DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
		495339	B. WING		02/27/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY M	ANOR NURSING HOME			2003 COBB STREET FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 000	INITIAL COMMENTS		F 00	0	
	survey was conducte 2/26/19. Corrections a with the following 42 Long Term Care requ code survey/report with The census in this 12	0 certified bed facility was			
		survey. The survey sample nt resident reviews and 4			
F 609 SS=D		Violations	F 60	9	3/13/19
		se to allegations of abuse, or mistreatment, the facility			
	involving abuse, negli mistreatment, includir source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to adult protective servic for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the a	ng injuries of unknown priation of resident property, itely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established the results of all administrator or his or her			
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE
Electroni	cally Signed				03/13/2019

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.

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/10/2019 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495339	B. WING			02	/27/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HOLLY M	ANOR NURSING HOME				003 COBB STREET			
	Ι			F	ARMVILLE, VA 23901		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 609	accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT by: Based on staff interv and clinical record re- the facility staff failed abuse was reported i than 2 hours for one sample, Resident #10 On 2/24/19 at 5:16 p. Resident #102 stated room and hit me on the reported immediately the unit Assistant Dire 5:22p.m. The facility allegation to State Ag within the required time not reported until 02/2 more than 2 hours af allegation to facility states The findings include: Resident #102 was a 02/01/2018. Her diag limited to, Hypertensi Alzheimer's disease, Disorder (1). Resider Minimum Data Set (N Quarterly Assessment Reference Date (ARD	tative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken. T is not met as evidenced view, facility document review view, it was determined that to ensure an allegation of mmediately, but not later of 50 residents in the survey 02. m., during an interview I someone came into my he head. The allegation was to RN (registered nurse) #3, ector of Nursing (ADON) at staff failed to report the gency and other officials neframe. The allegation was 24/2019 22:09 (10:09p.m.)", ter surveyors reported the taff.	F	609	1)Resident #102, report of her cell ph 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 facility compliance for appropriate time stamps within 2 hours of report of allegation. 5)Date: April 1, 2019	s I by		

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PRINTED: 04/10/2019 FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/10/2019 MAPPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í			(X3) DATE	D. 0938-0391 SURVEY PLETED
		495339	B. WING			02/	27/2019
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HOLLY M	ANOR NURSING HOME				2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 609	Resident #102 was or assistance of one per transfers, hygiene, ar supervision and setur Resident #102 was in tour of the facility on 0 during this interview, surveyors, "Last Satu my room and hit me of was unable to recall w she had reported the Surveyors immediate RN #3, the unit Assist (ADON) at 5:22p.m. F speak with Resident # The following morning provided surveyors w Reported Incident (FF on Resident #102's a with the fax confirmat Office of Licensure ar confirmation had a tra reading "02/24/2019 2 than 2 hours after sur allegation made by R A review of the facility "Abuse Prevention", r 'Under Section "V. Inv C. The facility will inva allegations involving a or mistreatment, inclu source and misappro are reported immedia	derate to severe impairment. oded as requiring limited son for bed mobility, ad dressing, and requiring o assistance for eating. Atterviewed during the initial 02/24/2019 at 5:16p.m., Resident #102 stated to rday, someone came into on the head". Resident #102 who had hit her or whether incident to facility staff. ly reported the allegation to tant Director of Nursing RN #3 stated she would #102 immediately. g, 02/25/2019, facility staff ith the initial Facility RI) report they had compiled llegation of abuse, along ion for transmission to the nd Certification. The fax ansmission timestamp 22:09 (10:09p.m.)", more veyors reported the esident #102 to facility staff. If policy on abuse, entitled evealed the following: vestigation":	F	609	Ξ		

