the dining staff ensured residents seated at the same table are served around the same time. OSM #2 stated, "They (the tickets) should be grouped together, but the problem is the specialty order, that seems to slow it (the process) down." OSM #2 was asked how long a specialty item would take to be served, OSM #2 stated "No more than 10 minutes." OSM #2 was asked if a resident was observed not to have her food at a table where others were eating should the servers go back and check on the food to see what the delay is. OSM #2 stated, "Yes, that is good customer service, which is our goal. We work where they (the residents) live." OSM #2 was asked if he was aware that residents had not been served and were seated at tables with people who were eating. OSM #2 stated, "I did not notice that. When I come into the dining room I make sure that food is being served and that everything is running." OSM #2 was asked if it is acceptable for someone to wait an extended period to be served food when others at the table have been served, and finished their meal. OSM #2 stated it was not. OSM #2 was asked how he thought it made the residents feel to have to watch others eat while they were waiting on their food. OSM #2 stated, "It is upsetting not to be served timely." A policy was requested from OSM #2 at this time regarding the dining experience.

On 2/8/18 at 11:15 a.m., OSM #2, provided an orientation agenda for review. When asked if this agenda provided information about the dining service, OSM #2 stated that it did not. OSM #2 was asked if there were any policies regarding the dining experience and the process to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 550	Continued From page 28	F 550		

residents were served timely, OSM #2 stated that the agenda was all he had. A review of the orientation agenda did not reference dining services.

On 2/8/18 at 3:58 p.m., a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance. ASM #1 and ASM #2 were made aware of the above findings. A policy was requested at this time regarding dignity.

On 2/8/18 at 1:05 p.m., an interview was conducted with Resident #46. Resident #46 was asked if she remembered lunch on 2/7/18. Resident #46 stated she did. Resident #46 was asked if she remembered having to wait an extended period before she was served lunch. Resident #46 said that it was terrible. Resident #46 stated, "They just forgot me and didn't bring my lunch." When asked how it made her feel to be seated at the table with other residents who were eating and had finished by the time she received her food, Resident #46 stated it made her mad and disgusted. When asked if any of the staff working in the dining room had checked on her meal, Resident #46 stated, "They never asked me anything. I just waited and they finally brought me my food. It took them an hour to bring me my lunch."

No further information was provided prior to the end of the survey process.

2. On 2/7/18 during the lunch service in the Atkins dining room the facility staff failed to serve Resident #24 her meal until after the resident seated at her table had been served and eaten his meal. Resident #24 waited 40 minutes for her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 550	Continued From page 29	F 550		

meal to be served.

Resident #24 was admitted to the facility on 6/1/07 with readmission on 11/28/16 with diagnoses that include, but are not limited to high blood pressure, dementia, heart failure, chronic kidney disease, and difficulty with swallowing.

Resident #24's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/16/18, coded Resident #24 as scoring a four out of a possible 15, indicating that Resident #24 is severely cognitively impaired with decisions regarding daily living. Resident #24 is also coded as requiring supervision of one person for eating.

On 2/7/18 at 9:51 a.m., a telephone interview was conducted with a resident's family member. The family member stated staff will take some residents' food orders in the dining room but other residents will sit there and not receive food for two hours.

On 2/7/18, Resident #24 was observed seated in the Atkins dining room for lunch at approximately 11:00 a.m.,. Resident #24 was removed from the Atkins dining room by an aide at approximately 11:05 a.m., for toileting and returned to the dining room at 11:15 a.m. for her lunch. Resident #24 was seated with one other resident who was being assisted with his meal by a therapist; he was served his meal at approximately 11:20 a.m.,. Resident #24 had been provided a drink, her meal was not served until11:57 a.m.,. The resident seated at her table had finished his meal and had been removed from the table by the therapist at 11:50 a.m.,. The staff server was not observed checking on Resident #24's meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 550	Continued From page 30	F 550		

On 02/08/18 at 08:55 a.m., an interview was conducted with OSM (other staff member) #8, a dietary server. OSM #8 was asked to describe the process for the resident's dining experience. OSM #8 stated, "We greet them, we have their tickets, we take their ticket to the table and ask them what they want to drink and then tell them selections of meals on the ticket and ask what they want." OSM #8 was asked if the residents had assigned seating. OSM #8 stated, "Residents choose to sit wherever they like. When residents are seated, we do a first come first serve basis. If people are seated at a table around the same time then we try to make sure that all the residents on one table have their food at the same time." OSM #8 was asked why they tried to serve people at the same table at the same time. OSM #8 stated, "It is good customer service, I don't want someone to have to wait too long and watch others eat and not get their food. We don't want them upset or mad at all." OSM #8 was asked what she did when she noticed someone had not been served. OSM #8 stated, "I walk up to the lady and make sure she gets her food and apologize for the wait. Normally that never happens. Food can be so slow coming out." When asked about the delay, OSM #8 stated the kitchen wants to make sure it (the food) is perfect and the tickets can change. OSM #8 was asked how the kitchen is made aware of what each resident wanted for lunch. OSM #8 stated, "We just take the tickets to the kitchen as the residents are seated." OSM #8 was asked if there is a process for handling tickets to ensure a table is served at the same time. OSM #8 stated the tickets are submitted on a first come, first served basis. OSM #8 was asked how it would make her feel if she were at a restaurant with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 550	Continued From page 31	F 550		

family and food was served to everyone else except her. OSM #8 stated, "I would be upset." OSM #8 was asked if she remembered Resident #24 seated at the table with one other resident, OSM #8 stated that she did. OSM #8 was asked if she noticed Resident #24 did not have her food, OSM #8 stated, "I didn't catch that otherwise I would have done something. I must have thought that she had already ate." OSM #8 was asked whether she asked Resident #24 about her food. OSM #8 stated she did not.

On 02/08/18 at 09:15 a.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked if she remembered the lunch service in Atkins dining room on 2/7/18. CNA #2 stated, "I was assisting a resident with her meal, she needs cueing." CNA #2 was asked if she noticed people waiting a while to be served their meal. CNA #2 stated, "Sometimes, yes." When asked why, CNA #2 stated, "I think it varies, sometimes it is not that way, and sometimes it can be a lack of staff members. Some people come a little later. The way their ticket gets placed in the kitchen." CNA #2 was asked if tickets at a table should be given to the kitchen at the same time if all residents are seated at the table. CNA #2 stated, "Yes." CNA #2 was asked why it is important to present the tickets for a table at the same time. CNA #2 stated, "So that everyone can eat at the same time." CNA #2 was asked if she noticed residents were sitting at tables where food had been served to some and not the others during the 2/7/18 lunch service. CNA #2 stated, "Yes." CNA #2 was asked if she noticed some residents waited for a long time to receive their meals. CNA #2 stated, "Yes, but I think it was situational." CNA #2 agreed most residents were seated at their tables

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 550	Continued From page 32	F 550		

between 11 a.m. and 11:15 a.m. When informed at 11:45a.m., eleven residents (out of 30 in the dining room) were observed without food, CNA #2 stated, "I didn't notice the exact number but I did notice that there were quite a few." CNA #2 was asked if she remembered Resident #24 who was seated at the table beside her, did not have her food. CNA #2 stated, " She was originally in the dining area early but one of the aides took her back to her room for incontinence care so she was in the dining room a little later, maybe about 10 minutes, she was there enough time to do her ticket." When asked if Resident #24 had to wait for her food, CNA #2 stated she did. When asked if any of the servers asked Resident #24 about her food, CNA #2 stated, "Not that I recall."

On 02/08/18 at 09:28 a.m., an interview was conducted with OSM #7, the cook. OSM #7 was asked to describe the dining room / kitchen process. OSM #7 stated, "The servers bring the tickets to me with the choices already checked off as to what the residents want." OSM #7 was asked if the tickets are presented in any kind of order. OSM #7 stated, "They bring them in first come first served." OSM #7 was asked how the kitchen staff make sure the residents get their food at the same time as other residents seated at their table. OSM #7 stated, "When the CNAs (certified nursing assistants) bring the residents into the dining room they will try to seat them together so they can be served together. The servers let me know and we have a dietary aide in the kitchen who makes sure who gets the food first." OSM #7 was asked, in reference to the lunch service observation on 2/7/18, why people did not get their food served at the same time as others seated at their tables. OSM #7 stated, "I wasn't here yesterday. The aide that makes sure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 550	Continued From page 33	F 550		

who gets the food when the residents are seated was not here yesterday either." OSM #7 was asked how she would feel if she were out with her family and they got their food and she did not. OSM #7 stated, "I would feel insulted, and I would complain."

