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 _____	02/27/2019

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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted from 2/24/19 through 2/26/19. 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 116 at the time of the survey. The survey sample consisted of 46 current resident reviews and 4 closed record reviews.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		3/13/19

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

Electronically Signed | 03/13/2019

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F 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 an allegation of abuse was reported immediately, but not later than 2 hours for one of 50 residents in the survey sample, Resident #102. On 2/24/19 at 5:16 p.m., during an interview Resident #102 stated someone came into my room and hit me on the head. The allegation was reported immediately to RN (registered nurse) #3, the unit Assistant Director of Nursing (ADON) at 5:22p.m. The facility staff failed to report the allegation to State Agency and other officials within the required timeframe. The allegation was not reported until 02/24/2019 22:09 (10:09p.m.)", more than 2 hours after surveyors reported the allegation to facility staff. The findings include: Resident #102 was admitted to the facility on 02/01/2018. Her diagnoses included, but were not limited to, Hypertension (high blood pressure), Alzheimer's disease, and Unspecified Psychotic Disorder (1). Resident #102's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 02/05/2019. The Brief Interview for Mental Status coded Resident #102	F 609	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	

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F 609	Continued From page 2	F 609		

as a 7, indicating moderate to severe impairment. Resident #102 was coded as requiring limited assistance of one person for bed mobility, transfers, hygiene, and dressing, and requiring supervision and setup assistance for eating.

Resident #102 was interviewed during the initial tour of the facility on 02/24/2019 at 5:16p.m., during this interview, Resident #102 stated to surveyors, "Last Saturday, someone came into my room and hit me on the head". Resident #102 was unable to recall who had hit her or whether she had reported the incident to facility staff. Surveyors immediately reported the allegation to RN #3, the unit Assistant Director of Nursing (ADON) at 5:22p.m. RN #3 stated she would speak with Resident #102 immediately.

The following morning, 02/25/2019, facility staff provided surveyors with the initial Facility Reported Incident (FRI) report they had compiled on Resident #102's allegation of abuse, along with the fax confirmation for transmission to the Office of Licensure and Certification. The fax confirmation had a transmission timestamp reading "02/24/2019 22:09 (10:09p.m.)", more than 2 hours after surveyors reported the allegation made by Resident #102 to facility staff.

A review of the facility policy on abuse, entitled "Abuse Prevention", revealed the following:

'Under Section "V. Investigation":
C. The facility will investigate and report allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately [sic], but not later than 2 hours after the allegation is made, if the events

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that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures as in accordance with federal and state regulations and guidelines."

Surveyors informed the ASM (administrative staff member) #1, the Administrator and ASM #3, the Director of Nursing of concerns regarding the timely submission of the FRI (facility reported incident) related to Resident #102's allegation of abuse at the end of day meeting on 02/26/2019. At this meeting, Administrative Staff Member (ASM) #3, the Director of Nursing, stated that the fax machine timestamp was wrong, and that the FRI was sent out much earlier. However, no documentation to this effect was submitted to surveyors prior to exit.

No further documentation was provided.

1. Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there. - https://medlineplus.gov/psychoticdisorders.html

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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 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	F 656		4/1/19

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F 656	Continued From page 5 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 review, and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for two residents (Residents #23 and # 81) of 50 sampled residents. 1. The facility staff failed to develop and/or implement a comprehensive person-centered care plan to address Resident #23's diagnosis of depression and treatment of his depression with an antidepressant. 2. The facility staff failed to implement and follow Resident #81's comprehensive care plan for the administration of oxygen. Resident #81 was observed receiving oxygen at a flow rate set between 1 and 1.5L/min (liters /minute) during two observations instead of the 2L/min (liters/minute) ordered by the physician. The findings include: 1. Resident #23 was admitted to the facility on 07/22/2016. Diagnoses for Resident #23 included but were not limited to Depression, Anxiety Disorder, and Heart Failure. Resident #23's 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.	F 656	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	

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Resident #23's clinical record was reviewed on 02/25/20. Resident #23's clinical record documented...diagnosis of Depression dated 02/28/2017. Additionally, Resident #23 had a documented physician order dated 11/10/2017 for Zoloft 25 mg (milligram) (1) tablet Take 1 tablet by mouth every morning. Review of the record revealed Resident #23 did not have a depression care plan.

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 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."

