State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0291	A. BUILDING: _____ B. WING _____	02/27/2019

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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure survey was conducted 2/24/19 through 2/26/19. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 120 certified bed facility was 116 at the time of the survey. The survey sample consisted of 46 current resident reviews and 4 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-250. Resident Assessment and Care Planning. Cross reference to F641 12VAC5-371-180. Infection Control. 12VAC5-371-180(C)(7) cross reference to F695 12VAC5-371-180. Infection Control. 12VAC5-371-180(C)(7) cross reference to F880 12VAC5-371-150. (A) cross references with Federal deficiency 609 12 VAC 5-371-250 (G). Cross references with federal deficiency 656.	F 001	F609 1)Resident #102, report of her cell phone flying off the wall from behind her and hitting her on the front of her head was reported to the OLC. 2)No further allegations made by any resident to report. 3)All fax machines checked for time stamp accuracy and corrected accordingly. Reporting timeframes reviewed with facility reporting staff in order to check time stamps on faxes. 4)Any FRIs submitted will be reviewed by facility compliance for appropriate time stamps within 2 hours of report of allegation. 5)Date: April 1, 2019 F641 Level 1 deficiency no POC required.	4/1/19

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

Electronically Signed | 03/13/19

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F 001	Continued From page 1	F 001	F656 1)Resident #23's care plan was updated to include depression. Resident # 81's oxygen administration orders were clarified for titration, care plan was updated to reflect revised titration orders, and O2 titration orders were followed. 2)A 100% care plan audit of residents taking antidepressants will be completed to ensure depression (mood disorder) and oxygen administration is included; an oxygen administration training for nursing staff will be provided which includes orders and titration training. 3)A 10% quarterly audit will be completed by the facility designee for inclusion of a depression (mood disorder) care plan for those taking antidepressants x 3 months; A 10% quarterly audit for O2 administration/care plan will be completed by the DON or designee to verify order matches flow rate x 3 months. 4)Audit finding will be submitted for review and recommendation to the QA committee. 5)Date: April 1, 2019 F 695 1)Resident # 81's oxygen administration orders were clarified for titration, care plan was updated to reflect revised titration orders, and O2 titration orders were followed. Resident # 16's neb mask was placed in a bag (nonporous surface). 2)A 100% audit of O2 titration orders were reviewed and checked for administration/flow rate and a 100% audit	

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F 001	Continued From page 2	F 001	of O2 storage in a plastic bag or on a clean (non-soiled) surface/location will be completed, with identified concerns corrected. 3)Oxygen administration training, including titration and equipment storage, for nursing staff will be provided. A 10% quarterly audit for O2 administration and storage of equipment will be completed by the DON or designee to verify order matches flow rate x 3 months. 4)Audit finding will be submitted for review and recommendation to the QA committee. 5)Date: April 1, 2019 F812 1)The facility staff discarded: the cottage cheese, ground turkey lunchmeat, American cheese slices (containing approximately eighteen slices), the chopped garlic, sliced tomatoes/lettuce tray, opened squash, and frozen breaded chicken and frozen beef patties. The facility staff cleaned and sanitized the meat slicer, food processor and mixer immediately after being identified. 2)All other items were checked and no additional concerns identified. 3)The dining staff will be in-serviced on dating, labeling, storage and sanitization of small appliances after use. The manager (designee) on duty each day will be responsible for ongoing staff training and implementation. 4)The kitchens will be audited by facility designee quarterly and findings presented to the QA committee for review and recommendations.	

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F 001	Continued From page 3	F 001	5)Date: April 1, 2019 F880 1)Resident # 16's neb mask was placed in a bag (nonporous surface). 2)A 100% audit of O2 storage in a plastic bag or on a clean (non-soiled/nonporus) surface/location will be completed, with identified concerns corrected. 3)Oxygen administration training, including titration and equipment storage, for nursing staff will be provided. A 10% quarterly audit for O2 storage of equipment will be completed by the DON or designee to verify order matches flow rate and proper storage x 3 months. 4)Audit finding will be submitted for review and recommendation to the QA committee. 5)Date: April 1, 2019	