On 02/08/18 at 09:39 a.m., an interview was conducted with OSM #2, the director of dining services. OSM #2 was asked if he had observed the lunch service on 2/7/18 in Atkins dining room. OSM #2 stated, "Yes I popped in." OSM #2 was asked what the process was to ensure the residents are served their meals timely. OSM #2 stated, "We have restaurant seating, the servers get the tickets and fill them out with the resident and then bring the tickets to the kitchen. If the residents choose the main meal then the service is quick because it is pre-prepared. If the residents have a specialty request it takes a little longer." OSM #2 was asked how the dining staff ensured that people seated at the same table are served around the same time. OSM #2 stated, "They (the tickets) should be grouped together, but the problem is the specialty order that seems to slow it (the process) down." OSM #2 was asked how long a specialty item would take to be served, OSM #2 stated "No more than 10 minutes." OSM #2 was asked if a resident was observed not to have her food at a table where others were eating should the servers go back and check on the food to see what the delay is. OSM #2 stated, "Yes, that is good customer service, which is our goal. We work where they (the residents) live." OSM #2 was asked if he was aware that residents had not been served and were seated at tables with people who were eating. OSM #2 stated, "I did not notice that. When I come into the dining room I make sure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 550	Continued From page 34 that food is being served and that everything is running." OSM #2 was asked if it is acceptable for someone to wait an extended period to be served food when others at the table have been served, and finished their meal. OSM #2 stated that it was not. OSM #2 was asked how he thought that it made the residents feel to have to watch others eat while they were waiting on their food. OSM #2 stated, "It is upsetting not to be served timely." A policy was requested at this time regarding the dining experience. On 2/8/18 at 11:15 a.m., OSM #2, provided an orientation agenda for review. When asked if this agenda provided information about the dining service, OSM #2 stated that it did not. OSM #2 was asked if there were any policies regarding the dining experience and the process to ensure residents were served timely OSM #2 stated that the agenda was all he had. A review of the orientation agenda did not reference dining services. On 2/8/18 at 3:38 p.m., a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance. ASM #1 and ASM #2 were made aware of the above findings. A policy was requested at this time regarding dignity. No further information was provided prior to the end of the survey process.	F 550		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 623		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 623	Continued From page 35	F 623		

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 623	Continued From page 36	F 623		

notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 37 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide required notifications prior to a facility initiated transfer for three of 24 residents in the survey sample, Resident #93, Resident #40 and Resident #45. 1. The facility staff failed to provide written documentation evidencing Resident #93, the resident's RP (responsible party) and the ombudsman were notified in writing when Resident #93 was transferred to the hospital on 1/13/18. 2. The facility staff failed to provide written documentation evidencing, Resident #40, the resident's RP and the ombudsman were notified in writing when Resident #40 was transferred to the hospital on 11/17/17. 3. The facility staff failed to provide written documentation evidencing Resident # 45, the resident's representative and the ombudsman were notified in writing when she was transferred to the hospital on 11/29/17.	F 623	1) Written notification regarding transfer of Resident # 93 (hospital transfer 1/13/18), Resident #40 (Hospital transfer 11/17/17), Resident #45 (hospital transfer 11/29/17) provided to the ombudsman and RP. 2) The facility notified the Ombudsman's office that they would be sending regular updates for facility transfers/discharge despite their direction not to send voluntary transfer discharge data. All notifications from Nov to present date were sent for transfers for resident currently in the facility. 3) The facility will send written notifications for transfer in addition to it's normal process of calling the RP. Written communication with the Ombudsman's office resumed. 4) Medical records will complete random audit of 10% of transfers for written notification of transfers. Ongoing concerns will be reported to the facility QA committee for recommendations. 5) Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 38	F 623		

The findings include:

1. Resident #93 was admitted to the facility on 10/21/11 with a readmission on 1/15/18 with diagnoses that included, but are not limited to an irregular heartbeat, heart failure, respiratory failure, low blood pressure and shortness of breath.

Resident #93's most recent MDS (minimum data set), a 14 day scheduled assessment with an ARD (assessment reference date) of 1/29/18, coded Resident #93 as having a BIMS (brief interview of mental status) score of 13 out of a possible 15, indicating that Resident #93 is cognitively intact with decision of daily living.

A review of Resident #93's clinical record revealed, in part, the following progress note; "1/13/2018 12:12 PM. Res (Resident #93) OOF (out of facility) to (name of emergency room) for eval (evaluation) @ (at) 1140am (11:40 a.m.) sec (secondary) to elevated temp, (temperature), c/o (complaint of) feeling "weak with body aches all over." Daughter in agreement with MD's (medical doctors) order to send for eval and will accompany res to ER (emergency room)."

Further review of Resident #93's clinical record did not reveal any documentation evidencing the ombudsman, the resident, and RP were provided written notification of the transfer to the emergency room.

On 2/8/18 at 8:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1, a floor nurse. LPN #1 was asked what type of notifications are completed when a resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 39	F 623		

transferred to the hospital. LPN #1 stated, "I notify the resident and the RP of what is occurring and document that they have been notified." When asked if she would send a written notification of the transfer to the resident, RP and ombudsman, LPN #1 stated she would not.

During an interview on 2/8/18 at 10:00 a.m. with ASM (administrative staff member) # 2 (the director of compliance), ASM # 2 stated it was their practice to send an email to the ombudsman when a Resident transferred to the hospital. Then in April of 2017, the ombudsman requested they only send notification for involuntary transfers/discharges. A copy of this email, dated April 2017, was provided to the survey team. Prior to exit ASM # 2 presented copies of emails notifying the ombudsman prior to the ombudsman email of April 2017.

On 2/8/18 at 3:58 p.m., a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance. ASM #2 was asked who was responsible to send a written notification to the resident, RP and ombudsman when a resident was transferred to the hospital. ASM #2 stated they had not been doing that, and had not understood that was a requirement and the written notifications had not been completed. ASM #2 was made aware of the above findings and asked to provide a policy regarding transfer and discharges.

An interview was conducted on 2/9/18 at 3:25 p.m. with OSM (other staff member) #1, the social worker. OSM #1 was asked who was responsible for providing written notifications to the resident, RP and the ombudsman when a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 40	F 623		

resident was transferred to the hospital. OSM #1 stated nursing was responsible for such notifications.

A review of the facility policy titled "Transfer and Discharge. - Transfer to a medical facility such as the hospital ER" revealed, in part, the following documentation; "12. A letter of transfer shall include: Reason for transfer or discharge. b. The effective date of the transfer or discharge. C. The location to which the resident is to be transferred or discharged."

No further information was provided prior to the end of the survey process.

2. The facility staff failed to provide written documentation evidencing, Resident #40, the resident's RP and the ombudsman were notified in writing when Resident #40 was transferred to the hospital on 11/17/17.

Resident #40 was admitted to the facility on 9/10/11 with a readmission on 11/24/17 with diagnoses that included, but are not limited to, pressure ulcer, nutritional deficiency, multiple sclerosis [1] (a disabling disease of the brain and spinal cord (central nervous system). and peripheral vascular disease (poor circulation in the lower limbs).

Resident #40's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/8/2017, coded Resident #40 as having a BIMS (brief interview of mental status) score of eight out of a possible 15, indicating that Resident #40 is cognitively moderately impaired with decisions of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 41	F 623		

daily living.

A review of Resident #40's clinical record revealed, in part, the following progress note; "11/17/2017 10:10 PM. Pt (patient) transferred via rescue squad to (name of hospital emergency room) at 5:30 PM, per MD (medical doctor) order. Pt B/P (blood pressure) low, change in mental status. Her sister POA (power of attorney) notified of transfer, as well as her husband."

Further review of Resident #40's clinical record did not reveal any documentation evidencing the ombudsman, the resident and RP were provided with written notification of the transfer to the ER.

On 2/8/18 at 8:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1, a floor nurse. LPN #1 was asked what type of notifications are completed when a resident was transferred to the hospital. LPN #1 stated, "I notify the resident and the RP of what is occurring and document that they have been notified." When asked if she would send a written notification of the transfer to the resident, RP and ombudsman, LPN #1 stated she would not.

During an interview on 2/8/18 at 10:00 a.m. with ASM (administrative staff member) # 2 (the director of compliance), ASM # 2 stated it was their practice to send an email to the ombudsman when a Resident transferred to the hospital. Then in April of 2017, the ombudsman requested they only send notification for involuntary transfers/discharges. A copy of this email, dated April 2017, was provided to the survey team. Prior to exit ASM # 2 presented copies of emails notifying the ombudsman prior to the ombudsman

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 42	F 623		

email of April 2017.

On 2/8/18 at 3:58 p.m., a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance. ASM #2 was asked who was responsible to send a written notification to the resident, RP and ombudsman when a resident was transferred to the hospital. ASM #2 stated they had not been doing that, and had not understood that was a requirement and the written notifications had not been completed. ASM #2 was made aware of the above findings and asked to provide a policy regarding transfer and discharges.

An interview was conducted on 2/9/18 at 3:25 p.m. with OSM (other staff member) #1, the social worker. OSM #1 was asked who was responsible for providing written notifications to the resident, RP and the ombudsman when a resident was transferred to the hospital. OSM #1 stated nursing was responsible for such notifications.

A review of the facility policy titled "Transfer and Discharge. - Transfer to a medical facility such as the hospital ER" revealed, in part, the following documentation; "12. A letter of transfer shall include: a. Reason for transfer or discharge. b. The effective date of the transfer or discharge. C. The location to which the resident is to be transferred or discharged."

No further information was provided prior to the end of the survey process.

[1] This information was obtained from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 43	F 623		

following website; https://www.mayoclinic.org/diseases-conditions/multiple-sclerosis/symptoms-causes/syc-20350269 3. The facility staff failed to provide written documentation evidencing Resident # 45's representative and the ombudsman were notified in writing when she was transferred to the hospital on 11/29/17.

Resident # 45 was admitted to the facility on 11/21/15 and readmitted on 12/2/17 with diagnoses that included but were not limited to dementia, hypertension, gastroesophageal reflux disease, diabetes, high cholesterol, and peripheral vascular disease.

Resident # 45's most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 12/17/17 coded Resident # 45 as being cognitively impaired.

Review of the clinical record for Resident # 45 revealed a signed physician's order dated 11/29/17 at 4:30 p.m. The order documented, "Send resident to (name of local hospital) due to altered mental status, congested cough."

Review of the facility transfer form dated 11/29/17 at 1620 (4:20 p.m.) documented, "Reason for Transfer: Altered Alertness with increased drooling, congested cough. BP (blood pressure) 144/95, Temperature 100.2, pulse: 114, Respirations: 24, no pain, alert, lethargic, (name of the responsible party) was notified." Signed by LPN (licensed practical nurse) # 2.

The facility's "Nurse's Notes" for Resident # 45 dated 11/29/17 at 5:00 p.m., documented "Resident sent to (name of local hospital) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 44	F 623		

evaluation. VS (vital signs): 100.2 (temperature) - 114 (pulse) - 24 (respirations) - 144/95 (blood pressure)." Signed by LPN # 2.

Further review of the clinical record for Resident # 45 failed to evidence documentation that the ombudsman and Resident # 45's representative received written notification of Resident # 45's transfer to the hospital.