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	MENT OF HEALTH AN						FORM	0: 04/10/2019 APPROVED 0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495339	B. WING			_	02/	27/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HOLLY M	ANOR NURSING HOME				2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	that cause the allegat in serious bodily injury if the events that caus involve abuse and do injury, to the Administ other officials (includin Agency and adult prof law provides for jurisd facilities) in accordance established procedure federal and state regu Surveyors informed the member) #1, the Admin Director of Nursing of timely submission of t incident) related to Ref abuse at the end of da At this meeting, Admin (ASM) #3, the Director fax machine timestam FRI was sent out much documentation to this surveyors prior to exit No further documenta 1. Psychotic disorders disorders that cause a perceptions. People w with reality. Two of the delusions and hallucin beliefs, such as thinki against you or that the messages. Hallucinat such as hearing, seein is not there	ion involve abuse or result y, or not later than 24 hours se the allegation do not not result in serious bodily trator of the facility and to ing to the State Survey tective services where state diction in long term care ce with State law through es as in accordance with ulations and guidelines." The ASM (administrative staff hinistrator and ASM #3, the concerns regarding the the FRI (facility reported esident #102's allegation of ay meeting on 02/26/2019. nistrative Staff Member or of Nursing, stated that the hp was wrong, and that the ch earlier. However, no effect was submitted to t. ation was provided.	F	609				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495339 B. WING 02/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Develop/Implement Comprehensive Care Plan F 656 F 656 4/1/19 CFR(s): 483.21(b)(1) SS=D §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 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495339 B. WING 02/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 5 F 656 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 staff interview, facility document F656 review, and clinical record review, it was 1)Resident #23's care plan was updated determined that the facility staff failed to develop to include depression. and/or implement the comprehensive care plan Resident # 81's oxygen administration for two residents (Residents #23 and # 81) of 50 orders were clarified for titration, care plan sampled residents. was updated to reflect revised titration orders, and O2 titration orders were 1. The facility staff failed to develop and/or followed. implement a comprehensive person-centered 2)A 100% care plan audit of residents care plan to address Resident #23's diagnosis of taking antidepressants will be completed depression and treatment of his depression with to ensure depression (mood disorder) and an antidepressant. oxygen administration is included; an oxygen administration training for nursing 2. The facility staff failed to implement and follow staff will be provided which includes Resident #81's comprehensive care plan for the orders and titration training. administration of oxygen. Resident #81 was 3)A 10% guarterly audit will be completed observed receiving oxygen at a flow rate set by the facility designee for inclusion of a between 1 and 1.5L/min (liters /minute) during depression (mood disorder) care plan for those taking antidepressants x 3 months; two observations instead of the 2L/min (liters/minute) ordered by the physician. A 10% guarterly audit for O2 administration/care plan will be completed The findings include: by the DON or designee to verify order matches flow rate x 3 months. 1. Resident #23 was admitted to the facility on 4)Audit finding will be submitted for review and recommendation to the QA 07/22/2016. Diagnoses for Resident #23 included but were not limited to Depression, Anxiety committee. Disorder, and Heart Failure. Resident #23's 5)Date: April 1, 2019 Minimum Data Set (MDS) with an Assessment Reference Date of 12/15/2018 coded Resident #23 with moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #23 as requiring extensive assistance of one staff member with activities of daily living and supervision with eating.

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		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · ·	E SURVEY IPLETED
		495339	B. WING		02	2/27/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY MA	ANOR NURSING HOME			2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	9 6	F 656	3		
	02/25/20. Resident #2 documenteddiagnos 02/28/2017. Additiona documented physicial Zoloft 25 mg (milligran mouth every morning revealed Resident #2 care plan.	sis of Depression dated ally, Resident #23 had a n order dated 11/10/2017 for m) (1) tablet Take 1 tablet by . Review of the record 3 did not have a depression				
	An interview was conducted on 02/26/2019 at approximately 9:10 a.m. with RN (registered nurse) #2 regarding developing and implementing care plans. RN #2 was asked if a resident has a diagnosis of depression, should it be care planned. RN #2 stated, "Yes it should be care planned." RN #2 was asked if a resident receives anti-depressant medication, should that be care planned. RN #2 stated, "Yes it should be care planned. RN #2 stated, "Yes it should be care planned." RN #2 was asked who is responsible for developing, implementing, and updating the care plan. RN #2 stated, "The Assistant Director of Nursing and the Director of Nursing are responsible for developing, implementing, and updating the care plan. RN #2 was asked would she implement a care plan for a resident with a diagnosis of depression who received anti-depressant medication. RN #2 stated, "Yes."					
	staff member) #3 (dire 02/26/2019 at approx policy titled, "Medical documented "Medical be completed accordi care. Documentation	ed from ASM (administrative ector of nursing) on imately 5:04 p.m. the facility				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495339	B. WING			02/	27/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
HOLLY M	ANOR NURSING HOME				2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	resident or change in Care plans will be der address the residents admission and update needs of the resident On 02/26/2019 at app #1 (president/CEO/ad (director of compliand nursing) were made at No further information References: (1) Zoloft - a medicati This information was www.medlineplus.gov ml 2. The facility staff fai Resident #81's comp administration of oxyg observed receiving or between 1 and 1.5L/r two observations inst (liters/minute) ordered Resident #81 was ad 1/11/19, and was read Diagnoses included to blood pressure, whee failure with hypoxia (17 The most recent MDS Medicare five day ass (assessment reference resident as having a st	level of assistance occurs. veloped and implemented to a care needs upon ed according to the changed s. " oroximately 6:00 p.m., ASM dministrator), ASM #2 ee), and ASM #3 (director of aware of findings. In was presented prior to exit. on used to treat depression. obtained from the website: //druginfo/meds/a697048.ht led to implement and follow rehensive care plan for the gen. Resident #81 was kygen at a flow rate set nin (liters /minute) during ead of the 2L/min d by the physician. mitted to the facility on	F	656			