A copy of the facility policy regarding care planning was requested from ASM (administrative staff member) #3 (director of nursing) on 02/26/2019 at approximately 5:04 p.m. the facility policy titled, "Medical Records, Resident", documented "Medical record documentation will be completed according to the resident's level of care. Documentation will occur when an activity, event, or incident that is not of usual for the

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resident or change in level of assistance occurs. Care plans will be developed and implemented to address the residents care needs upon admission and updated according to the changed needs of the residents. "

On 02/26/2019 at approximately 6:00 p.m., ASM #1 (president/CEO/administrator), ASM #2 (director of compliance), and ASM #3 (director of nursing) were made aware of findings.

No further information was presented prior to exit.

References:

(1) Zoloft - a medication used to treat depression. This information was obtained from the website: www.medlineplus.gov/druginfo/meds/a697048.html

2. The facility staff failed to implement and follow Resident #81's comprehensive care plan for the administration of oxygen. Resident #81 was observed receiving oxygen at a flow rate set between 1 and 1.5L/min (liters /minute) during two observations instead of the 2L/min (liters/minute) ordered by the physician.

Resident #81 was admitted to the facility on 1/11/19, and was readmitted on 1/29/19. Diagnoses included but were not limited to: high blood pressure, wheezing, acute respiratory failure with hypoxia (1) and pneumonitis (2).

The most recent MDS (minimum data set), a Medicare five day assessment, with an ARD (assessment reference date) of 2/5/19 coded the resident as having a score of 3 out of 15 on the BIMS (brief interview for mental status) indicating

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the resident was severely cognitively impaired. Section O0100 did not document Resident #81's oxygen use.

The physician order, dated 2/22/19, documented, "Oxygen at 2L/min (liters/minute) as needed to keep O2 (oxygen) 92% or more. Please check pulse ox (oximetry) on room air every shift, please attempt to wean off O2."

Review of Resident #81's comprehensive care plan dated 1/29/19 documented, "Administer oxygen as ordered by physician for shortness of breath."

On 02/24/19 at approximately 4:52 p.m., an observation was made of Resident #81. Resident #81 was seated in her wheelchair wearing a nasal cannula attached to an oxygen concentrator. The oxygen contractors flow rate was observed set between 1 and 1.5L/min O2. Another surveyor then verified this observation.

On 02/25/19 at approximately 9:02 a.m., a second observation was made of Resident #81. Resident #81 was again wearing a nasal cannula that was attached to an oxygen concentrator. Resident #81's oxygen concentrator, flow rate was again set between 1 and 1.5L/min O2.

On 2/26/19 at approximately 2:05 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3. LPN #3 was asked about the purpose of a care plan. LPN #3 stated, "It tells us how to care for a resident." LPN #3 was asked if a care plan should be followed, LPN #3 replied, "Yes."

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On 02/26/19 at approximately 2:11 p.m., an interview was conducted with LPN #4. LPN #4 was asked about the purpose of a care plan. LPN #4 replied, "It documents the whole plan of care for a resident." LPN #4 was asked if a care plan should be followed. LPN #4 replied, "Of course." LPN #4 was asked if Resident #81's care plan regarding oxygen administration was being followed if her oxygen was set to the wrong rate. LPN #4 replied, "No, it would not."

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/respiratoryfailure.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

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F 656	Continued From page 10 diagnosis. Treatment focuses on avoiding irritants and reducing inflammation. This information was obtained from the website: https://www.mayoclinic.org/diseasesconditions/pneumonitis/symptoms-causes/syc-20352623?p=1	F 656		
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 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 and staff interview, the facility staff failed to administer and store respiratory equipment according to professional standards of practice, for two of 50 residents, Residents #16 and #81. 1. Resident #16, facility staff failed to store a 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. 2. The facility staff failed to clarify a physician's order for the administration of oxygen and failed to administer oxygen to Resident #81 at 2 liters/minute (L/min) as ordered by the physician. Resident #81 was observed with her oxygen flow rate set at 1 and 1.5L/min, during separate	F 695	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 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	4/1/19

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F 695	Continued From page 11 observations. The findings include: 1. Resident #16, facility staff failed to store a 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	F 695	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	

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a Ziploc bag dated 02/24/2019.