During an interview on 2/8/18 at 9:15 a.m. with OSM (other staff member) # 1 (the social worker), OSM # 1 was asked who was responsible for notifying, in writing, the ombudsman and the responsible party of the transfer to the hospital. OSM # 1 stated, "Will have to get back to you -- I'm not sure about that situation. Will have to get back to you." A request at this time was made for any documentation OSM # 1 could provide concerning written notice having been given to the ombudsman and the responsible party for Resident # 45's transfer to the hospital.

During an interview on 2/8/18 at 10:00 a.m. with ASM (administrative staff member) # 2 (the director of compliance), ASM # 2 stated it was their practice to send an email to the ombudsman when a resident transferred to the hospital. Then in April of 2017, the ombudsman requested they only send notification for involuntary transfers/discharges. A copy of this email, dated April 2017, was provided to the survey team. Prior to exit ASM # 2 presented copies of emails notifying the ombudsman prior to the ombudsman email of April 2017.

During an interview on 2/8/18 at 1:10 p.m. with ASM # 2, ASM # 2 stated they had no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 623	Continued From page 45 documentation on anyone in the facility indicating that the ombudsman or the responsible party had been given written notification of a resident transfer as outlined in the new regulations. On 2/8/18/18 at 3:50 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above findings. No further information was presented prior to exit.	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 645	Continued From page 46	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 645	Continued From page 47 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a PASARR (Preadmission Screening and Resident Review) was complete for one of 24 residents in the survey sample, Resident # 63. The facility staff failed to ensure Resident # 63's PASARR was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. The findings include: Resident # 63 was admitted to the facility on 12/30/15 with diagnoses that included but were not limited to: psychotic disorder with delusions, aortic valve stenosis, high cholesterol, gastroesophageal reflux disease, high blood pressure, peripheral vascular disease, and dementia with behaviors. Resident # 63's most recent MDS (minimum data set), a quarterly with an ARD (assessment reference date) of 1/3/18, coded the resident as cognitively impaired. Review of Resident # 63's clinical record (both paper and electronic) failed to reveal the resident's PASARR, or any documentation concerning the PASARR. On 2/7/18 at 2:35 p.m., Resident # 63's PASARR was requested via a written list given to ASM (administrative staff member) # 2 (the director of compliance).	F 645	1)PASARR screening completed on Resident # 63 prior to survey team exit. 2)PASARR screening completed on all residents prior to the exit of the survey team and placed in the clinical records. 3)PASARR screening will be requested from all referral sources in advance of facility admission. 4)The facility added PASARR requirements to its preadmission referral request list, and outside referral sources, such as hospitals, will be notified on a case by case basis if PASARRs are not provided. The facility designee will then complete a PASARR upon admission if the referring sources refuse to comply. Ongoing concerns will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 645	Continued From page 48	F 645		

On 2/7/18 at approximately 4:00 p.m. Resident # 63's PASARR dated 2/7/18 was presented.

During an interview on 2/8/18 at 9:15 a.m. OSM (other staff member) # 1, the social worker, OSM # 1 was asked who was responsible to do the PASARR. OSM # 1 stated she did not do the PASARR but that the Admissions Coordinator was responsible.

During an interview on 2/8/18 at approximately 9:30 a.m. with OSM # 5 (admission coordinator), OSM # 5 was asked what the process was for completing the PASARR. OSM # 5 stated, "We request them from the hospital and if they do not provide them then it is something that is done on admission. There is a problem with getting them from the hospital but we do the PASARR." OSM # 5 was asked who was responsible if the resident comes to the facility without a PASARR. OSM # 5 stated, "It is my responsibility to get the PASARR. If they do not have it, I am responsible to do the PASARR." OSM # 5 was asked to review Resident # 63's PASARR and was asked why the Resident # 63's PASARR was completed on 2/7/18. OSM # 5 stated, "Can I get back with you please? I need to talk with (name of ASM # 2) about why I did one on 2/7/18."

On 2/8/18 at 10:00 a.m., in an interview with ASM # 2, ASM # 2 was asked why Resident # 63's PASARR was dated 2/7/18. ASM # 2 stated they were not aware that PASARRs were to be done - and they cannot get them from the hospital. ASM # 2 further stated when the PASARRs were requested on 2/7/18 staff was instructed to do a PASARR on all the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 645	Continued From page 49 During an interview on 2/8/18/18 at 3:50 p.m., ASM #1 (the administrator), ASM #2 (the director of compliance) were made aware of the above findings. The facility policy titled, "ADMISSION/TRANSFER/DISCHARGE" documented, Under "Procedure: ...4...a. Prospective admissions should be older than 18 years of age, unless a lower age is allowed by the state agency. Preadmission screenings should be completed, such as ...PASARR ..." No further information was presented prior to exit.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 50 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement and follow the comprehensive care plan for two of 24 residents in the survey sample, Residents #106 and #42. 1. The facility staff failed to implement and follow Resident #106's care plan regarding the assessment of the resident's dialysis access site. 2. The facility staff failed to implement and follow Resident # 42's comprehensive care plan for the treatment of diabetes. The findings include: 1. The facility staff failed to implement and follow	F 656	1)Resident's #106's care plan for AVF monitoring was added to the nursing interventions prior to exit of the survey team. Resident #42's care plan for DM treatment was reviewed with the nurse on duty as well as the requirement to administer medications per MD orders prior to the exit of the survey. 2)No other resident identified without nursing interventions to monitor AVF. No other residents identified with post meal insulin administration based on meal consumption. 3)Random 10% audits will be completed of dialysis residents with AVFs to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 51 Resident #106's care plan regarding the assessment of the resident's dialysis access site (1). Resident #106 was most recently admitted to the facility on 1/11/18. Resident #106's diagnoses included but were not limited to diabetes, high blood pressure and end stage renal disease. Resident #106's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 1/25/18, coded the resident as cognitively intact. Section O documented Resident #106 received dialysis. Resident #106's comprehensive care plan with a problem onset date of 12/12/17 documented, "Dialysis...Observe Left Arm Shunt (dialysis access) site for presence of bruit (2), redness or swelling as indicated and report negative findings to MD (medical doctor) accordingly..." Review of Resident #106's January 2018 and February 2018 MARs (medication administration records)/ TARs (treatment administration records) (prior to 2/7/18) failed to reveal documentation that Resident #106's left arm shunt site was assessed. Review of nurses' notes from 1/11/18 through 2/6/18 (except for a note dated 1/11/18) failed to reveal documentation that Resident #106's left arm shunt site was assessed. On 2/7/18 at 4:21 p.m., Resident #106 was sitting in the bedroom. The resident's dialysis access site located on the resident's left arm was covered with a dressing. Resident #106 was asked if the facility staff ever assesses her dialysis access site. Resident #106 stated, "I don't think they do here so much as they do at dialysis." Resident #106 stated she goes to dialysis three days a week and the staff there	F 656	monitoring interventions are in place. Unannounced Med pass observations of 10% of nurses providing insulin administration will be made to identify deviations from standards of practice. 4)Ongoing concerns from med pass observations and audits will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 52	F 656		

listen to the area with a stethoscope and check the dressing.

On 2/7/18 at 4:30 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the care that should be provided to a resident who receives dialysis. RN #1 stated the facility staff protects the resident's arm that contains the fistula (a type of access site). RN #1 stated this is noted on the care plan under impaired mobility or in a separate care plan. RN #1 was asked if anything else should be done. RN #1 stated, "I want to say that translates down to nursing interventions. We protect the extremity and note on the MAR or TAR." RN #1 was asked if nurses should assess for thrill (3) and bruit. RN #1 stated, "We do that. Yes." RN #1 stated the nurses should assess for thrill and bruit every shift.

On 2/7/18 at 5:21 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of compliance) were made aware of the above findings.

On 2/8/18 at 7:40 a.m., ASM #2 presented a physician order list dated 2/7/18 that documented, "Nursing Intervention: Assess dialysis shunt for bruitt (sic) and thrill q (every) shift. Monitor for post dialysis bleeding from site. Notify MD (medical doctor) of abnormal findings."

On 2/8/18 at 8:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding the care that should be provided to a resident receiving dialysis. LPN #1 stated, "With a fistula there is a bruit and thrill and you always want to make sure that's going." When asked to clarify what she meant by "to make sure that's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 53	F 656		

going," LPN #1 stated, "Feel it and make sure you can hear it." When asked how this should be done, LPN #1 stated a stethoscope should be used. When asked how often this should be done, LPN #1 stated she would have to check. When asked how other nurses would know the area needs to be assessed and how often, LPN #1 stated this information should be relayed during the shift change report and should be documented on the treatment record. LPN #1 was asked the purpose of a care plan. LPN #1 stated the purpose of a care plan was to inform staff how to take care of the patient and care plans were on the computer. When asked if staff needed to follow residents' care plans, LPN #1stated, "You should follow the care plan."

The facility document titled, "Resident Assessment- CARE PLAN DOCUMENTATION GUIDELINES" documented, "Develop a coordinated plan to provide appropriate care for each problem identified. It should be updated regularly to address changes in status and interventions necessary to meet the resident's needs. All disciplines involved in care should coordinate efforts toward the same goal. Nursing service has the overall responsibility to coordinate care among all disciplines to achieve the established goals..."

No further information was presented prior to exit.