Facility ID: VA0291

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		ONSTRUCTION	(X3) DATE	
		495339	B. WING			02/	27/2019
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY MA	ANOR NURSING HOME				3 COBB STREET RMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	the resident was severe Section O0100 did no oxygen use. The physician order, of "Oxygen at 2L/min (litt keep O2 (oxygen) 924 pulse ox (oximetry) or please attempt to weat Review of Resident # plan dated 1/29/19 do oxygen as ordered by breath." On 02/24/19 at approxi- observation was mad #81 was seated in her cannula attached to a oxygen contractors flo between 1 and 1.5L/m then verified this obset On 02/25/19 at approx- second observation was Resident #81 was again that was attached to a Resident #81's oxyge was again set betweet On 2/26/19 at approxi- interview was conduc Practical Nurse) #3. If the purpose of a care- us how to care for a re-	erely cognitively impaired. t document Resident #81's dated 2/22/19, documented, ers/minute) as needed to % or more. Please check in room air every shift, an off O2." 81's comprehensive care ocumented, "Administer physician for shortness of ximately 4:52 p.m., an e of Resident #81. Resident r wheelchair wearing a nasal n oxygen concentrator. The ow rate was observed set nin O2. Another surveyor ervation. ximately 9:02 a.m., a vas made of Resident #81. ain wearing a nasal cannula an oxygen concentrator. n concentrator, flow rate in 1 and 1.5L/min O2.	F 6	56			

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	-					FORM): 04/10/2019 1 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495339	B. WING		_	02/:	27/2019
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
			2	003 COBB STREET			
HOLLY MA	ANOR NURSING HOME		F	ARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	On 02/26/19 at approinterview was conductives was conductives asked about the #4 replied, "It documents for a resident." LPN # should be followed. LL LPN #4 was asked if regarding oxygen address for a resident." LPN #4 replied, "No, it On 02/26/19 at approint (administrative staff m Administrator, ASM # and ASM #2, the Quarmade aware of the above the formation was obtain https://www.nlm.nih.gilure.html. 2. Pneumonitis (nooterm that refers to infl Technically, pneumor because the infection Pneumonitis, however to refer to noninfection include airborne irritation formation. Common include airborne irritation is treatments and dozer pneumonitis. Difficulty accompanied by a dry	ximately 2:11 p.m., an ted with LPN #4. LPN #4 purpose of a care plan. LPN ents the whole plan of care 4 was asked if a care plan PN #4 replied, "Of course." Resident #81's care plan ninistration was being n was set to the wrong rate. it would not." ximately 5:05 p.m., ASM nember) #1, the 3, the Director of Nursing lity Control Nurse were bove findings. n was provided prior to exit. ch not enough oxygen gs into your blood. This ned from the website: ov/medlineplus/respiratoryfa moe-NIE-tis) is a general ammation of lung tissue. hia is a type of pneumonitis causes inflammation. r, is usually used by doctors us causes of pneumonitis nts at your job or from your some types of cancer his of drugs can cause y breathing - often y (nonproductive) cough - is mptom of pneumonitis.	F 656				

