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 _____	01/21/2016

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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/20/16 through 1/21/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 bed certified facility was 108 at the time of the survey. The survey sample consisted of 19 current resident reviews (Residents #1 through #19) and 5 closed record reviews (Residents #20 through #24).	F 000	F000 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all Federal and State regulations, the facility has or will take the actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the date(s) indicated.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review and facility document review, it was determined that the facility staff failed to obtain a criminal background check per facility policy for two of five employee records reviewed, OSM (other staff member) #4 and OSM #5. The facility staff failed to provide evidence that criminal background checks were obtained for OSM #4 and OSM #5 (physical therapy employees) prior to survey date (1/20/16) and within thirty days of hire.	F 226		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT / CEO — (X6) DATE: 02/03/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 The findings include: Review of OSM #4's employee records revealed OSM #4 was hired on 7/3/15. A criminal background check was not obtained until 1/20/16 (not within thirty days of date of hire). Review of OSM #5's employee records revealed his hire date of 9/11/15. A criminal background check was not obtained until 1/20/16 (not within thirty days of date of hire). On 1/21/16 at 8:30 a.m., an interview was conducted with OSM #3, the physical therapy director. He stated that human resources was responsible for checking criminal background checks. On 1/21/16 at 9:00 a.m., an interview was conducted with ASM (administrative staff member) #1, the CEO (chief executive officer). ASM #1 stated that therapy employees were contracted and the vendor did not pull the criminal background checks. He stated that he has had this problem before and was assured by (name of vendor) that they hired someone to specifically obtain background checks for new employees. ASM #1 stated, "I just called and told them that the background checks were not within the thirty days. They know I am not happy about this." No further information was provided prior to exit. The facility policy titled "Abuse Prevention" documented in part, "Criminal record checks from the VA State Police will be obtained on all new employees within 30 days of date of hire. If contract staff is used [i.e. housekeeping, dietary,	F 226	F226 1) Employees identified as contracted staff #4 and #5 had criminal background checks requested and placed in their files on 1/20/16. 2) Corporate offices of the contractor were notified immediately of the findings and all other contract employees will have criminal background checks completed with copies placed in the facility's files. 3) Contractor will submit proof of proper background checks including criminal record reports within 30 days of a new contract employee's start date at the facility. The Woodland HR Department will monitor and track this process to assure that adherence to facility policies. 4) The facility QA committee will monitor for continued compliance. RECEIVED FEB 10 2016 VDH/OLC	02/19/16

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F 226	Continued From page 2 rehab etc.] the vendor providing the contracted service will be asked to obtain criminal record checks for all staff assigned to the nursing facility and to make the criminal record check information available to the nursing facility in a timely manner."	F 226		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain the dumpster in a sanitary manner. The facility's compacting trash dumpster was observed on 1/20/16 and trash was found lying on the ground around the dumpster. The findings include: On 1/20/16 at approximately 8:30 a.m. facility's compacting dumpster was observed. The dumpster was located in the back of the facility. On the ground around the dumpster was the following: six pairs of used plastic gloves, used pieces of cardboard, an empty juice bottle, several broken pieces of Styrofoam and numerous other pieces of debris. During an observation on 1/20/16 at approximately 11:15 a.m. with OSM (other staff member) # 1, maintenance worker, the facility's	F 372		

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F 372	Continued From page 3 dumpster was observed. On the ground around the dumpster was the following: six pairs of used plastic gloves, used pieces of cardboard, an empty juice bottle, several broken pieces of Styrofoam and numerous other pieces of debris. On 1/20/16 at approximately 11:20 a.m. an interview was conducted with OSM # 1. When asked about the condition of the immediate environment around the dumpster, OSM # 1 stated, "It shouldn't be like this. When staff dumps the trash they should pick up any trash on the ground." The facility policy "Solid Waste Disposal" documented, "Monitor dumpster area for cleanliness." On 1/20/16 at 16:25 p.m. ASM (administrative staff member) # 1, chief executive officer and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 372	F372 1) Debris noted at the facility compactor area was immediately removed on the day of the findings, 1/20/16. 2) Other campus refuse disposal areas were inspected and found to be maintained in a good sanitary manner. 3) Instruction was provided to the Director of Maintenance on the expectation for maintaining all refuse/dumpster areas. 4) Routine observations will be made of refuse areas by facility administrative staff and any failure to maintain the area in a sanitary manner will be immediately addressed by the Administrator.	02/01/16