(1) "A vascular access is a hemodialysis patient's lifeline. A vascular access makes life-saving hemodialysis treatments possible. Hemodialysis is a treatment for kidney failure that uses a machine to send the patient's blood through a filter, called a dialyzer, outside the body. The access is a surgically created vein used to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 54	F 656		

remove and return blood during hemodialysis. The blood goes through a needle, a few ounces at a time. The blood then travels through a tube that takes it to the dialyzer. Inside the dialyzer, the blood flows through thin fibers that filter out wastes and extra fluid. The machine returns the filtered blood to the body through a different tube. A vascular access lets large amounts of blood flow continuously during hemodialysis treatments to filter as much blood as possible per treatment..." This information was obtained from the website: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/vascular-access

(2) "When blood flows through a narrow artery, it sometimes makes a whooshing sound, called a bruit." This information was obtained from the website: https://www.niddk.nih.gov/health-information/kidney-disease/renal-artery-stenosis

(3) "How does a patient care for and protect a vascular access...Checking the thrill in the access every day. The thrill is the rhythmic vibration a person can feel over the vascular access..." This information was obtained from the website: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/vascular-access

2. The facility staff failed to follow Resident # 42's comprehensive care plan for the treatment of diabetes.

Resident #42 was admitted to the facility on 2/21/11 with a readmission on 8/2/17 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 55	F 656		

diagnoses including, but not limited to muscle weakness, reflux disease, shortness of breath, chronic kidney disease and diabetes.

Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/13/17, coded Resident #42's BIMS (brief interview of mental status) score as seven out of a possible 15, indicating that Resident #42 is severely cognitively impaired with decisions of daily living.

A review of Resident #42's comprehensive care plan dated 8/2/17 revealed, in part, the following documentation: "Problem / Need. Risk for hyper/hypoglycemia (high/low blood sugar) r/t (related to) diabetes. Goal & Target Date: (Name of Resident #42) will remain free from signs and syptoms (sic) of hyper/hypoglycemia through next review. Approaches. Perform Accuchecks (blood sugar checks) as ordered by physician and prn (as needed) if you suspect abnormal blood sugar. May follow standing orders if hypoglycemia occurs. Administer medication as ordered by physician."

A review of Resident #42's physician orders revealed, in part, the following order related to the treatment of diabetes:

- "9/19/17. Novolog [1] (a fast acting insulin used to treat diabetes) 100 unit/ml (milliliters) vial. Inject 10 units subcutaneously (under the skin) immediately after lunch. *Hold dose if patient does not eat 75% of meal or if BS (blood sugar) < (is less than) 100* (If BS 100-130 give 1/2 of scheduled dose)."

- "9/4/17. Novolog 100 unit/ml vial inject 1-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 56	F 656		

units subcutaneously 3 times daily before meals. Sliding scale if BS: 150 -199 = 1 unit, 200 - 249 = 2 units, 250 - 299 = 4 units, 300 - 349 = 6 units, 350 - 399 = 8 units, 400 - 450 = 10 units, 450 or > (greater) = 12 units & call MD (medical doctor)."

On 2/7/18 at 10:45 a.m. LPN (licensed practical nurse) #4, a floor nurse, was observed obtaining an accucheck from Resident #42 and administering Novolog insulin. Resident #42's accucheck was measured at 324. LPN #4 then reviewed the MAR (medication administration record) and stated that for an accucheck of 324 Resident #42 would receive sliding scale insulin 6 units plus Resident #42 had a scheduled order for 10 units of Novolog three times per day. LPN #4 drew up 16 units of Novolog insulin and administered the insulin to Resident #42 in her left upper stomach area.

During an interview on 2/7/18 at approximately 12:45 p.m. with OSM (other staff member) # 3, dietary staff, OSM # 3 was asked at what time the residents on the Lee Unit are served lunch in their rooms. OSM # 3 stated when everyone in the dining room is served then the residents on the floor (Lee Unit) are served lunch.

Lunch trays were not observed on the Lee unit at any time on 12/7/18 between 11 a.m. and noon.

On 2/7/18 at 2:15 p.m., an interview was conducted with LPN #4. LPN #4 was asked to describe the process followed when giving medications to a resident. LPN #4 stated, "I give the medication as instructed." LPN #4 was asked to review Resident #42's orders for insulin and to state what the orders were for her noon medications. LPN #4 stated, "(Name of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 57	F 656		

#42) receives Novolog 10 units immediately after lunch." When asked when she gave the Novolog 10 units today, LPN #4 stated, "I gave it before lunch, at 10:45 a.m." LPN #4 was asked what time the Novolog 10 units was due. LPN #4 stated, "12:30 PM." When asked why she administered the Novolog sliding scale and scheduled Novolog at the same time, LPN #4 stated, "I read it wrong, it is two separate orders." When asked if Resident #42 had eaten lunch prior to administering the two doses of Novolog, LPN #4 stated that she had not.

On 2/7/18 at 3:48 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 was asked what a nurse should do prior to administering medications. ASM #3 stated, "The nurse should check the orders, check the patient, do the five rights of medication administration." ASM #3 was informed of the above concern and was asked if LPN #4 had conducted the five rights of medication administration prior to administering the two doses of insulin at the same time to Resident #42. ASM #3 stated she did not know, as she was not there when it was administered. ASM #3 stated, "She (LPN #4) checked the order, she read it, she just messed up." At this time this writer and ASM #3 reviewed the documentation for the insulin administeration conducted (and observed by this writer) on 2/7/18 at 10:57 a.m. and at 11:30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11:30 a.m. when the nurse was observed administering the 10 units with the 6 units sliding scale at 10:57 a.m. ASM #3 stated the nurse (LPN #4) had not signed off on the second order at the time the medication was administered, as she had forgotten to do it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 656	Continued From page 58 when the medication was actually administered. On 2/8/18 at 8:10 a.m., an interview was conducted with LPN #1, a floor nurse. LPN #1 was asked to describe the purpose of the comprehensive care plan. LPN #1 stated, "It is to know how to take care of the patient, what their specifics are (for care)." LPN #1 was asked how she would know what was on the care plan. LPN #1 stated, "The care plans are on the computer, we have knowledge of why the residents are there and how to care for them." LPN #1 was asked if the nursing staff should follow the comprehensive care plan. LPN #1 stated, "Yes, you should follow the care plan." At a meeting conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance on 2/8/18 at 3:58 p.m. the above concerns were provided. A copy of the facility policy for following the care plan was requested at this time. No further information was presented prior to the end of the survey process. [1] Novolog is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. This information was obtained from the following website: https://www.drugs.com/novolog.html	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 684	Continued From page 59 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the physician orders for one of 24 residents in the survey sample, Resident #42. The facility staff failed to administer insulin to Resident # 42's as ordered by the physician. The findings include: Resident #42 was admitted to the facility on 2/21/11 with a readmission on 8/2/17 with diagnoses including, but not limited to muscle weakness, reflux disease, shortness of breath, chronic kidney disease and diabetes. Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/13/17, coded Resident #42's BIMS (brief interview of mental status) score as seven out of a possible 15, indicating that Resident #42 is severely cognitively impaired with decisions of daily living. A review of Resident #42's comprehensive care plan dated 8/2/17 revealed, in part, the following documentation: "Problem / Need. Risk for hyper/hypoglycemia (high/low blood sugar) r/t (related to) diabetes. Goal & Target Date:	F 684	1)Resident #42's insulin orders were reviewed with the nurse on duty during the survey at the time the error was recognized. 2)No other residents in the facility had insulin orders for post meals based on consumption. 3)Unannounced med pass observations will be made for 10% of the nurses administering insulin will be complete to identify deviations from standards of practice. 4)Ongoing concerns from med pass observations of will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 684	Continued From page 60	F 684		

(Name of Resident #42) will remain free from signs and symptoms (sic) of hyper/hypoglycemia through next review. Approaches. Perform Accuchecks (blood sugar checks) as ordered by physician and prn (as needed) if you suspect abnormal blood sugar. May follow standing orders if hypoglycemia [2] occurs. Administer medication as ordered by physician."

A review of Resident #42's physician orders revealed, in part, the following order related to the treatment of diabetes:

- "9/19/17. Novolog [1] (a fast acting insulin used to treat diabetes) 100 unit/ml (milliliters) vial. Inject 10 units subcutaneously (under the skin) immediately after lunch. *Hold dose if patient does not eat 75% of meal or if BS (blood sugar) < (is less than) 100* (If BS 100-130 give 1/2 of scheduled dose)."

- "9/4/17. Novolog 100 unit/ml vial inject 1-16 units subcutaneously 3 times daily before meals. Sliding scale if BS: 150 -199 = 1 unit, 200 - 249 = 2 units, 250 - 299 = 4 units, 300 - 349 = 6 units, 350 - 399 = 8 units, 400 - 450 = 10 units, 450 or > (greater) = 12 units & call MD (medical doctor)."

On 2/7/18 at 10:45 a.m. LPN (licensed practical nurse) #4, a floor nurse, was observed obtaining an accucheck from Resident #42 and administering Novolog insulin. Resident #42's accucheck was measured at 324. LPN #4 then reviewed the MAR (medication administration record) and stated that for an accucheck of 324 Resident #42 would receive sliding scale insulin 6 units plus Resident #42 had a scheduled order for 10 units of Novolog three times per day. LPN #4 drew up 16 units of Novolog insulin and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 684	Continued From page 61	F 684		

administered the insulin to Resident #42 in her left upper stomach area.

During an interview on 2/7/18 at approximately 12:45 p.m. with OSM (other staff member) # 3, dietary staff, OSM # 3 was asked at what time the residents on the Lee Unit are served lunch in their rooms. OSM # 3 stated when everyone in the dining room is served then the residents on the floor (Lee Unit) are served lunch.

Lunch trays were not observed on the Lee unit at any time on 12/7/18 between 11 a.m. and noon.

On 2/7/18 at 2:15 p.m., an interview was conducted with LPN #4. LPN #4 was asked to describe the process followed when giving medications to a resident. LPN #4 stated, "I give the medication as instructed." LPN #4 was asked to review Resident #42's orders for insulin and to state what the orders were for her noon medications. LPN #4 stated, "(Name of Resident #42) receives Novolog 10 units immediately after lunch." When asked when she gave the 10 units to Resident #42 today, LPN #4 stated, "I gave it before lunch, at 10:45 a.m." LPN #4 was asked what time the Novolog insulin 10 units was due. LPN #4 stated, "12:30 p.m." When asked why she administered the Novolog sliding scale insulin and scheduled Novolog insulin at the same time, LPN #4 stated, "I read it wrong, it is two separate orders." When asked if Resident #42 had eaten lunch prior to administering the two doses of Novolog insulin, LPN #4 stated she (Resident #42) had not. LPN #4 was asked to obtain a repeat blood sugar at this time. This writer accompanied LPN #4 into Resident #42's room, permission was obtained from the resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 684	Continued From page 62	F 684		

obtain the accucheck. The accucheck was 64, LPN #4 offered Resident #42 a soda at this time.