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE S COMPLI	
			A. BUILD	NG _			
		495339	B. WING			02/2	7/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	NOR NURSING HOME						
				Г /	ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETIO DATE
F 656	Continued From page	e 10	F	656			
		focuses on avoiding irritants					
	obtained from the we	nation. This information was					
		ic.org/diseasesconditions/pn					
		-causes/syc-20352623?p=1					
F 695		stomy Care and Suctioning	F	695		4	/1/19
SS=D	CFR(s): 483.25(i)						
	§ 483.25(i) Respirato	ry care, including					
	-	nd tracheal suctioning.					
	•	ure that a resident who					
		re, including tracheostomy ctioning, is provided such					
		professional standards of					
		nensive person-centered					
		nts' goals and preferences,					
	and 483.65 of this su	bpart.					
		r is not met as evidenced					
	by:				5 005		
	facility staff failed to a	on and staff interview, the			F 695		
		it according to professional			 Resident # 81's oxygen administration orders were clarified for titration, care place 		
		, for two of 50 residents,			was updated to reflect revised titration		
	Residents #16 and #				orders, and O2 titration orders were		
					followed. Resident # 16's neb mask was	3	
		lity staff failed to store a anitary manner according to			placed in a bag (nonporous surface).		
		ds of practice. During tour of			 A 100% audit of O2 titration orders we reviewed and checked for 	ie	
	•), Resident #16's mask			administration/flow rate and a 100% auc	dit	
	2	ebulizer was observed,			of O2 storage in a plastic bag or on a		
	uncovered sitting on	Resident #16's bed.			clean (non-soiled) surface/location will b	e	
	2 The facility staff fo	iled to clarify a physician's			completed, with identified concerns corrected.		
	-	tration of oxygen and failed			3)Oxygen administration training,		
	to administer oxygen				including titration and equipment storage	e.	
		as ordered by the physician.			for nursing staff will be provided. A 10%		
		served with her oxygen flow			quarterly audit for O2 administration and		
	rate set at 1 and 1.5L					by	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495339 B. WING 02/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 695 Continued From page 11 F 695 observations. the DON or designee to verify order matches flow rate x 3 months. 4)Audit finding will be submitted for review The findings include: and recommendation to the QA committee. 1. Resident #16. facility staff failed to store a 5)Date: April 1, 2019 nebulizer mask in a sanitary manner according to professional standards of practice. During tour of the facility on 2/24/19, Resident #16's mask attachment for the nebulizer was observed, uncovered sitting on Resident #16's bed. Resident #16 was admitted to the facility on 08/21/2014. Her diagnoses included, but were not limited to, Hypertension (high blood pressure), Heart Failure (inability of the heart to pump efficiently), and Asthma. Resident #16's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/13/2018. The Brief Interview for Mental Status (BIMS) coded Resident #16 at 11, indicating moderate impairment. Resident #16 was coded as requiring limited assistance of 1 person for transfers, bed mobility, ambulation, dressing, and hygiene, and requiring supervision and setup assistance for eating. Resident #16's room was observed during initial tour of the facility on 02/24/2019 at 5:11p.m. At this time, it was noted that Resident #16 had a Nebulizer on the bedside table. The mask attachment for the nebulizer was observed sitting, uncovered, on Resident #16's bed. The mask and tubing were dated 02/17/2018. The next day, 02/25/2019, it was noted that the tubing and mask had been replaced, and were in

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/10/2019 M APPROVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		495339	B. WING			02	/27/2019
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY MA	NOR NURSING HOME				2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	conducted with Licens #3 regarding nebulize that nebulizer equipm a bag when not in use respiratory equipment and oxygen tubing, and the night shift. A review of the facility Administration revealed heading "Procedure": be stored in a plastic (non-soiled) surface/de The Administrator AS member) #1 and Dire were informed of the meeting on 02/26/201 documentation was p 2. The facility staff fail order for the administ to administer oxygen liters/minute (L/min) a Resident #81 was obs rate set at 1 and 1.5L observations. Resident #81 was administ 1/11/19, and was read Diagnoses included b	2/24/2019. 15a.m., an interview was sed Practical Nurse (LPN) er treatments. LPN #3 stated tent should always be kept in e. LPN #3 also stated all t, such as nebulizer masks re changed each Sunday by y policy on Oxygen ed the following under the "12. The equipment should bag or on a clean ocation". M (administrative staff ctor of Nursing, ASM #3 findings at the end of day 19. No further rovided. led to clarify a physician's ration of oxygen and failed to Resident #81 at 2 as ordered by the physician. served with her oxygen flow /min, during separate mitted to the facility on	F	695			
	The most recent MDS Medicare five day ass	I) and pneumonitis (2). 6 (minimum data set), a sessment, with an ARD se date) of 2/5/19 coded the					

