CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

OCITICATI	31 311 (1123131112 31		(X2) MUL	TIPLE (CONSTRUC	CTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDI				(X3) DATE :	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BOILDI					
		l					C	;
		495339	B. WING				11/1	7/2022
NAME OF PE	ROVIDER OR SUPPLIER		Ī	\$T	REET ADDI	RESS, CITY, STATE, ZIP CODE		
HOLLY MA	ANOR REHAB AND NUI	RSING			03 COBB S ARMVILLE	STREET E, VA 23901		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI TAG	1		EACH CORRECTIVE ACTION SHOULD BI COSS-REFERENCED TO THE APPROPRIA		DATE
TAG	REGULATURY OR I	LSC IDENTIFYING INFORMATION)	IAG		CR	DEFICIENCY)		
E 000			E	000				
	Initial Comments							
	Initial Comments							l l
,		πergency Preparedness						
ì	Survey was conducted	ed on 11/14/22 through						
	11/17/22. The facility	was in substantial		ĺ				
	compliance with 42 C	FR Part 483.73,						
		g-Term Care Facilities. No						
	emergency prepared	ness complaints were						
	investigated during th	ne survey.						
F 000	INITIAL COMMENTS		F (000				
		İ		-				
j	An unannounced Me	edicare/Medicald standard						
-		d 11/14/22 through 11/17/22.						
i								
	•	ired for compliance with 42						
	CFR Part 483 Federa requirements. The L							İ
		ow. Five complaints were						
		ne survey (VA00055276-		1				
		00055600- substantiated with						
		761- substantiated with						
		766- substantiated with						
		758- substantiated with						
	deficiency).							i
							1	
		20 certified bed facility was						
		survey. The survey sample		1				
	consisted of 33 resid	ent reviews.						
			1	1				
			_					10/05/0000
F 558	Reasonable Accomm	nodations Needs/Preferences	F	558	1.	Siderail assessments were comple		12/25/2022
SS=E	CFR(s): 483.10(e)(3)					residents #38, #59 and #63. Resid		
						no longer resides at the facility. (Frab bars	
		ght to reside and receive	1	ļ		orders received from the Nurse		
	services in the facility					practitioner and grab bars were a	pplied to	
	accommodation of re					the residents' beds and bed conti	rols are	
	preferences except v					within reach for residents # 38, #	59, and	
		or safety of the resident or		į		#63. The residents' care plans have		
	other residents.	-				updated to reflect a current indiv		
	This REQUIREMEN	T is not met as evidenced				plan of care. Holly Manor Heath a		
	by:					Rehab has identified that all resid		
		on, resident interview, facility	1			at risk from this alleged deficient		
		•			9	AP 11412 114111 CITE CITED AN APRILIS	,	•
					142			1
	i .							1

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2. The Director of Nursing/designee has performed an assessment audit of all current residents with a BIMS of 13 or greater to ensure that resident siderail preferences are honored, and side rail assessments have been completed. Grab bars were applied to the beds of residents identified in the audit and staff have ensured that bed controls are within reach. Care plans have been updated to reflect a current individualized plan of care for assistive bars.

- 3. The Director of Nursing/designee will inservice licensed nursing staff, including LPNs and RNs, regarding honoring resident siderail preferences and ensuring that bed controls are within reach. The inservice includes, but is not limited to, the importance of honoring resident preferences, the importance of bed controls being within reach, and completing the siderail assessment in a timely and accurate manner to assist residents with transfers and bed mobility.
- 4. The Director of Nursing/designee will conduct an audit of newly admitted resident's charts 5x a week for 4 weeks and then monthly for 2 months to ensure that siderail assessments have been completed and resident assistive bar preferences are honored. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate corrective actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.

5. Date of Compliance: 12/25/22

TITLE

(X6) DATE

Esteban Duran-Ballen

Regional Director of Operations

12/15/2022

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.