On 2/7/18 at 3:48 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 was asked what a nurse should do prior to administering medications. ASM #3 stated, "The nurse should check the orders, check the patient, do the five rights of medication administration." ASM #3 was informed of the above concern and was asked if LPN #4 had conducted the five rights of medication administration prior to administering the two doses of insulin at the same time to Resident #42. ASM #3 stated that she did not know, as she was not there when it was administered. ASM #3 stated, "She (LPN #4) checked the order, she read it, she just messed up." At this time this writer and ASM #3 reviewed the documentation for the insulin administration conducted (and observed by this writer) on 2/7/18 at 10:57 a.m. and at 11:30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11:30 a.m., when the nurse (LPN #4) was observed administering the 10 units of novolog insulin with the 6 unit's sliding scale insulin at 10:57 a.m. ASM #3 stated the nurse had not signed off on the second order at the time the medication was administered as she had forgotten to do it when the medication was actually administered. ASM #3 presented to this writer a list of Resident #42 meal intakes. The 2/7/18 lunch was recorded as 50 %. ASM #3 was asked if the order for Novolog 10 units should have been administered, ASM #3 stated that it should not.

On 2/8/18 at 8:10 a.m., an interview was conducted with LPN #1, a floor nurse. LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 63	F 684		

was asked to state the time parameters for administering a medication to a resident. LPN #1 stated, "We can give the medication up to an hour before the time due and an hour after the time due. If you are trying to give the medication outside of the time parameter, the medication will not show up, it will not "fire" you cannot see it on the screen, it will be white. I guess you could try to give outside of the time but it (the system) will give you a warning that it is not time. I guess you could circumvent but that wouldn't make sense." LPN #1 was asked how that works when giving insulin, when there were two orders an hour apart, before and after lunch. LPN #1 stated, "If the order states before and after lunch then you would have to follow the order as it is written." LPN #1 was asked the risk of combining two orders of insulin, LPN #1 stated, "The blood sugar could drop, and the reason for the dose after lunch based on the meal is to make sure they don't get too much insulin."

On 2/8/18 at 3:11 p.m., an interview was conducted with ASM #4, the medical doctor. ASM #4 was asked to state the goal for Resident #42's blood sugars using his current insulin orders. ASM #4 stated, "To get her blood sugars under a tighter control because her eating habits are unpredictable." ASM #4 was asked what his expectation was when he provided specific insulin orders to nursing. ASM #4 stated, "I expect that the orders are followed. (Name of Resident #42) is difficult to gain control of blood sugars to prevent excessive highs and lows. The insulin regime she is on and is not a normal regime, this is more cause for the nursing staff to be diligent. Any insulin order requires, by nature of the drug, a greater diligence because of the risks (hypoglycemia), which has been the main thrust

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 684	Continued From page 64	F 684		

of changes to prevent hypoglycemic emergency. Mostly due to the residents' erratic intake, I am concerned with hypoglycemic events with her." ASM #4 was asked if he would expect the after meal scheduled order of insulin to be given before meals. ASM #4 stated that he would not because of her previous "spells" of hypoglycemia and erratic intake. If she doesn't eat I don't want her to the have the scheduled Novolog because of the risk of hypoglycemia." ASM #4 was asked what he thought of Resident #42 receiving both the pre meal sliding scale dose of Novolog and the post meal scheduled Novolog at the same time (prior to the meal). ASM #4 stated, "In theory if she received both insulin doses prior to the meal it could potentially be too much. She always eats something so it is unlikely. I want to keep her above 80 (blood sugar), below that is not ideal for her." ASM #4 was made aware at this time that Resident #42 had received both doses of insulin (the pre meal sliding scale Novolog and post meal scheduled Novolog) at 10:57 a.m. and then at 2:27 p.m. this writer had asked the nurse to re-check Resident #42's blood sugar and it was 64. ASM #4 stated he had received an email from the nurse on 2/7/18 stating (name of Resident #42's) blood sugar at lunchtime was 325 and the resident was given the sliding scale dose, and the three-hour blood sugar re-check was 64. The nurse did not state both insulins had been given prior to lunch, and did not indicate the resident only ate 50% of her meal. ASM #4 further stated, "Perhaps she contacted another physician."

At a meeting conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance on 2/8/18 at 3:58 p.m. the above concerns were discussed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 65 No further information was presented prior to the end of the survey process. [1] Novolog is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. This information was obtained from the following website: https://www.drugs.com/novolog.html [2] Hypoglycemia is the most common adverse effect of all insulin therapies, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness may be life threatening or cause death. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5 [2] Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. This information was obtained from the website:https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 695	Continued From page 66 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care per the physician's order for one of 24 residents in the survey sample, Resident #23. The facility staff failed to monitor Resident #23's oxygen saturation on room air as ordered by the physician and failed to assess the residents need for oxygen therapy accurately. The finding include: Resident #23 was admitted to the facility on 2/26/2007 and readmitted on 9/24/13 with diagnoses that included but were not limited to orthostatic hypotension (low blood pressure with standing), iron deficiency anemia, heart failure, hypothyroidism and COPD (chronic obstructive pulmonary disease). Resident #23's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/12/17. Resident #23 was coded as being moderately cognitvely impaired for the ability to make daily decisions scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #23 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living).	F 695	1)Resident #23's oxygen saturation was obtained on RA per orders upon realization of concern. 2)Charge Nurse on duty was re-educated on obtaining oxygen saturations on RA per MD orders. 3)Unannounced med pass observations (during which oxygen checks are done) will be made for 10% of the nurses administering oxygen will be complete to identify deviations from standards of practice. 4)Ongoing concerns will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 695	Continued From page 67	F 695		

On 02/06/18 through 2/08/18, several observations were made of Resident #23 with oxygen in place at 2 liters/min (minute) via nasal cannula connected to an oxygen concentrator. These observations were made on 2/6/18 at 2:44 p.m., 2/7/18 at 8:22 a.m., 9:11 a.m., and 4:00 p.m., and 2/8/18 at 8:01 a.m., and 9:47 a.m.

Review of Resident #23's most recent POS (physician order sheet) documented the following orders:

1. "Oxygen via NC (nasal cannula) at 2 L (liters)/min (minute) as needed to keep 02 saturation greater than 90 percent for respiratory distress or shortness of breath. May titrate up to 4 liters/min." This order was initiated on 1/2/18.

2. "Pulse OX [1] (oximetry): check pulse ox on room air every shift." This order was initiated on 1/2/18.

Review of Resident #23's February 2018 MAR (Medication Administration Record) revealed Resident #23's pulse oximetry levels were in the high 90s on 2/6/18 through 2/8/18 on room air. The following was documented:

"2/06/18 at 7:00 a.m., Sp02 [2] levels: 96 percent.
2/06/18 at 3:00 p.m. Sp02 levels: 96 percent.
2/06/18 at 11:00 p.m., Sp02 levels: 97 percent.
2/07/18 at 7:00 a.m., Sp02 levels: 96 percent.
2/07/18 at 3:00 p.m., Sp02 levels: 93 percent.
2/08/18 at 7:00 a.m., Sp02 levels: 97 percent."

Review of Resident #23's "activity intolerance" care plan dated 9/24/13 documented the following active intervention: "Administer 02 (oxygen) prn."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 695	Continued From page 68	F 695		

On 2/08/18 at 8:35 a.m., an interview was conducted with RN (registered nurse) #2, a unit manager. When asked the purpose of checking oxygen saturations on room air for a resident who receives prn (as needed) oxygen, RN #2 stated the purpose was to check to see if a resident can maintain high oxygen saturation on their own. When asked if oxygen would be placed on a resident who is reaching 02 levels in the high 90s on room air and on their own, RN #2 stated the resident would not need oxygen if they were reaching high levels on their own. When asked who was responsible for taking the pulse ox, RN #2 stated the nurses were responsible. When asked if she was familiar with Resident #23, RN #2 stated that she was. When asked about Resident #23's oxygen order, RN #2 stated that she would have to check her care plan.

On 2/08/18 at 8:38 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked what she would do with an order to check oxygen saturation on room air, LPN #1 stated, "I would check her oxygen levels on room air." When asked what nurses would do if the resident's oxygen level was in the high 90s on room air, LPN #1 stated that she would not administer oxygen because the resident did not need it.

On 2/08/18 at 11:46 a.m., an interview was conducted with LPN #3, Resident #23's nurse. When asked who was responsible for checking the pulse ox for residents receiving oxygen, LPN #3 stated it was the nurses' responsibility to check the pulse ox. When asked how she would check pulse ox for a resident receiving oxygen, LPN #3 stated that if a resident were on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 695	Continued From page 69	F 695		

continuous order for oxygen, she would check pulse ox. with the oxygen via nasal cannula in place. LPN #3 stated if the oxygen order was prn (as needed); she would check oxygen saturation without the oxygen in place. LPN #3 stated if a resident's oxygen level were not above 90 percent on room air, then she would apply oxygen. When asked if she was familiar with Resident #23, LPN #3 stated she was. When asked if she knew Resident #23's oxygen order, LPN #3 stated she could not remember right off hand. LPN #3 stated, "I know she has it (oxygen) on." When asked how she checked Resident #23's oxygen saturation that morning, LPN #3 stated she checked Resident #23's oxygen saturation with the nasal cannula in place and oxygen on at 2 liters. LPN #3 stated she was not sure of the pulse oximetry order. When asked the purpose of checking pulse oximetry levels on room air, LPN #3 stated, "To check to see what their baseline is." LPN #3 stated she was not sure if the other nurses were checking Resident #23's pulse oximetry with her nasal cannula in place or on room air.