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	-	D HUMAN SERVICES				RINTED: 04/10/2019 FORM APPROVED
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		MB NO. 0938-0391 X3) DATE SURVEY COMPLETED
		495339	B. WING			02/27/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, 2	ZIP CODE	
HOLLY M	ANOR NURSING HOME			003 COBB STREET ARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIAT IENCY)	(X5) COMPLETION DATE
F 695	resident as having a s BIMS (brief interview the resident was seve Section O0100 did no oxygen use. The physician order of "Oxygen at 2L/min (lift keep O2 (oxygen) 92 pulse ox (oximetry) of please attempt to wea Review of the residen administration record 2L/min (liters/minute) (oxygen) 92% or more documented that oxyg 2/26/19 at 11:37 a.m. saturation) level of 85 Further Review of the administration record 2L/min (liters/minute) (oxygen) 92% or more as being administered February 25th 2019. On 02/24/19 at appro observation was mad #81 was seated in he cannula attached to a oxygen contractors fit between 1 and 1.5L/m then verified this obset On 02/25/19 at appro second observation was mad	scores of 3 of 15 on the for mental status) indicating erely cognitively impaired. At document Resident #81's lated 2/22/19 documented, ers/minute) as needed to % or more. Please check in room air every shift, an off O2." At SMAR (medication) documented, "Oxygen at as needed to keep O2 e." The MAR further gen was administered on for an oxygen (o2 %. Tresidents MAR (medication) documented, "Oxygen at as needed to keep O2 e." The MAR further gen was administered on for an oxygen (o2 %. Tresidents MAR (medication) documented, "Oxygen at as needed to keep O2 e." Oxygen was documented d on February 22nd through ximately 4:52 p.m., an e of Resident #81. Resident r wheelchair wearing a nasal n oxygen concentrator. The ow rate was observed set nin O2. Another surveyor ervation.	F 695			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/10/2019 / APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE	
		495339	B. WING				02/	27/2019
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HOLLY MA	ANOR NURSING HOME				2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 695	was again set betwee On 02/26/19 at appro- interview was conduct practical nurse) #4. Ll oxygen flow rate on a meter. LPN #4 replied (medical doctor) orde and turn the knob unt up to the liter per minit On 02/26/19 at appro- interview was conduct nurse) #3. When aske oxygen flow rate to be physician's order, RN high it can cause a pr serious. I will call the transfer the resident t about the oxygen ord stated, "I would follow asked how would she stated, "When the O2 turn the flow rate dow would titrate the oxygo oxygen saturation wa stated, "I would titrate and come back to che level during the nebul every four hour." When nurse's scope of prace rate, RN#3 stated, "Y is considered a medic When asked if the nu dose without a physic "No".	n concentrator, flow rate en 1 and 1.5L/min O2. ximately 01:11 p.m., an ted with LPN (licensed PN #4 regarding setting the n oxygen concentrator flow d, "First you look the MD's r, then get down to eye level il the middle of the ball floats ute line the doctor ordered." ximately 1:43 p.m., an ted with RN (registered ed why it is important for the	F	695				
	According to the facili	ties oxygen administration						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495339 B. WING 02/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 695 Continued From page 15 F 695 policy "Check physician's order for liter flow and method of administration. Set the flow meter to the rate ordered by the physician." On 02/26/19 at approximately 5:05 p.m., ASM (administrative staff member) #1. the Administrator, ASM #3, the Director of Nursing and ASM #2, the Quality Control Nurse were made aware of the above findings. No further information was provided prior to exit. 1. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfa ilure.html. 2. Pneumonitis (noo-moe-NIE-tis) is a general term that refers to inflammation of lung tissue. Technically, pneumonia is a type of pneumonitis because the infection causes inflammation. Pneumonitis, however, is usually used by doctors to refer to noninfectious causes of lung inflammation. Common causes of pneumonitis include airborne irritants at your job or from your hobbies. In addition, some types of cancer treatments and dozens of drugs can cause pneumonitis. Difficulty breathing - often accompanied by a dry (nonproductive) cough - is the most common symptom of pneumonitis. Specialized tests are necessary to make a diagnosis. Treatment focuses on avoiding irritants and reducing inflammation. This information was obtained from the website: https://www.mayoclinic.org/diseasesconditions/pn eumonitis/symptoms-causes/syc-20352623?p=1 F 812 Food Procurement, Store/Prepare/Serve-Sanitary F 812 3/13/19 CFR(s): 483.60(i)(1)(2) SS=E

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495339 B. WING 02/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 812 Continued From page 16 F 812 §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 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 bv: Based on observation, staff interview, and facility 1)The facility staff discarded: the cottage document review it was determined that the cheese, ground turkey lunchmeat, facility staff failed to store and serve food in a American cheese slices (containing sanitary manner in two of two facility kitchens. approximately eighteen slices), the chopped garlic, sliced tomatoes/lettuce 1. The facility staff failed to maintain a five-pound tray, opened squash, and frozen breaded container of cottage cheese and approximately chicken and frozen beef patties. The two cups of ground turkey lunch meat, on the facility staff cleaned and sanitized the serving line, at a temperature of 41 degrees F meat slicer, food processor and mixer (Fahrenheit) or lower in the facility kitchen for the immediately after being identified. Lee and Grace residential units. 2)All other items were checked and no additional concerns identified. 2. The facility staff failed to remove a five pound 3)The dining staff will be in-serviced on container of cottage cheese with approximately dating, labeling, storage and sanitization one cup remaining with a use-by-date of 2/15/19 of small appliances after use. The and a manufacturer's date of 2/11/19. In addition, manager (designee) on duty each day will the facility staff failed to wrap an opened package be responsible for ongoing staff training