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

ABCRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID:BCJ811

Facility ID: VA0291

Facility ID: VA0291

If continuation sheet Page 1 of 146

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			(X2) MULTIPLE CONSTRUCTION		(Y2) DATE SUDVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A. BUILDI	NG	(X3) DATE SURVEY COMPLETED	
AILD I DIII C	. COMMEDITION			···	С	
					1	
		495339	B. WING	ATTICET ADDRESS OFFICE THE CODE	11/17/2022	
NAME OF I	PROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLYM	ANOR REHAB AND NU	IPSING	- 1	2003 COBB STREET FARMVILLE, VA 23901		
HOLLI W	ANOR REHAD AND IT	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		<u> </u>		
(X4) ID PREFIX		TEMENT OF DÉFICIENCIES MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	I CATE	
				DEFICIENCY)		
F 558			F 5	58	_	
	Cartinual From 200	a 1 decument review, and				
	, ,	e 1 document review, and , it was determined the				
		accommodate the needs				
		dent's preferences for the				
		for four of 33 residents in				
		esidents #38, #59, #63 and				
	#15.					
	The findings include:					
	1 For Resident#38 (R38), the facility staff failed				
	,	s preference to have bed				
Ш		om to stand at the bedside				
Ш	and failed to accomn	nodate the resident's ability				
	to reach their bed cor	ntrols.				
		IDS (minimum data set)				
		erly assessment, with an	ľ			
	assessment reference					
		a 13 out of 15 on the BIMS				
		ental status) score, indicating quitively impaired for making				
	l ·	ection G - Functional Status,				
		ed as requiring supervision				
		l, transfers, walking in the				
	ū	the corridor with one person				
		vas coded as requiring				
		for their toileting needs. In				
		and Bowel, the resident was				
		ently incontinent of both	1			
	bowel and bladder.					
	Observation was	de of R38 on 11/15/2022 at				
		nt was lying in their bed.		_		
	There were no side r					
		ller was attached to the				
	nightstand, R38 state	d they can't reach the		_		
	control if they are lyir	ng on their left side as the				
		ht side of the bed and out of				
	their reach. When as	ked how long it had been				

(X3) DATE SURVEY

COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

Facility ID: VA0291

A. BUILDING _

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 12/05/2022 FORM APPROVED

OMB NO 0938-0391

CENTERS	FOR MEDICARE & N	MEDICAID SERVICES				. 0938-0391
					0	;
		495339	B. WING		11/1	7/2022
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		į
HOLLY M	ANOR REHAB AND NU	IRSING		FARMVILLE, VA 23901		
				PROVIDER'S PLAN OF CORRECTION	u I	0(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED 8Y FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPS		DATE
		·		DEFICIENCY)		
E 550			F 55	9		
F 558			1 55	9		- 1
	Continued From page	e 2 this way, R38 stated				
		ey took the side rails off the				
	bed.	y took are side rails on are				
	Dea.					
	An interview was con	ducted with P38 on				
		m. When asked if they used				
		ey had them, R38 stated				
		rning in the bed. They stated				
		Ip him get up out of the bed.				
	at the bedside to use	used them to help him stand		1		
	at the pedside to use	the unital.				į
	A - 1-4 1	dusted with CNA (portified				
		ducted with CNA (certified				
		on 11/16/2022 at 9:00 a.m.				
		ad required more assistance				
		s of daily living) care since				:
		emoved, CNA #5 stated,				
	yes, they were able t	to get up and stand at the				
		38] now wets themselves at				
	times. [R38] used the	rails to move in bed.		ļ		
		4 4 PN-1: A				!
l i		ntrapment Risk Assessment				
		ocumented in part, "1. Is the				
		T in bed mobility - no. 2. Is				
	the resident NON-AM	nsive assistance - no. 3.				i
	=					
		ve alteration in safety gnitive decline and poor				
		o. 4. Will the use of side rails				
	optimize resident ind	ependence in bed mobility				
	and transfer - no. 5. (
		he side rails, independently				
		g, for bed mobility - no. 6.				
	Dose the resident ha	ve difficulty with balance or				
İ		en in bed or transferring				İ
	tfrom hed - no. 7. Do	pes the resident have a				
		potension, vertigo, syncope,				
	or dizziness - no. 8	Is the resident on any				
	medications that may	y require increased safety				
	precautions (i.e., anti	coagulants, psychoactive				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	IPLETED
1						С
		405220	B 145110		11/	17/2022
		495339	B. WING			