On 02/26/2019 at 10:15a.m., an interview was conducted with Licensed Practical Nurse (LPN) #3 regarding nebulizer treatments. LPN #3 stated that nebulizer equipment should always be kept in a bag when not in use. LPN #3 also stated all respiratory equipment, such as nebulizer masks and oxygen tubing, are changed each Sunday by the night shift.

A review of the facility policy on Oxygen Administration revealed the following under the heading "Procedure": "12. The equipment should be stored in a plastic bag or on a clean (non-soiled) surface/location".

The Administrator ASM (administrative staff member) #1 and Director of Nursing, ASM #3 were informed of the findings at the end of day meeting on 02/26/2019. No further documentation was provided.

2. The facility staff failed to clarify a physician's order for the administration of oxygen and failed to administer oxygen to Resident #81 at 2 liters/minute (L/min) as ordered by the physician. Resident #81 was observed with her oxygen flow rate set at 1 and 1.5L/min, during separate observations.

Resident #81 was admitted to the facility on 1/11/19, and was readmitted on 1/29/19. Diagnoses included but were not limited to: high blood pressure, wheezing, acute respiratory failure with hypoxia (1) and pneumonitis (2).

The most recent MDS (minimum data set), a Medicare five day assessment, with an ARD (assessment reference date) of 2/5/19 coded the

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resident as having a scores of 3 of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. Section O0100 did not document Resident #81's oxygen use.

The physician order dated 2/22/19 documented, "Oxygen at 2L/min (liters/minute) as needed to keep O2 (oxygen) 92% or more. Please check pulse ox (oximetry) on room air every shift, please attempt to wean off O2."

Review of the residents MAR (medication administration record) documented, "Oxygen at 2L/min (liters/minute) as needed to keep O2 (oxygen) 92% or more." The MAR further documented that oxygen was administered on 2/26/19 at 11:37 a.m. for an oxygen (o2 saturation) level of 85%.

Further Review of the residents MAR (medication administration record) documented, "Oxygen at 2L/min (liters/minute) as needed to keep O2 (oxygen) 92% or more." Oxygen was documented as being administered on February 22nd through February 25th 2019.

On 02/24/19 at approximately 4:52 p.m., an observation was made of Resident #81. Resident #81 was seated in her wheelchair wearing a nasal cannula attached to an oxygen concentrator. The oxygen contractors flow rate was observed set between 1 and 1.5L/min O2. Another surveyor then verified this observation.

On 02/25/19 at approximately 9:02 a.m., a second observation was made of Resident #81. Resident #81 was again wearing a nasal cannula that was attached to an oxygen concentrator.

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Resident #81's oxygen concentrator, flow rate was again set between 1 and 1.5L/min O2.

On 02/26/19 at approximately 01:11 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 regarding setting the oxygen flow rate on an oxygen concentrator flow meter. LPN #4 replied, "First you look the MD's (medical doctor) order, then get down to eye level and turn the knob until the middle of the ball floats up to the liter per minute line the doctor ordered."

On 02/26/19 at approximately 1:43 p.m., an interview was conducted with RN (registered nurse) #3. When asked why it is important for the oxygen flow rate to be set according to the physician's order, RN#3 stated, "If the O2 is too high it can cause a problem, and if the problem is serious. I will call the doctor to write an order to transfer the resident to the hospital." When asked about the oxygen order for Resident #81 she stated, "I would follow the order as written." When asked how would she followed this order RN#3 stated, "When the O2 saturation is high, I would turn the flow rate down. "When asked how she would titrate the oxygen flow rate if a residents oxygen saturation was at below 92%, RN#3 stated, "I would titrated by increasing the flow rate and come back to check the oxygen saturation level during the nebulizer treatment which is given every four hour." When asked if it is within a nurse's scope of practice to titrate the O2 flow rate, RN#3 stated, "Yes, I can". When asked if O2 is considered a medication, RN#3 state, "yes." When asked if the nurse can alter a medication dose without a physicians order, RN#3 stated, "No".