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		MEDICAID SERVICES	(Y2) MUU TU		TION		NO. 0938-039
ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495339 NAME OF PROVIDER OR SUPPLIER		, <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			MPLETED	
		B. WING)2/27/2019		
			STREET ADDR	RESS, CITY, STATE, ZIP CODE			
HOLLY MANOR NURSING HOME				2003 COBB S			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 812	Continued From page	e 17	F 8'	2			
	of American cheese slices, containing approximately eighteen slices, on a shelf, in the reach-in refrigerator in the kitchen for the Lee and Grace residential units.			4)The ki designe to the Q recomm	blementation. A committee for review a A committee for review a anendations.	presented	
	3. The facility staff fa slicer, food processon manner in the kitcher residential units. The with debris on the sur gauge plate and unde bowel of the food pro wet and was observe tablespoon of water i the mixer was observe splattered on the spla the mixing bowl.		5)Date:	April 1, 2019			
	 4. The facility staff failed to remove a two pound container of chopped garlic with approximately one-and -a half pounds remaining, available for use, with an open date of 1/17/19, and a use-by-date of 2/17/19, and failed to wrap a stainless steel pan of sliced lettuce and tomatoes available for use. All the above items were observed sitting on a shelf in the walk-in refrigerator in the kitchen for the Lee and Grace residential und its. 5. The facility staff failed to ensure a twenty-pound box of frozen, sliced yellow squash with approximately ten pounds remaining, was sealed and not left open to the air and contamination in the walk-in freezer in the kitchen for the Lee and Grace residential units. 						
	container of frozen bi	ailed to ensure a plastic readed chicken tenders, bunds and a cardboard box					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/10/2019 // APPROVED). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495339	B. WING				02/	27/2019	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO	DE			
HOLLY MANOR NURSING HOME					003 COBB STREET ARMVILLE, VA 23901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE	
F 812	the air and potential of Jefferson kitchen for the The findings include: On 02/24/19 at appro- observation of the face and Grace residential OSM (other staff men 1. The facility staff facontainer of cottage of two cups of ground tu serving line, at a temp (Fahrenheit) or lower Lee and Grace reside An observation of the kitchen for the Lee an revealed an opened, cottage cheese sitting pan and a plastic two- turkey lunch meat sitt stainless steel pan. O obtain the temperatur and ground turkey. U thermometer, OSM # cheese. Observation revealed a reading of Fahrenheit. After place	with three patties he middle shelf of the sealed and not left open to ontamination, in the he Brantley residential unit. ximately 4:45 p.m., an ility's kitchen for the Lee units was conducted with her) # 1, dietary manager. iled to maintain a five-pound heese and approximately rkey lunch meat, on the berature of 41 degrees F in the facility kitchen for the ential units. food service line in the d Grace residential units full five-pound container of on ice in a stainless steel cup container of ground ing on ice in the same DSM # 1 was asked to es of the cottage cheeses sing a facility digital 1 placed it in the cottage of the thermometer	F	812	DEFICIENCY)			
	revealed fifty degrees about the temperature OSM # 1 stated, "It sh	Fahrenheit. When asked of the cottage cheese							

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 495339 B. WING 02/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 812 Continued From page 19 F 812 turkey OSM (other staff member) # 1 stated, "It should be colder." OSM # 1 removed the cottage cheese and turkey from the serving line and discarded them. 2. The facility staff failed to remove a five pound container of cottage cheese with approximately one cup remaining with a use-by-date of 2/15/19 and a manufacturer's date of 2/11/19. In addition, the facility staff failed to wrap an opened package of American cheese slices, containing approximately eighteen slices, on a shelf, in the reach-in refrigerator in the kitchen for the Lee and Grace residential units. An observation of the reach-in refrigerator with OSM # 1 in the kitchen for the Lee and Grace residential units, revealed a five pound container of cottage cheese, available for use, with approximately one cup remaining with a use-by-date of 2/15/19 and a manufacturer's date of 2/11/19. The observation also revealed a partially wrapped package of American cheese slices, containing approximately eighteen slices, also available for use sitting on a shelf in the reach-in refrigerator. When asked about the cottage cheese OSM # 1 stated it (cottage cheese) was expired and removed it from the refrigerator. When asked about the partially wrapped American cheese OSM # 1 agreed it was not wrapped properly, and then discarded the cheese. 3. The facility staff failed to maintain the meat slicer, food processor and mixer in a sanitary manner in the kitchen for the Lee and Grace residential units. The meat slicer was observed with debris on the surface of the base under the gauge plate and under the slice deflector. The