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR REHAB AND NURSING				2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DÉFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558			F :	558	3		
	Continued From page	e 3 meds,					
	medications with side	effects of					
	hypotension - Yes. Exhigh blood pressure) demonstrated a histor the rails - no. 10. Has a history of injury from including skin tears, it resident able (cognitist the call bell to call for the resident or resident or resident use of side rails - no. during care provided safety and security - 19. Other alternative side rails - low bed. 20 is recommended: no time24. Other recording the comprehensive of the comprehensive of the side of the comprehensive of the side of t	cplain - htn (hypertension -			61 = 1		
	member) # 2, the dire 11/16/2022 at 1:04 p. involved with the rem OSM #2 stated he rel beginning of the mon how that come about in-service with the climissed it. OSM #2 staresident could not rai they couldn't have rait them [administration] them as the controls a rail near the frame.	ducted with OSM (other staff ector of maintenance, on m. When asked if he was oval of all the side rails, moved the side rails the th [November]. When asked OSM #2 stated they had an nical staff, he stated he had ated he was told if the se and lower the side rails, Is. OSM #2 stated he told I that no one could release are on the outside of the bed OSM #2 stated he was not, he felt like the facility had					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			LE CONSTRUCTION 3	СОМ	SURVEY PLETED
		495339	B. WING			11/	17/2022
	PROVIDER OR SUPPLIER	IRSING			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		

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X4) ID	S FOR MEDICARE & MEDICAID SERVICES SUMMARY STATEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC
F 558		F 558	<u> </u>	
	Continued From page 4			
	Continued From Page 4			
	An interview was conducted with ASM #3, the			
	assistant director of nursing, on 11/16/2022 at			
	1:19 p.m. When asked the process for the use of			
	side rails, ASM #3 stated if a resident wants or			
	needs side rails, then an assessment is			
	completed. ASM #3 stated, "I go through that, I make sure that they are safe for them to have	1 1		
	side rails, such as if they have an air mattress,			
	that's one of the questions on the assessment. All	1		
	rails have been removed. If there is a request by	1 1		
	the resident, family, doctor, or therapy, we go			
	back in and reassess the resident." When asked	1 1		
	about the resident's ability to raise and lower the			
	side rails, ASM #3 stated the release button is not			
	on the bed frame, it's on the outside of the rail.			
	ASM #3 stated she still had residents that can			
	turn by themselves or are now a two person			
	assist. When asked what the residents that turn			
	are holding on to, ASM #3 stated, the bed frame,	1 1		
	some will use the mattress. When asked about	1 1		
	R38, ASM #3 stated when she did the	1 1		
	assessment, they didn't use the side rails to get			
	out of the bed. ASM #3 stated R38 is aware they are not to get up without assistance. When asked			
	about using the urinal, ASM #3 stated the	1		
- 1	resident has been using the urinal while sitting in			
1	the bed. When asked about the placement of	1		
	R38's bed control and where should they be,	1		
	ASM #3 stated they should be within the	1		
	resident's reach.	1		
	An interview was conducted with ASM #2, the			
	director of nursing, on 11/16/2022 at 2:35 p.m.			
	When asked the process for a resident to have			
	side rails, ASM #2 stated the resident must be			
	able to raise and lower the side rails			
	independently. When asked where that			1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495339	B. WING	C 11/17/2022
NAME OF PROVIDER OR SUPPLIER	430003	STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND NURSING		2003 COBB STREET FARMVILLE, VA 23901	

FORM APPROVED

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SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 558 F 558 Continued From page 5 the CMS (The Centers for Medicare/Medicaid services) regulation. ASM #2 stated, "This building had side rails not for the resident to use them but a safety net to keep the residents from falling." When asked if removing the side rails is allowing the resident reach their highest level of well-being, ASM #2 stated. "We are practicing safety for the residents." The facility policy, "Bed Rail Risk and Safety" documented in part, "Assess the Resident - 1. Any resident being considered for using a bed with bed rail(s) is evaluated by the facility's interdisciplinary team to determine whether the resident's functional status and bed mobility is improved through the use of bed rail(s), to identify any bed rail that might constitute physical restraint, and to identify individual characteristics that may increase the risk of entrapment by bed rails or mattress. 2. The bed rail evaluation. including the entrapment risk component, is completed: a. Admission, Readmission, b. Quarterly, c. At any time, there is a significant change in resident condition, i. A significant change in the resident's condition may be related to improvement and/or decline in the resident's functional, behavioral, or cognitive status as identified by the interdisciplinary team. Bed Rail Risk and Safety: 2 d. Any time the resident's bed complement is changed (e.g., addition of a specialty mattress, overlay, or an additional bed rail). 3. If the resident's evaluation identifies him or her as appropriate for the use of bed rail(s), the following procedures will be followed: a. Educate the resident/resident representative on the risks and obtain consent for use. i. The resident and/or resident representative's consent for use of the bed rails will be documented in the medical record. b. The resident's representative ROWIDERICALISM ISSUED (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED
			С
П	495339	B. WING	11/17/2022
NAME OF PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND NU	IRSING	2003 COBB STREET FARMVILLE, VA 23901	