According to the facilities oxygen administration

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F 695	Continued From page 15 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/respiratoryfailure.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/pneumonitis/symptoms-causes/syc-20352623?p=1	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/13/19

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F 812	Continued From page 16 §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 by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store and serve food in a sanitary manner in two of two facility kitchens. 1. The facility staff failed to maintain a five-pound container of cottage cheese and approximately two cups of ground turkey lunch meat, on the serving line, at a temperature of 41 degrees F (Fahrenheit) or lower in the facility kitchen for the Lee and Grace residential units. 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	F 812	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	

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F 812	Continued From page 17 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. 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 bowel of the food processor was stored for use wet and was observed with approximately a tablespoon of water in the bottom of the bowl and the mixer was observed with food debris splattered on the splashguard of the mixer above the mixing bowl. 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. 6. The facility staff failed to ensure a plastic container of frozen breaded chicken tenders, approximately two pounds and a cardboard box	F 812	and implementation. 4)The kitchens will be audited by facility designee quarterly and findings presented to the QA committee for review and recommendations. 5)Date: April 1, 2019	

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of frozen beef patties, with three patties remaining sitting on the middle shelf of the reach-in freezer were sealed and not left open to the air and potential contamination, in the Jefferson kitchen for the Brantley residential unit.

The findings include:

On 02/24/19 at approximately 4:45 p.m., an observation of the facility's kitchen for the Lee and Grace residential units was conducted with OSM (other staff member) # 1, dietary manager.

1. The facility staff failed to maintain a five-pound container of cottage cheese and approximately two cups of ground turkey lunch meat, on the serving line, at a temperature of 41 degrees F (Fahrenheit) or lower in the facility kitchen for the Lee and Grace residential units.

An observation of the food service line in the kitchen for the Lee and Grace residential units revealed an opened, full five-pound container of cottage cheese sitting on ice in a stainless steel pan and a plastic two-cup container of ground turkey lunch meat sitting on ice in the same stainless steel pan. OSM # 1 was asked to obtain the temperatures of the cottage cheeses and ground turkey. Using a facility digital thermometer, OSM # 1 placed it in the cottage cheese. Observation of the thermometer revealed a reading of forty-six degrees Fahrenheit. After placing the thermometer in the ground turkey, an observation of the reading revealed fifty degrees Fahrenheit. When asked about the temperature of the cottage cheese OSM # 1 stated, "It should be 41 degrees." When asked about the temperature of the ground

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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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bowel of the food processor was stored for use wet and was observed with approximately a tablespoon of water in the bottom of the bowl and the mixer was observed with food debris splattered on the splashguard of the mixer above the mixing bowl.

An observation of the food preparation table in the kitchen for the Lee and Grace residential units revealed a meat slicer, a food processor and an industrial mix sitting on top of a food preparation table.

Observation of the meat slicer revealed it was covered with a plastic bag. When asked if the meat slicer was clean and ready for use, OSM # 1 stated, "Yes." OSM # 1 then removed the bag covering the meat slicer. Further observation of the meat slicer revealed debris on the surface of the base under the gauge plate and under the slice deflector. OSM # 1 was asked to observe the debris on the meat slicer. When asked if the debris was food debris OSM # 1 stated yes and agreed the meat slicer was not clean.

An observation of the food processor revealed it was assembled with the bowl sitting on the base and the lid in place on top of the bowl. OSM # 1 was asked if the food processor was cleaned and ready for use. OSM # 1 stated yes. OSM # 1 then removed the bowl from the base, and then removed the top of the bowl. An observation of the inside of the bowl revealed approximately a tablespoon of water in the bottom of the bowl and the blade in place. When asked to describe what she saw in the bottom of the food processor bowl OSM # 1 stated, "There's water in it. It should air dried."

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Observation of the mixer revealed it was assembled sitting on the food preparation table. When asked if the mixer was clean and ready for use OSM # 1 stated, "Yes." Further observation of the mixer revealed food debris splattered on the splashguard of the mixer above the mixing bowl. OSM # 1 agreed the mixer was not clean.

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.

An observation of the walk-in refrigerator with OSM # 1 in the kitchen for the Lee and Grace residential units revealed a two pound container of chopped garlic available for use with approximately one-and -a half pounds remaining with an open date of 1/17/19 and a use-by-date of 2/17/19. The observation also revealed a partially unwrapped stainless steel pan of sliced lettuce and tomatoes also available for use, sitting on a shelf in walk-in refrigerator in the kitchen for the Lee and Grace residential units. When asked about the expired chopped garlic OSM # 1 stated it was expired, and discarded the chopped garlic.

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

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for the Lee and Grace residential units.