On 2/08/18 at 3:58 p.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Compliance. ASM #2 stated that checking pulse oximetry on room air was part of the oxygen assessment protocol to see if residents needed oxygen therapy. ASM #2 stated some residents feel more comfortable with oxygen in place and the nurses should be changing the orders in that situation.

On 2/08/18 at 3:58 p.m., ASM #1, the administrator and ASM #2, the Director of Compliance were made aware of the above concerns. No further information was presented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 70 prior to exit. The facility policy titled, "Oxygen Administration" documents in part, the following: "13. Monitor resident's response to therapy with pulse oximetry as necessary." No further information was presented prior to exit. [1] Pulse Oximmetry-"The pulse oximeter is a probe attached to the patient's finger that measures the differential absorption of infrared light by oxygenated and deoxygenated haemoglobin in capillaries. The display unit indicates the percentage of haemoglobin saturated with oxygen (Sp02)." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080222/. [2] Sp02 (saturated levels of oxygen) in residents with respiratory diseases should be at 90 percent or above. Supplemental oxygen should be used for Sp02 levels of less than 90 percent on room air. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113909/	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 698	Continued From page 71 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide dialysis care for one of 24 residents in the survey sample, Resident #106. The facility staff failed to assess patency of Resident #106's dialysis vascular access site (1). The findings include: Resident #106 was most recently admitted to the facility on 1/11/18. Resident #106's diagnoses included but were not limited to diabetes, high blood pressure and end stage renal disease. Resident #106's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 1/25/18, coded the resident as cognitively intact. Section O documented Resident #106 received dialysis. Review of Resident #106's clinical record revealed physician admission orders dated 1/11/18 that documented an order for dialysis every Monday, Wednesday and Friday. The orders failed to document any directions regarding the resident's dialysis access site. Review of further physician's orders from 1/11/18 through 2/6/18 failed to reveal orders regarding Resident #106's dialysis access site. Resident #106's January 2018 and February 2018 MARs (medication administration records)/TARs (treatment administration records) (prior to 2/7/18) failed to document any directions regarding the resident's dialysis access site. Nurses' notes from 1/11/18 through 2/6/18 failed to document an assessment for the presence of a	F 698	1)AVF monitoring was added to the nursing interventions for Resident #106 prior to exit of the survey team. 2)All residents with AVFs where audited to ensure nursing interventions were in place for AVF monitoring. 3)The facility will randomly audit 10% of residents chart with AVF to ensure nursing interventions for AVF monitor are in place. 4)Ongoing concerns will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 698	Continued From page 72	F 698		

thrill (2) or bruit (3) of Resident #106's dialysis access site except for a note dated 1/11/18. Resident #106's care plan with a problem onset date of 12/12/17 documented, "Dialysis...Observe Left Arm Shunt (dialysis access) site for presence of bruit, redness or swelling as indicated and report negative findings to MD (medical doctor) accordingly..."

On 2/7/18 at 4:21 p.m., Resident #106 was sitting in the bedroom. The resident's dialysis access site located on the resident's left arm was covered with a dressing. Resident #106 was asked if the facility staff ever assesses her dialysis access site. Resident #106 stated, "I don't think they do here so much as they do at dialysis." Resident #106 stated she goes to dialysis three days a week and the staff there listen to the area with a stethoscope and check the dressing.

On 2/7/18 at 4:30 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the care that should be provided to a resident who receives dialysis. RN #1 stated the facility staff protects the resident's arm that contains the fistula (a type of access site). RN #1 stated this is noted on the care plan under impaired mobility or in a separate care plan. RN #1 was asked if anything else should be done. RN #1 stated, "I want to say that translates down to nursing interventions. We protect the extremity and note on the MAR or TAR." RN #1 was asked if nurses should assess for thrill and bruit. RN #1 stated, "We do that. Yes." RN #1 stated the nurses should assess for thrill and bruit every shift.

On 2/7/18 at 5:21 p.m. ASM (administrative staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 698	Continued From page 73	F 698		

member) #1 (the administrator) and ASM #2 (the director of compliance) were made aware of the above findings.

On 2/8/18 at 7:40 a.m., ASM #2 presented a physician order list dated 2/7/18 that documented, "Nursing Intervention: Assess dialysis shunt for bruitt (sic) and thrill q (every) shift. Monitor for post dialysis bleeding from site. Notify MD Medical doctor) of abnormal findings."

On 2/8/18 at 8:10 a.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding the care that should be provided to a resident receiving dialysis. LPN #1 stated, "With a fistula there is a bruit and thrill and you always want to make sure that's going." When asked to clarify what she meant by "to make sure that's going," LPN #1 stated, "Feel it and make sure you can hear it." When asked how this should be done, LPN #1 stated a stethoscope should be used. When asked how often this should be done, LPN #1 stated she would have to check. When asked how other nurses would know the area needs to be assessed and how often, LPN #1 stated this information should be relayed during the shift change report and should be documented on the treatment record.

The facility policy titled, "Care of the Resident on Hemodialysis with an AV Shunt or Fistula" documented, "PURPOSE: Residents receiving hemodialysis via an AV [ateriovenous] shunt or fistula are at risk for complications related to the shunt, dialysis and end stage renal disease. The facility will monitor the resident for change in condition to prevent infection, hemorrhage, bruising, and decline in overall condition...SPECIFIC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 698	Continued From page 74	F 698		

PROCEDURE/REQUIREMENTS...4. Nursing staff may palpate the shunt or fistula for thrill and listen for bruit to monitor patency. If a thrill is not palpated and/or bruit not heard, the assessment will be documented in the nursing notes and the physician will be immediately notified for further direction and treatment...8. The physician will prescribe care instructions as deemed medically appropriate. 9. The care plan will include other dialysis care measures and precautions..."

No further information was presented prior to exit.

(1) "A vascular access is a hemodialysis patient's lifeline. A vascular access makes life-saving hemodialysis treatments possible. Hemodialysis is a treatment for kidney failure that uses a machine to send the patient's blood through a filter, called a dialyzer, outside the body. The access is a surgically created vein used to remove and return blood during hemodialysis. The blood goes through a needle, a few ounces at a time. The blood then travels through a tube that takes it to the dialyzer. Inside the dialyzer, the blood flows through thin fibers that filter out wastes and extra fluid. The machine returns the filtered blood to the body through a different tube. A vascular access lets large amounts of blood flow continuously during hemodialysis treatments to filter as much blood as possible per treatment..." This information was obtained from the website: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/vascular-access

(2) "How does a patient care for and protect a vascular access...Checking the thrill in the access every day. The thrill is the rhythmic vibration a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

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HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 698	Continued From page 75 person can feel over the vascular access..." This information was obtained from the website: https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/vascular-access (3) "When blood flows through a narrow artery, it sometimes makes a whooshing sound, called a bruit." This information was obtained from the website: https://www.niddk.nih.gov/health-information/kidney-disease/renal-artery-stenosis	F 698		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced	F 757		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 757	Continued From page 76 by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to ensure one of 24 residents in the survey sample, Resident #42, was free from unnecessary medications On 2/7/18 at 10:45 a.m., LPN (licensed practical nurse) #4 was observed administering a dose of insulin to Resident #42 that was ordered for administration at 12:30 p.m., following lunch, if the resident ate greater than 75% of the meal. Resident #42 was documented as eating only 50 % of her lunch on that day. The findings include: Resident #42 was admitted to the facility on 2/21/11 with a readmission on 8/2/17 with diagnoses including, but not limited to muscle weakness, reflux disease, shortness of breath, chronic kidney disease and diabetes. Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/13/17, coded Resident #42's BIMS (brief interview of mental status) score as seven out of a possible 15, indicating that Resident #42 is severely cognitively impaired with decisions of daily living. A review of Resident #42's comprehensive care plan dated 8/2/17 revealed, in part, the following documentation: "Problem / Need. Risk for hyper/hypoglycemia (high/low blood sugar) r/t (related to) diabetes. Goal & Target Date: (Name of Resident #42) will remain free from signs and symptoms (sic) of hyper/hypoglycemia through next review. Approaches. Perform	F 757	1)Resident #42's medication administration error was addressed appropriately after discovery during the survey process 2)The LPN #4 responsible for the erroneous medication (insulin) administration was provided education and counseling. 3)Unannounced med pass observations will be made for 10% of the nurses administering insulin will be complete to identify deviations from standards of practice. 4)Ongoing concerns will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

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HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 757	Continued From page 77	F 757		

Accuchecks (blood sugar checks) as ordered by physician and prn (as needed) if you suspect abnormal blood sugar. May follow standing orders if hypoglycemia [2] occurs. Administer medication as ordered by physician."

A review of Resident #42's physician orders revealed, in part, the following order related to the treatment of diabetes:

- "9/19/17. Novolog [1] (a fast acting insulin used to treat diabetes) 100 unit/ml (milliliters) vial. Inject 10 units subcutaneously (under the skin) immediately after lunch. *Hold dose if patient does not eat 75% of meal or if BS (blood sugar) < (is less than) 100* (If BS 100-130 give 1/2 of scheduled dose)."

- "9/4/17. Novolog 100 unit/ml vial inject 1-16 units subcutaneously 3 times daily before meals. Sliding scale if BS: 150 -199 = 1 unit, 200 - 249 = 2 units, 250 - 299 = 4 units, 300 - 349 = 6 units, 350 - 399 = 8 units, 400 - 450 = 10 units, 450 or > (greater) = 12 units & call MD (medical doctor)."