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F 558			F 558			
	Continued From page	e 6 will be notified as			İ	
		ysician/practitioner will be				
		c order for the use of bed				
		ny / type of rails, which side nd when they are to be in	Ē.	20		
	place) will be obtaine					
	 	-				
		dministrator, and ASM #2,			Í	
		g, were made aware of the			İ	
	above concern on 11	/16/2022 at 6:15 p.m.				
	No further information	n was provided prior to exit.	1			
		•				
20	0 Fee Desident#50 //	R59), the facility staff failed				
		s preference for having side		N.		
	rails to assist in bed n					
		DS (minimum data set)				
	assessment, a quarte	erly assessment, with an e date of 9/7/2022, the				
	resident scored a 15	out of 15 on the BIMS (brief				
		status) score, indicating the				
	resident was not cogr	nitively impaired for making				1
		ction G - Functional Status,				
		ed as requiring extensive ff member, in moving in the				
•	bed and for transfers				1	
		de on 11/14/2022 at 6:25				
		ner in the resident room. The have one side rail on the				
	bed was observed to	Mayo one side fall on 2.5				
						1
	An interview was con	ducted with R59 on				
	11/15/2022 at 3:21 p.	m. R59 stated they wanted bed. R59 stated they were				
	able to get one rails t	pack to put their touch-				
	controlled specialty c	all bell on. A second				
			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
					(

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F 558			F 558			\dashv
				77		
	Continued From pag					
		on 11/16/2022 at 9:16 a.m.				- 1
		e side rails, R59 stated				
	,	her rail, on the resident's				
	_	they could wrap their arm	1			
	over it to keep thems					
	changed him. R59 st	ated they could not do that				
	now.					
	dated 10/31/2022, do resident DEPENDEN the resident NON-AN ambulates with exter	ntrapment Risk Assessment, ocumented in part, "1. Is the T in bed mobility - no. 2. Is IBULATORY or only asive assistance - yes. 3. Is a lteration in safety			_	
		gnitive decline and poor				
		o. 4. Will the use of side rails				- 1
		ependence in bed mobility				
	and transfer - no. 5. (•				
		ne side rails, independently				
		g, for bed mobility - no. 6.				
		ve difficulty with balance or				
1		en in bed or transferring				
	to/from bed - yes. 7. I	Does the resident have a				
	history of postural hy	potension, vertigo, syncope.				
	or dizziness - no. 8. l	s the resident on any				
		require increased safety				
		coagulants, psychoactive				- 1
	meds, medications w					
	hypotension - Yes. Ex					
		e resident demonstrated a				
		ver or around the rails - yes.				
		demonstrated a history of				ŀ
		e side rails including skin no. 11. Is the resident able				
		nally) to use the call bell to				
		es. 12. Has the resident or				
		ve requested use of side				
		e use of side rails during				
		f optimize resident safety				
	<u> </u>					_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	ooiconto		C	-
					11/17/2022	
NAME OF S	PROVIDER OR SUPPLIER	495339	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	11/11/2022	\dashv

2003 COBB STREET FARMVILLE, VA 23901

Facility ID: VA0291

HOLLY MANOR REHAB AND NURSING

CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558			F 558			<u> </u>
	Continued From page	e 8 and security - no IS: 20. The following side				
	rail use is recommen		[[j	
	indicated at this time.					
	dated 11/15/2022 (du part, "1. Is the resider mobility - yes. 2. Is th NON-AMBULATORY extensive assistance	or only ambulates with - yes. 3. Does the resident				
!	cognitive decline and	ety awareness due to poor decisions making - no. rails optimize resident				
	independence in bed Can the resident den	mobility and transfer - no. 5. nonstrate use of the side				
	bed mobility - no. 6. (or with little prompting, for Does the resident have				
	in bed or transferring	e or poor trunk control when to/from bed - no. 7. Does	:			
		syncope, or dizziness - no.				
		any medications that may				
	require increased sat	rety precautions (i.e., hoactive meds, medications			İ	
		ypotension - Yes. Explain -]	
		nt demonstrated a history of	5.5		1	
		and the rails - no. 10. Has				
		rated a history of injury from				
	use of the side rails in	ncluding skin tears, bruising,	1			
		esident able (cognitively or				
	functionally) to use the				- 1	
	assistance - yes. 12.	Has the resident or resident	1 1		- 1	
		sted use of side rails - yes.	1			
		le rails during care provided	1 1			
		dent safety and security -				
	no RECOMMENDA	ATIONS: 19. Other red/trialed prior to side rails.				
	alternatives consider	eg/maled prior to side rails.				
	use is recommended	i: 22. If only 1 grab bar, 1/4,				
STATEMENT AND PLAN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	M ' '	CONSTRUCTION	(X3) DATE	SURVEY PLETED
					111) 7/2022