An observation of the walk-in freezer with OSM # 1 in the kitchen for the Lee and Grace residential units revealed a twenty-pound box of frozen, sliced yellow squash with approximately ten pounds remaining, available for use sitting on a shelf in the walk-in freezer. Observation of the box of squash revealed a plastic bag inside the box. Observation of the plastic bag revealed it contained frozen, sliced yellow squash and was open to the air and potential contamination. When asked about the opened box of frozen squash OSM # 1 stated, "The bag should have been secured."

6. The facility staff failed to ensure a plastic container of frozen breaded chicken tenders, approximately two pounds and a cardboard box of frozen beef patties, with three patties remaining sitting on the middle shelf of the reach-in freezer were sealed and not left open to the air and potential contamination, in the Jefferson kitchen for the Brantley residential unit.

An observation of the reach-in freezer with OSM # 1 in the kitchen for the Brantley residential unit revealed two pounds of frozen breaded chicken breast and a card board box of frozen beef patties with three patties remaining sitting on the middle shelf of the reach-in freezer. Observation of the plastic container of frozen breaded chicken tenders reveal the top was open approximately a third of the way exposing the frozen breaded chicken breast to the air. Observation of the cardboard box of frozen beef patties revealed the lid of the box was open and the plastic bag inside the box with three beef patties was open to the air. When asked about the opened container of

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frozen breaded chicken tenders and the opened box of beef patties OSM # 1 stated, "The lid should have been placed back on the container and the bag with the patties should have been closed."

On 02/25/19 at 5:20 p.m., an interview was conducted with OSM # 1, dietary manager regarding the finding in the Jefferson kitchen and the kitchen for the Lee and Grant residential units on 02/24/19. When asked why it was important to maintain the appropriate holding temperatures for cold foods OSM # 1 stated, "To reduce the risk of food borne illnesses. They (cottage cheeses and ground turkey lunch meat) were discarded." When asked to describe the process to ensure expired food is not available for use, OSM # stated, "The dates should be checked daily." When asked to describe the process for maintaining the meat slicer, food processor and mix in a sanitary manner, OSM # 1 stated, "It should thoroughly cleaned after every use. The equipment is broken down, washed with soap water, sanitized and air dried." When asked to describe the procedure for storing food items that have been opened in the refrigerator or the freezer, OSM # 1 stated, "Staff should ensure the food is properly wrapped a and dated. It should be resealed or closed immediately after removing what was needed."

The facility policy "Food Storage" documented, "14. Refrigerated Food Storage: f. 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-by-dates, or frozen (where applicable), or discarded. 15. Frozen Foods: c. All foods should be covered, labeled, and dated. All foods will be

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F 812	Continued From page 24 checked to assure that foods will be consumed by their safe use-by dates or discarded." The facility policy "Employee Sanitary Practices" documented, "8. Clean and sanitize equipment and work units after use." On 02/26/19 at approximately 5:05 p.m., ASM # 1 (administrative staff member), president/chief executive officer/administrator, ASM # 2, director of compliance and ASM # 3, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		4/1/19

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F 880	Continued From page 25 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 _____	02/27/2019

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) COMPLETION DATE
F 880	Continued From page 26 §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 by: Based on observation and staff interview, facility staff failed to store respiratory equipment according to professional standards of practice to prevent infection for one of 50 residents, Resident #16. The facility staff failed to ensure Resident #16's nebulizer mask was stored in a manner to prevent infection. During tour of the facility Resident #16's mask attachment for the nebulizer was observed, uncovered sitting on Resident #16's bed. The findings include: 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 as requiring supervision and setup assistance for eating. Resident #16's room was observed during initial	F 880	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 27	F 880		

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 to be 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 a Ziploc bag dated 02/24/2019.

On 02/26/2019 at 10:15a.m., an interview was conducted with Licensed Practical Nurse (LPN) #3 regarding nebulizer treatments. LPN #3 stated that nebulizer equipment should always be kept in a bag when not in use. LPN #3 also stated that all respiratory equipment, such as nebulizer masks and oxygen tubing, are changed each Sunday by the night shift.

A review of the facility policy on Oxygen Administration revealed the following under the heading "Procedure": "12. The equipment should be stored in a plastic bag or on a clean (non-soiled) surface/location".

The Administrator ASM (administrative staff member) #1 and Director of Nursing, ASM #3 were informed of the findings at the end of day meeting on 02/26/2019. No further documentation was provided.