On 2/7/18 at 10:45 a.m. LPN (licensed practical nurse) #4, a floor nurse, was observed obtaining an accucheck from Resident #42 and administering Novolog insulin. Resident #42's accucheck was measured at 324. LPN #4 then reviewed the MAR (medication administration record) and stated that for an accucheck of 324 Resident #42 would receive sliding scale insulin 6 units plus Resident #42 had a scheduled order for 10 units of Novolog three times per day. LPN #4 drew up 16 units of Novolog insulin and administered the insulin to Resident #42 in her left upper stomach area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 757	Continued From page 78	F 757		

During an interview on 2/7/18 at approximately 12:45 p.m. with OSM (other staff member) # 3, dietary staff, OSM # 3 was asked at what time the residents on the Lee Unit are served lunch in their rooms. OSM # 3 stated when everyone in the dining room is served then the residents on the floor (Lee Unit) are served lunch.

Lunch trays were not observed on the Lee unit at any time on 12/7/18 between 11 a.m. and noon.

On 2/7/18 at 2:15 p.m., an interview was conducted with LPN #4. LPN #4 was asked to describe the process followed when giving medications to a resident. LPN #4 stated, "I give the medication as instructed." LPN #4 was asked to review Resident #42's orders for insulin and to state what the orders were for her noon medications. LPN #4 stated, "(Name of Resident #42) receives Novolog 10 units immediately after lunch." When asked when she gave the 10 units to Resident #42 today, LPN #4 stated, "I gave it before lunch, at 10:45 a.m." LPN #4 was asked what time the Novolog insulin 10 units was due. LPN #4 stated, "12:30 p.m." When asked why she administered the Novolog sliding scale insulin and scheduled Novolog insulin at the same time, LPN #4 stated, "I read it wrong, it is two separate orders." When asked if Resident #42 had eaten lunch prior to administering the two doses of Novolog insulin, LPN #4 stated she (Resident #42) had not. LPN #4 was asked to obtain a repeat blood sugar at this time. This writer accompanied LPN #4 into Resident #42's room, permission was obtained from the resident to obtain the accucheck. The accucheck was 64, LPN #4 offered Resident #42 a soda at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 757	Continued From page 79	F 757		

On 2/7/18 at 3:48 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 was asked what a nurse should do prior to administering medications. ASM #3 stated, "The nurse should check the orders, check the patient, do the five rights of medication administration." ASM #3 was informed of the above concern and was asked if LPN #4 had conducted the five rights of medication administration prior to administering the two doses of insulin at the same time to Resident #42. ASM #3 stated that she did not know, as she was not there when it was administered. ASM #3 stated, "She (LPN #4) checked the order, she read it, she just messed up." At this time this writer and ASM #3 reviewed the documentation for the insulin administration conducted (and observed by this writer) on 2/7/18 at 10:57 a.m. and at 11:30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11:30 a.m., when the nurse (LPN #4) was observed administering the 10 units of novolog insulin with the 6 unit's sliding scale insulin at 10:57 a.m. ASM #3 stated the nurse had not signed off on the second order at the time the medication was administered as she had forgotten to do it when the medication was actually administered. ASM #3 presented to this writer a list of Resident #42 meal intakes. The 2/7/18 lunch was recorded as 50 %. ASM #3 was asked if the order for Novolog 10 units should have been administered, ASM #3 stated that it should not.

On 2/8/18 at 8:10 a.m., an interview was conducted with LPN #1, a floor nurse. LPN #1 was asked to state the time parameters for administering a medication to a resident. LPN #1 stated, "We can give the medication up to an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 757	Continued From page 80	F 757		

hour before the time due and an hour after the time due. If you are trying to give the medication outside of the time parameter, the medication will not show up, it will not "fire" you cannot see it on the screen, it will be white. I guess you could try to give outside of the time but it (the system) will give you a warning that it is not time. I guess you could circumvent but that wouldn't make sense." LPN #1 was asked how that works when giving insulin, when there were two orders an hour apart, before and after lunch. LPN #1 stated, "If the order states before and after lunch then you would have to follow the order as it is written." LPN #1 was asked the risk of combining two orders of insulin, LPN #1 stated, "The blood sugar could drop, and the reason for the dose after lunch based on the meal is to make sure they don't get too much insulin."

On 2/8/18 at 3:11 p.m., an interview was conducted with ASM #4, the medical doctor. ASM #4 was asked to state the goal for Resident #42's blood sugars using his current insulin orders. ASM #4 stated, "To get her blood sugars under a tighter control because her eating habits are unpredictable." ASM #4 was asked what his expectation was when he provided specific insulin orders to nursing. ASM #4 stated, "I expect that the orders are followed. (Name of Resident #42) is difficult to gain control of blood sugars to prevent excessive highs and lows. The insulin regime she is on and is not a normal regime, this is more cause for the nursing staff to be diligent. Any insulin order requires, by nature of the drug, a greater diligence because of the risks (hypoglycemia), which has been the main thrust of changes to prevent hypoglycemic emergency. Mostly due to the residents' erratic intake, I am concerned with hypoglycemic events with her."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 757	Continued From page 81	F 757		

ASM #4 was asked if he would expect the after meal scheduled order of insulin to be given before meals. ASM #4 stated that he would not because of her previous "spells" of hypoglycemia and erratic intake. If she doesn't eat I don't want her to the have the scheduled Novolog because of the risk of hypoglycemia." ASM #4 was asked what he thought of Resident #42 receiving both the pre meal sliding scale dose of Novolog and the post meal scheduled Novolog at the same time (prior to the meal). ASM #4 stated, "In theory if she received both insulin doses prior to the meal it could potentially be too much. She always eats something so it is unlikely. I want to keep her above 80 (blood sugar), below that is not ideal for her." ASM #4 was made aware at this time that Resident #42 had received both doses of insulin (the pre meal sliding scale Novolog and post meal scheduled Novolog) at 10:57 a.m. and then at 2:27 p.m. this writer had asked the nurse to re-check Resident #42's blood sugar and it was 64. ASM #4 stated he had received an email from the nurse on 2/7/18 stating (name of Resident #42's) blood sugar at lunchtime was 325 and the resident was given the sliding scale dose, and the three-hour blood sugar re-check was 64. The nurse did not state both insulins had been given prior to lunch, and did not indicate the resident only ate 50% of her meal. ASM #4 further stated, "Perhaps she contacted another physician."

At a meeting conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance on 2/8/18 at 3:58 p.m. the above concerns were discussed.

No further information was presented prior to the end of the survey process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 757	Continued From page 82 [1] Novolog is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. This information was obtained from the following website: https://www.drugs.com/novolog.html [2] Hypoglycemia is the most common adverse effect of all insulin therapies, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness may be life threatening or cause death. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5 [2] Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. This information was obtained from the	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to ensure a resident was free from a significant medication error for one of 24 residents in the survey sample, Resident #42.	F 760	1)LPN #4 responsible for the medication administration error was provided education and counseling. 2)The facility provided medication administration/Insulin administration	3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 760	Continued From page 83 On 2/7/18 at 10:45 a.m. LPN (licensed practical nurse) #4 was observed administering a dose of insulin to Resident #42 that was ordered for administration at 12:30 p.m., following lunch, if the resident ate greater than 75% of the meal. Resident #42 was documented as eating only 50 % of her lunch on that day. Staff were requested to check Resident #42's blood sugar at approximately 2:15 p.m.; the blood sugar reading was 64. The findings include: Resident #42 was admitted to the facility on 2/21/11 with a readmission on 8/2/17 with diagnoses including, but not limited to muscle weakness, reflux disease, shortness of breath, chronic kidney disease and diabetes. Resident #42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/13/17, coded Resident #42's BIMS (brief interview of mental status) score as seven out of a possible 15, indicating that Resident #42 is severely cognitively impaired with decisions of daily living. A review of Resident #42's comprehensive care plan dated 8/2/17 revealed, in part, the following documentation: "Problem / Need. Risk for hyper/hypoglycemia (high/low blood sugar) r/t (related to) diabetes. Goal & Target Date: (Name of Resident #42) will remain free from signs and symptoms (sic) of hyper/hypoglycemia through next review. Approaches. Perform Accuchecks (blood sugar checks) as ordered by physician and prn (as needed) if you suspect abnormal blood sugar. May follow standing	F 760	in-services for facility charge nurses. 3)Unannounced med pass observations will be made for 10% of the nurses administering insulin will be complete to identify deviations from standards of practice. 4)Ongoing concerns will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 760	Continued From page 84	F 760		

orders if hypoglycemia [2] occurs. Administer medication as ordered by physician."

A review of Resident #42's physician orders revealed, in part, the following order related to the treatment of diabetes:

- "9/19/17. Novolog [1] (a fast acting insulin used to treat diabetes) 100 unit/ml (milliliters) vial. Inject 10 units subcutaneously (under the skin) immediately after lunch. *Hold dose if patient does not eat 75% of meal or if BS (blood sugar) < (is less than) 100* (If BS 100-130 give 1/2 of scheduled dose)."

- "9/4/17. Novolog 100 unit/ml vial inject 1-16 units subcutaneously 3 times daily before meals. Sliding scale if BS: 150 -199 = 1 unit, 200 - 249 = 2 units, 250 - 299 = 4 units, 300 - 349 = 6 units, 350 - 399 = 8 units, 400 - 450 = 10 units, 450 or > (greater) = 12 units & call MD (medical doctor)."

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During an interview on 2/7/18 at approximately 12:45 p.m. with OSM (other staff member) # 3, dietary staff, OSM # 3 was asked at what time the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 760	Continued From page 85	F 760		

residents on the Lee Unit are served lunch in their rooms. OSM # 3 stated when everyone in the dining room is served then the residents on the floor (Lee Unit) are served lunch.

Lunch trays were not observed on the Lee unit at any time on 12/7/18 between 11 a.m. and noon.