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558			F 558	3		
	Continued From pag	e 9			1	
	1/2 or full side rails is	used, identify side - left. 23. ise: to station soft touch call				
	documented in part, (activity of daily living deficit AEB (as exhib ADLs." The "Interven	care plan dated 5/11/2022 Focus: [R59] has an ADL) self-care performance ited by) requires assist with tions" documented in part, ide rail to assist with call bell on 11/15/2022.				
	practical nurse) #4 or When asked if R59 h stated, yes. When as LPN #4 stated the sa else, the resident cou rails independently. I back. When asked w	ducted with LPN (licensed in 11/16/2022 at 9:31 a.m. ad side rails before, LPN #4 ked why they were removed, me reason for everyone ildn't raise or lower the side LPN #4 stated [R59] got one my, LPN #4 stated she was lived it was to put his call bell				
	member) # 2, the direct of the control of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the missed it. OSM #2 states it. OSM #2 sta	ducted with OSM (other staff ector of maintenance, on m. When asked if he was oval of all the side rails, moved the side rails the th (November). When asked , OSM #2 stated they had an nical staff, he stated he had ated he was told if the se and lower the side rails, ls. OSM #2 stated he told) that no one could release are on the outside of the bed OSM #2 stated he was not , he felt like the facility had				
	stepped back in time					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEWCUA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION 3	(X3) DATE COM	PLETED
		495339	B. WING		11/1	7/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		

2003 COBB STREET

FARMVILLE, VA 23901

HOLLY MANOR REHAB AND NURSING

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	
F 558			F 558			
	Continued From page	e 10				
		ducted with ASM #3, the				
		ursing, on 11/16/2022 at				
		d the process for the use of			1	
		ited if a resident wants or				
	needs side rails, then					
		tated, "I go through that, I				
		are safe for them to have				
		hey have an air mattress,			i	- 1
		tions on the assessment. All wed. If there is a request by				
		loctor, or therapy, we go				
		the resident." When asked				
		bility to raise and lower the				
		ted the release button is not				
		on the outside of the rail.	i			
		ill had residents that can				
	turn by themselves or	r are now a two person				-
		hat the residents that turn				-
		M #3 stated, the bed frame,				
	some will use the ma	ittress. When asked about				
		"We've now made him more			i	
		sked if that is promoting his				
		being and honoring his				
		stated, "If he feels that way,				
		romoting his highest level of			l	
	well-being."				1	
	An interview was con	ducted with ASM #2, the			i	
		n 11/16/2022 at 2:35 p.m.			1	
		ess for a resident to have				
	side rails, ASM #2 sta	ated the resident must be				
	able to raise and low					
	independently. When					
		d, ASM #2 stated it's part of			İ	
	the CMS (centers for					
	services) regulation.	ASM #2 stated, "Inis			İ	
	building had side rail	s not for the resident to use to keep the residents from				
	mem but a salety net	to rech the residents from				
			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA	A. BUILDING			PLETED
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495339	B. WING		C 11/17/2022
NAME OF PROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558			F 558			
	Continued From page	e 11 falling." When asked				
	if removing the side a					1
	•	ighest level of well-being,				
	ASM #2 stated, "We a	are practicing safety for				- 1
	the residents."					
	ASM #4. the interim a	administrator, and ASM #2,				
		g, were made aware of the				
		/16/2022 at 6:15 p.m.			İ	
	No further informatio	n was provided prior to exit.				
	3. For Resident#63 (R63) the facility staff failed			1	
		's preference for the use of				
		bed mobility and reduce			1	
	anxiety.				i	
	On the most recent M	IDS (minimum data set)				
	assessment, a signifi	cant change assessment,				
	i e	reference date of 10/5/2022,				
		15 out of 15 on the BIMS				
ľ	,	ental status) score, indicating	:			
		gnitively impaired for making ection G - Functional Status			l	1
		quiring extensive assistance				
	of one staff member	* *				
		of two staff members for				
	transfers.					
	R63 was observed or	n 11/15/2022 at				
		.m., in bed. There were no				
		the bed. R63 stated they]	
	want their side rails b	ack. R63 stated, "They took]	
		some law." R63 stated they				
		ld onto [rails] when they turn,				
	and they can try to re	position themselves in bed."				j
	The "Side Rail and Fo	ntrapment Risk Assessment,				
		cumented in part, "1. Is the				
		T in bed mobility - yes. 2. Is				
074754545	or periornoles	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	-		PLETED
					(