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/10/2019 // APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,				(X3) DATE SURVEY COMPLETED		
		495339	B. WING				02/	27/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
HOLLY MANOR NURSING HOME					003 COBB STREET ARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 812	bowel of the food prod wet and was observe tablespoon of water in the mixer was observe splattered on the splat the mixing bowl. An observation of the the kitchen for the Lee revealed a meat slice industrial mix sitting of table. Observation of the me covered with a plastic meat slicer was clean 1 stated, "Yes." OSM covering the meat slice the meat slicer reveal the base under the ga slice deflector. OSM the debris on the meat debris was food debri agreed the meat slice An observation of the was assembled with t and the lid in place or was asked if the food ready for use. OSM a then removed the bow removed the top of th the inside of the bowl tablespoon of water in the blade in place. W she saw in the bottom	cessor was stored for use d with approximately a n the bottom of the bowl and ed with food debris shguard of the mixer above food preparation table in e and Grace residential units r, a food processor and an in top of a food preparation eat slicer revealed it was bag. When asked if the and ready for use, OSM # 1 # 1 then removed the bag cer. Further observation of ed debris on the surface of auge plate and under the # 1 was asked to observe at slicer. When asked if the s OSM # 1 stated yes and	F	812				

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(V2) DAT	E SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	· ,			COMPLETED		
		B. WING		02	2/27/2019			
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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 812	Observation of the mi assembled sitting on When asked if the mi use OSM # 1 stated, of the mixer revealed the splashguard of th bowl. OSM # 1 agree 4. The facility staff fa container of chopped one-and -a half pound use, with an open dat use-by-date of 2/17/1 stainless steel pan of available for use. All to observed sitting on a refrigerator in the kitcher residential und its. An observation of the OSM # 1 in the kitcher residential units revea of chopped garlic ava approximately one-ar with an open date of 2/17/19. The observa unwrapped stainless and tomatoes also av shelf in walk-in refrige Lee and Grace reside about the expired cho it was expired, and di	ixer revealed it was the food preparation table. xer was clean and ready for "Yes." Further observation food debris splattered on e mixer above the mixing ed the mixer was not clean. illed to remove a two pound garlic with approximately ds remaining, available for te of 1/17/19, and a 9, and failed to wrap a sliced lettuce and tomatoes the above items were shelf in the walk-in hen for the Lee and Grace and for the Lee and Grace aled a two pound container illable for use with nd -a half pounds remaining 1/17/19 and a use-by-date of ation also revealed a partially steel pan of sliced lettuce vailable for use, sitting on a erator in the kitchen for the ential units. When asked opped garlic OSM # 1 stated scarded the chopped garlic.	F 812					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 04/10/2019 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		495339	B. WING			02	/27/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY MANOR NURSING HOME					2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	 in the kitchen for the units revealed a twen sliced yellow squash is pounds remaining, avid shelf in the walk-in free box of squash revealed box. Observation of the contained frozen, slice open to the air and power when asked about the squash OSM # 1 state been secured." The facility staff fa container of frozen brapproximately two poof frozen beef patties, remaining sitting on the reach-in freezer were the air and potential of Jefferson kitchen for the streaged two pounds breast and a card boar patties with three patterned the plastic container to the revealed two pounds breast and a card boar patties with three patterned the plastic container to the plastic container to the main the top third of the way expose chicken breast to the 	e residential units. walk-in freezer with OSM # e Lee and Grace residential ty-pound box of frozen, with approximately ten vailable for use sitting on a eezer. Observation of the ed a plastic bag inside the the plastic bag revealed it ed yellow squash and was otential contamination. e opened box of frozen ed, "The bag should have iled to ensure a plastic eaded chicken tenders, unds and a cardboard box , with three patties ne middle shelf of the sealed and not left open to contamination, in the the Brantley residential unit. reach-in freezer with OSM the Brantley residential unit of frozen breaded chicken ard box of frozen beef cies remaining sitting on the ach-in freezer. Observation er of frozen breaded chicken of the sealed and proximately a sing the frozen breaded air. Observation of the	F	812			
	lid of the box was ope the box with three bee	en beef patties revealed the en and the plastic bag inside ef patties was open to the ut the opened container of					