On 2/7/18 at 2:15 p.m., an interview was conducted with LPN #4. LPN #4 was asked to describe the process followed when giving medications to a resident. LPN #4 stated, "I give the medication as instructed." LPN #4 was asked to review Resident #42's orders for insulin and to state what the orders were for her noon medications. LPN #4 stated, "(Name of Resident #42) receives Novolog 10 units immediately after lunch." When asked when she gave the 10 units to Resident #42 today, LPN #4 stated, "I gave it before lunch, at 10:45 a.m." LPN #4 was asked what time the Novolog insulin 10 units was due. LPN #4 stated, "12:30 PM." When asked why she administered the Novolog sliding scale insulin and scheduled Novolog insulin at the same time, LPN #4 stated, "I read it wrong, it is two separate orders." When asked if Resident #42 had eaten lunch prior to administering the two doses of Novolog insulin, LPN #4 stated she (Resident #42) had not. LPN #4 was asked to obtain a repeat blood sugar at this time. This writer accompanied LPN #4 into Resident #42's room, permission was obtained from the resident to obtain the accucheck. The accucheck was 64, LPN #4 offered Resident #42 a soda at this time.

On 2/7/18 at 3:48 p.m., an interview was conducted with ASM (administrative staff member) #3, the director of nursing. ASM #3 was asked what a nurse should do prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 760	Continued From page 86	F 760		

administering medications. ASM #3 stated, "The nurse should check the orders, check the patient, do the five rights of medication administration." ASM #3 was informed of the above concern and was asked if LPN #4 had conducted the five rights of medication administration prior to administering the two doses of insulin at the same time to Resident #42. ASM #3 stated that she did not know, as she was not there when it was administered. ASM #3 stated, "She (LPN #4) checked the order, she read it, she just messed up." At this time this writer and ASM #3 reviewed the documentation for the insulin administration conducted (and observed by this writer) on 2/7/18 at 10:57 a.m. and at 11:30 a.m. ASM #3 was asked why or how the 10 units of scheduled insulin were documented at 11:30 a.m., when the nurse (LPN #4) was observed administering the 10 units of novolog insulin with the 6 unit's sliding scale insulin at 10:57 a.m. ASM #3 stated the nurse had not signed off on the second order at the time the medication was administered as she had forgotten to do it when the medication was actually administered. ASM #3 presented to this writer a list of Resident #42 meal intakes. The 2/7/18 lunch was recorded as 50 %. ASM #3 was asked if the order for Novolog 10 units should have been administered, ASM #3 stated that it should not.

On 2/8/18 at 8:10 a.m., an interview was conducted with LPN #1, a floor nurse. LPN #1 was asked to state the time parameters for administering a medication to a resident. LPN #1 stated, "We can give the medication up to an hour before the time due and an hour after the time due. If you are trying to give the medication outside of the time parameter, the medication will not show up, it will not "fire" you cannot see it on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 760	Continued From page 87	F 760		

the screen, it will be white. I guess you could try to give outside of the time but it (the system) will give you a warning that it is not time. I guess you could circumvent but that wouldn't make sense." LPN #1 was asked how that works when giving insulin, when there were two orders an hour apart, before and after lunch. LPN #1 stated, "If the order states before and after lunch then you would have to follow the order as it is written." LPN #1 was asked the risk of combining two orders of insulin, LPN #1 stated, "The blood sugar could drop, and the reason for the dose after lunch based on the meal is to make sure they don't get too much insulin."

On 2/8/18 at 3:11 p.m., an interview was conducted with ASM #4, the medical doctor. ASM #4 was asked to state the goal for Resident #42's blood sugars using his current insulin orders. ASM #4 stated, "To get her blood sugars under a tighter control because her eating habits are unpredictable." ASM #4 was asked what his expectation was when he provided specific insulin orders to nursing. ASM #4 stated, "I expect that the orders are followed. (Name of Resident #42) is difficult to gain control of blood sugars to prevent excessive highs and lows. The insulin regime she is on and is not a normal regime, this is more cause for the nursing staff to be diligent. Any insulin order requires, by nature of the drug, a greater diligence because of the risks (hypoglycemia), which has been the main thrust of changes to prevent hypoglycemic emergency. Mostly due to the residents' erratic intake, I am concerned with hypoglycemic events with her." ASM #4 was asked if he would expect the after meal scheduled order of insulin to be given before meals. ASM #4 stated that he would not because of her previous "spells" of hypoglycemia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 760	Continued From page 88	F 760		

and erratic intake. If she doesn't eat I don't want her to the have the scheduled Novolog because of the risk of hypoglycemia." ASM #4 was asked what he thought of Resident #42 receiving both the pre meal sliding scale dose of Novolog and the post meal scheduled Novolog at the same time (prior to the meal). ASM #4 stated, "In theory if she received both insulin doses prior to the meal it could potentially be too much. She always eats something so it is unlikely. I want to keep her above 80 (blood sugar), below that is not ideal for her." ASM #4 was made aware at this time that Resident #42 had received both doses of insulin (the pre meal sliding scale Novolog and post meal scheduled Novolog) at 10:57 a.m. and then at 2:27 p.m. this writer had asked the nurse to re-check Resident #42's blood sugar and it was 64. ASM #4 stated he had received an email from the nurse on 2/7/18 stating (name of Resident #42's) blood sugar at lunchtime was 325 and the resident was given the sliding scale dose, and the three-hour blood sugar re-check was 64. The nurse did not state both insulins had been given prior to lunch, and did not indicate the resident only ate 50% of her meal. ASM #4 further stated, "Perhaps she contacted another physician."

At a meeting conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of compliance on 2/8/18 at 3:58 p.m. the above concerns were discussed.

No further information was presented prior to the end of the survey process.

[1] Novolog is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 760	Continued From page 89 Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. This information was obtained from the following website: https://www.drugs.com/novolog.html [2] Hypoglycemia is the most common adverse effect of all insulin therapies, including NOVOLOG. Severe hypoglycemia can cause seizures, may lead to unconsciousness may be life threatening or cause death. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5 [2] Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. This information was obtained from the website:https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		3/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 812	Continued From page 90 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to store and serve food in a sanitary manner in one of two facility kitchens (the kitchen on the Jefferson unit) and one of two dining rooms (the Atkins dining room). 1. The facility staff failed to discard an expired container of chicken dumplings in the kitchen on the Jefferson unit. 2. The facility staff was observed serving individual desert bowls in an unsanitary manner during the 2/7/18 lunch service in the Atkins dining room. The findings include: 1. The facility staff failed to discard an expired container of chicken dumplings in the kitchen on the Jefferson unit. Observation of the facility kitchens were conducted on 2/6/18 at 11:48 a.m. On 2/6/18 at 11:51 a.m., an expired container of chicken dumplings was found in the reach- in refrigerator of the Jefferson kitchen on the Lee unit. The container had a "created date" of 1/31/18, written on the container. The container also had a "use	F 812	1)The facility promptly discarded the out of date dumplings. The facility dining room server (OSM#6) was in-serviced on proper handling of bowls when serving food. 2)No other out of date food items identified. No other staff observed improperly handling& serving food. 3)Unannounced kitchen inspections will be provided on a monthly basis to inspect for dating and discarding of products. 4)Ongoing concerns will be reported to the facility QA committee for recommendations. 5)Complete date: March 25, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 812	Continued From page 91	F 812		

by" date of 2/4/18.

On 2/06/18 at 11:59 a.m., an interview was conducted with OSM (other staff member) #6, the cook. When asked who was responsible for checking the refrigerator for expired items, OSM #6 stated he checked the refrigerator every night. When asked if the container of chicken dumplings was expired, OSM #6 stated that the chicken dumpling expired on 2/4/18. OSM #6 stated, "I'll throw this out."

On 2/08/18 at approximately 9:00 a.m., an interview was conducted with OSM #2, the Director of Dining Services. When asked who was responsible for ensuring the refrigerator was free from expired food items, OSM #2 stated any staff member should be checking the refrigerator daily. OSM #2 stated the kitchen manager should also be checking to see if this was done. When asked why the kitchen refrigerator should be free from expired food items, OSM #2 stated residents could get sick if they eat expired food items.

On 2/08/18 at 3:58 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the Director of Compliance were made aware of the above findings.

The facility policy titled, "Food Storage" documents in part the following,"All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use dates, or frozen (where applicable), or discarded."

2. The facility staff was observed serving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 812	Continued From page 92	F 812		

individual desert bowls in an unsanitary manner during the 2/7/18 lunch service in the Atkins dining room.

On 2/7/18 lunch, service was observed between 11:00 a.m. and 12 noon in the Atkins dining room. At 11:35 a.m. OSM (other staff member) #8, the dining room server, was observed serving uncovered, individual portions of desert from a tray by picking up each bowl using her thumb and finger, in a pinching motion, from the tray. Her thumb was inside each bowl and she was not wearing gloves during the service.

On 2/8/18 at 8:55 a.m., an interview was conducted with OSM #8. OSM #8 was asked how she should serve an uncovered container of food to the residents. OSM #8 stated she should pick up at the base and serve. OSM #8 was asked if it was appropriate to use a pinching technique at the lip of the container, inserting her thumb into the bowl when serving. OSM #8 stated that it was not appropriate. OSM #8 was asked if she remembered serving apple crisp to the residents during the lunch service on 2/7/18 in the Atkins dining room. OSM #8 stated she did remember and she remembered picking up the bowls with her thumb inside of the bowl.

On 2/8/18 at 9:39 a.m., an interview was conducted with OSM #2, the director of dining services. OSM #2 was asked to describe the correct manner of serving uncovered containers of food to the residents'. OSM #2 stated, "We use Serve Safe recommendations which are to pick up the containers from the base." OSM #2 was made aware of the observations made in the Atkins dining room on 2/7/18 at lunchtime. OSM #2 was asked if it was sanitary to pick up a bowl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(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
F 812	Continued From page 93	F 812		

using a pinching motion in which the thumb was inside the bowl. OSM #2 stated that it was not. OSM #2 was made aware of the observation made on 2/7/17 during the lunch serving in the Atkins dining room. OSM #2 was asked to provide the Serve Safe recommendation regarding serving open containers of food.

On 2/8/18 at 11:15 a.m., OSM #2 approached this writer and stated he was unable to locate any reference on how to serve bowls of food to residents in a sanitary manner.

On 2/8/18 at 3:58 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the Director of Compliance were made aware of the above findings.

No further information was presented prior to the end of the survey process.