		IDENTIFICATION NUMBER:	A. BUILD	ING	COMPLETED
l					С
١		495339	B. WING		11/17/2022
ŀ	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
۱				2003 COBB STREET	
١	HOLLY MANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901	II
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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	9E	(XS) COMPLETION DATE
F 558			F 558			
	i	e 12 the resident NON-		20		
		ly ambulates with extensive				
		oes the resident have	!			ļ
		vareness due to cognitive				i
		isions making - no. 4. Will				ĺ
	the use of side rails of					ĺ
		mobility and transfer - no. 5.	l i			
	·	nonstrate use of the side				
		or with little prompting, for	j			
		Does the resident have				
		e or poor trunk control when				
		to/from bed - no. 7. Does				
	the resident have a h					
		syncope, or dizziness - no.				
		any medications that may				ļ
	require increased sat					}
1		noactive meds, medications	i			
		ypotension - no. 9. Has the				- 1
		ed a history of climbing over				- 1
		no. 10. Has the resident				- 1
Ì	4. 4 	ry of injury from use of the	1			- 1
		in tears, bruising, etc yes.]			
	11. Is the resident ab		1 1			ŀ
	functionally) to use th					i
		Has the resident or resident				- 1
		sted use of side rails - no.				- 1
		le rails during care provided				
		dent safety and security -			1	
		TIONS: 24. Resident is	i		1	
	unable to raise and le					
	independently."	5401 0100 10110	i			
	macpondents.					
	The comprehensive	care plan revised on			-	
		evidence documentation				
	related to the use of					1
1	10,000 10 0,0 000 0,1					
	An interview was con	ducted with LPN (licensed				
	practical nurse) # 4,1					
	11/16/2022 at 9:33 a	.m. When asked why R63			ĺ	
	didn't have side rails.	LPN #4 stated the resident				
CTATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COME	PLETED
1					l c	;

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
					С
ĺ		495339	B. WING		11/17/2022
ł	NAME OF PROVIDER OR SUPPLIER	<u> </u>	_	STREET ADDRESS, CITY, STATE, ZIP CODE	
ı				2003 COBB STREET	
ı	HOLLY MANOR REHAB AND NURSING			FARMVILLE, VA 23901	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558			F 558			
1	Continued From 200	o 13 had thorn, but they				i
	were removed. When	e 13 had them, but they				
		as unable to raise and				ļ
		re considered a restraint.				
	_	can move in the bed by				
		stated they can wiggle,		0	İ	
		ails to hold themselves				ŀ
		Ives up. When asked if				
	•	it in bed mobility for R63,				
	LPN #63 stated, yes.	it in bed mobility for 1.05,				
	LPN #65 stated, yes.				-	
	An interview was con	ducted with CNA (certified			i	
	,	on 11/16/2022 at 11:00 a.m.				i
	When asked about th	e use of side rails for R63,				
	CNA #7 stated, when	they had the side rails, they				
	could use them, they	can help hold themselves				
	up on the rails. The ra	ils helped to hold them over				
	to be cleaned. Now it	's harder to provide care.	ı			1
	CNA #7 stated, [R63]	has anxiety and is afraid to				
	fall out of the bed. [Ri	63] now pushes against the				
	wall and that someting	nes is a disadvantage. CNA				1
	#7 stated she pushed	the bed against the wall but				
	[R63] still has a fear	of falling out of the bed.				
	An intoniowwae con	ducted with OSM (other staff		10.0	J	
		ector of maintenance, on				ŀ
	-	m. When asked if he was				
	,	oval of all the side rails,				
		noved the side rails the				
		th (November). When asked				
		, OSM #2 stated they had an				
		nical staff, he stated he had				
_	missed it. OSM #2 sta			11		
	resident could not rai	se and lower the side rails,				
		ls. OSM #2 stated he told			ļ	į
) that no one could release				
		are on the outside of the bed				
		OSM #2 stated he was not				
	•	, he felt like the facility had			i	
	stepped back in time					
			(X2) MULTIPL	E CONSTRUCTION	(Y2) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			PLETED
				-		
						17/2022
NAME OF S	POVINCE OR SUPPLIER	495339	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	1112022