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		MEDICAID SERVICES			OMB NO. 0938-0
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		02/27/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
HOLLY MANOR NURSING HOME				2003 COBB STREET FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE
F 812	Continued From page	e 23	F 8	12	
		en tenders and the opened			
		SM # 1 stated, "The lid			
		ced back on the container			
	closed."	patties should have been			
		p.m., an interview was			
	conducted with OSM				
		in the Jefferson kitchen and e and Grant residential units			
		asked why it was important			
		priate holding temperatures			
		1 stated, "To reduce the			
	risk of food borne illne cheeses and ground	turkey lunch meat) were			
	-	ked to describe the process			
		d is not available for use,			
		lates should be checked			
		o describe the process for slicer, food processor and			
	-	ner, OSM # 1 stated, "It			
	should thoroughly cle	aned after every use. The			
		down, washed with soap			
		air dried." When asked to re for storing food items that			
		the refrigerator or the			
		ted, "Staff should ensure the			
		ped a and dated. It should			
	be resealed or closed what was needed."	I immediately after removing			
		od Storage" documented,			
		od Storage: f. All foods			
		beled and dated. All foods sure that foods (including			
	leftovers) will be cons				
		en (where applicable), or			
		en Foods: c. All foods should			
	be covered, labeled,	and dated. All foods will be			

Facility ID: VA0291

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
495339		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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET
F 812	10	e 24 at foods will be consumed by	F 812	2	
	their safe use-by date				
		nployee Sanitary Practices" an and sanitize equipment ise."			
	(administrative staff n executive officer/adm	ximately 5:05 p.m., ASM # 1 nember), president/chief inistrator, ASM # 2, director SM # 3, director of nursing, the findings.			
		was provided prior to exit.			
F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)		F 880		4/1/19
	infection prevention a designed to provide a comfortable environm	blish and maintain an nd control program safe, sanitary and nent and to help prevent the nsmission of communicable			
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:			
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/10/2019 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495339	B. WING		_	02/2	27/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
HOLLY MA	ANOR NURSING HOME			003 COBB STREET ARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	procedures for the probut are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possibilit circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A system identified under the fat corrective actions take §483.80(e) Linens. Personnel must hand	ndards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of e or infections should be semission-based precautions ent spread of infections; lation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable atin lesions from direct or their food, if direct he disease; and procedures to be followed rect resident contact.	F 880				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 495339 B. WING 02/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 880 Continued From page 26 F 880 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced bv: F880 Based on observation and staff interview, facility staff failed to store respiratory equipment 1)Resident # 16's neb mask was placed in according to professional standards of practice to a bag (nonporous surface). prevent infection for one of 50 residents, Resident 2)A 100% audit of O2 storage in a plastic #16. bag or on a clean (non-soiled/nonporus) surface/location will be completed, with The facility staff failed to ensure Resident #16's identified concerns corrected. nebulizer mask was stored in a manner to 3)Oxygen administration training, prevent infection. During tour of the facility including titration and equipment storage, Resident #16's mask attachment for the nebulizer for nursing staff will be provided. A 10% was observed, uncovered sitting on Resident quarterly audit for O2 storage of #16's bed. equipment will be completed by the DON or designee to verify order matches flow rate and proper storage x 3 months. The findings include: 4)Audit finding will be submitted for review and recommendation to the QA Resident #16 was admitted to the facility on committee. 08/21/2014. Her diagnoses included, but were not 5)Date: April 1, 2019 limited to, Hypertension (high blood pressure), Heart Failure (inability of the heart to pump efficiently), and Asthma. Resident #16's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/13/2018. The Brief Interview for Mental Status (BIMS) coded Resident #16 at 11, indicating moderate impairment. Resident #16 was coded as requiring limited assistance of 1 person for transfers, bed mobility, ambulation, dressing, and hygiene, and as requiring supervision and setup assistance for eating. Resident #16's room was observed during initial

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/10/2019 // APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· <i>`</i>		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495339	B. WING			_	02/	27/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HOLLY M	ANOR NURSING HOME				2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	tour of the facility on 0 this time, it was noted Nebulizer on the beds attachment for the ne- sitting, uncovered, on mask and tubing were The next day, 02/25/2 tubing and mask had a Ziploc bag dated 02 On 02/26/2019 at 10: conducted with Licens #3 regarding nebulize that nebulizer equipm a bag when not in use respiratory equipment and oxygen tubing, ar the night shift. A review of the facility Administration reveale heading "Procedure": be stored in a plastic (non-soiled) surface/o The Administrator ASI member) #1 and Dire	02/24/2019 at 5:11p.m. At d that Resident #16 had a side table. The mask bulizer was observed to be a Resident #16's bed. The e dated 02/17/2018. 2019, it was noted that the been replaced, and were in 2/24/2019. 15a.m., an interview was sed Practical Nurse (LPN) er treatments. LPN #3 stated nent should always be kept in e. LPN #3 also stated that all t, such as nebulizer masks re changed each Sunday by / policy on Oxygen ed the following under the "12. The equipment should bag or on a clean ocation". M (administrative staff cotor of Nursing, ASM #3 findings at the end of day 19. No further	F	880				

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