2003 COBB STREET

FARMVILLE, VA 23901

NAME OF PROVIDER OR SUPPLIER

HOLLY MANOR REHAB AND NURSING

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETION
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		DATE
17.0	(120001)0111 01111			DEFICIENCY)		
F 558			F 558		+	
F 556		ļ	. 555			
	Continued From page	e 14]
	An interview was con-	ducted with ASM #3, the				
		ursing, on 11/16/2022 at				
		d the process for the use of				
	side rails, ASM #3 sta	ited if a resident wants or				
	needs side rails, then	an assessment is				
	completed. ASM #3 s	tated, "I go through that, I			1	
	make sure that they a	re safe for them to have	ľ			
	side rails, such as if the	ney have an air mattress,				
		tions on the assessment. All				
	rails have been remo	ved. If there is a request by				
		loctor, or therapy, we go			ľ	1
		the resident." When asked				
		bility to raise and lower the			-	
		ted the release button is not			1	
		on the outside of the rail.				
		ill had residents that can				
		r are now a two person				
		hat the residents that turn			ŀ	-
		M #3 stated, the bed frame,			ŀ	
		ttress, When asked about			ŀ	
		they are a two person				
		est way to reposition them.				
		their fear factor and anxiety				
		ne assessment, ASM #3				
	stated, "Yes, it does. reassessed for the us]	
	reassessed for the us	se of side falls.			ì	
	An intention was oon	ducted with ASM #2, the				
		1 11/16/2022 at 2:35 p.m.				
		ess for a resident to have				
	side rails. ASM #2 sta	ited the resident must be				
	able to raise and low					
	independently. When				l	
		d, ASM #2 stated it's part of				
İ		s for Medicare/Medicaid			i	
1	services) regulation.					
	building had side rail	s not for the resident to use	ľ			
	them but a safety net	to keep the residents from				
			AVOLUMI TODI S	CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	SURVEY PLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			_
					C	
		495339	B. WING		11/1	7/2022

STREET ADDRESS, CITY, STATE, ZIP CODE

2003 COBB STREET FARMVILLE, VA 23901

Facility ID: VA0291

NAME OF PROVIDER OR SUPPLIER

HOLLY MANOR REHAB AND NURSING

PRINTED: 12/05/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (X4) 1D PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST 8E PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 558 F 558 Continued From page 15 falling." When asked if removing the side rails is allowing the resident reach their highest level of well-being, ASM #2 stated, "We are practicing safety for the residents." ASM #4, the interim administrator, and ASM #2, the director of nursing, were made aware of the above concern on 11/16/2022 at 6:15 p.m. No further information was obtained prior to exit. 4. For Resident #15 (R15), the facility staff failed to honor a resident's preferences for bed rails to maintain their level of ADL (activities of daily living) self-performance and promote their sense of self-determination and independence. R15 used the bed rails on their bed to increase their ADL self-performance with staff assistance in transferring and bed mobility and requested their use however they were removed from the bed causing R15 to require more physical assistance from staff when transferring to the recliner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/30/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section G documented R15 requiring extensive assistance of two or more persons for bed mobility, one person for transfers and limited assistance of one person for walking in the room. Section G further documented R15 using a walker and a wheelchair. The previous quarterly MDS with an ARD of 8/10/2022 documented R15 requiring limited assistance of two or more persons for bed mobility, one person for transfers and limited assistance of one person for walking in the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED C
	495339	B. WING		11/17/2022
NAME OF PROVIDER OR SUPPLIER	400000		DDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND N	URSING	I	B STREET LLE, VA 23901	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
ŀ	F 558			F 558			
l	F 3361					1	1
l		Continued From page	e 16			l	ŀ
ı							i
ı			30 a.m., an interview was				
ı			n their room. R15 was				
l		_	ecliner in their room. R15				1
l			ed rails on their bed until a				1
l			when someone came in and				
l	1		ated that they were told that				
l	i		ulation that said that no one				
l			5 stated that they used the				1
l			for to them being removed			1	
l			ck. R15 stated that they				
ĺ			en turning and repositioning				į
		and when transferring	g out of bed they used the				
			onto to push themselves up.				
		R15 stated that now to	hey were trying to use the dit was further from the bed				
			the bed rail was. R15				
١			eir transfer much harder for				
l		them now.	en dansion maon natasi to				[
l		ulein now.					i
l		The side rail and entr	apment risk assessment for				!
ŀ			documented in part, "Will			- 1	
		the use of side rails o				i	
ļ			mobility and transfer? Yes.				-
l			ent pulls on side rail to assist			[i
l			ning. Can the resident			l	
l		demonstrate use of the	ne side rails, independently				i
l		or with little prompting				1	
l		YesHas the residen	it or resident representative				
l		requested use of side	rails? YesWill the use of				i
l		side rails during care	provided by staff optimize				1
l		resident safety and s	ecurity? NoHas the bed				
ľ			pleted and demonstrated				
I		matthe bed is safe fu	unctionally and rails and e risk for entrapment? Yes.				
I		mattress do not creat	nsidered/trialed prior to side				
		collect alternatives col	de rails indicated at this				
		time Other recomme	endations: Resident unable				
			le rails independentlyThe			~	
Į		10 1010 0110 10110101010					
1	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	` '	E CONSTRUCTION		SURVEY
		F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		СОМ	PLETED
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I			405000	D 14410		11/	17/2022

FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558		F 558		
	Continued From page 17 resident has an ADL self-care performance deficit. Intervention: Physical assist as needed with ADL's. Encourage the resident to use the bell to call for assistance."		, 50	
	The ADL-Transferring documentation for R15 was reviewed from 10/20/2022-11/16/2022. It documented in part, "Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair)." The documentation showed R15 not participating or requiring two staff members to complete the task on two days. The documentation showed R15 being independent or staff providing less than 1/2 effort needed to complete the task on all other days. The ADL-Bed Mobility documentation for R15 was reviewed from 10/20/2022-11/16/2022. It documented in part, "Bed Mobility: Support Provided- How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture." The documentation showed R15 requiring no assistance, setup help only or one person physical assistance each day during the time frame reviewed.			
	The comprehensive care plan for R15 dated 11/01/2022 documented in part, "The resident has an ADL self-care performance deficit Date Initiated: 11/01/2022. Revision on: 11/01/2022." Under "Interventions" it			<u>.</u>
	documented in part, "Monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Date Initiated: 05/04/2022."		.8	
	On 11/15/2022 at 1:06 p.m., an interview was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495339	B. WING		11/17/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND NO	URSING		2003 COBB STREET FARMVILLE, VA 23901	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

(of on red on red on red of OS we red that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that are red	Continued From page 18 conducted with OSM other staff member) #4, long term care ombudsman. OSM #4 stated that they had eceived multiple calls from residents and family members regarding the bed rails being removed rom residents beds. OSM #4 stated that they had been told that maintenance had removed all of the bed rails about two or three weeks ago. OSM #4 stated that there were new regulations and the facility had to be estraint free so they had removed all of the bed	F 558	
(of on red on red on red of OS we red that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that and red of CS that are red	other staff member) #4, long term care ombudsman. OSM #4 stated that they had eceived multiple calls from residents and family nembers regarding the bed rails being removed rom residents beds. OSM #4 stated that they had been told that maintenance had removed all of the bed rails about two or three weeks ago. OSM #4 stated that they were told that there were new regulations and the facility had to be estraint free so they had removed all of the bed		
Oi co LF	ails and go through the steps to see if the esidents needed the bed rails. OSM #4 stated hat they had met with the residents and the administrative staff about this concern but had no resolution at the current time.		
ha di ne sta do	On 11/16/2022 at 9:28 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that they were told that bed rails were a restraint if the resident could not put them up or down themselves and they were a safety nazard. LPN #4 stated that they were told by the director of nursing that bed rails were not necessary and were a safety hazard. LPN #4 stated that they had tried to put a bed rail up and down when in a bed and they were unable to do it themselves.		1 *
as str al ar it	On 11/16/2022 at 9:34 a.m., an interview was conducted with OSM #6, PTA (physical therapy assistant), therapy program manager. OSM #6 stated that when the facility first started removing all of the residents bed rails they were involved and would assess the residents mobility to see if it would be decreased from removing the bed rails. OSM #6 stated that they would assess to see if the resident could position themselves		

I(X1) PROVIDER/SUPPLIER/CUAI			(X3) DATE SURVEY COMPLETED
			C
495339	B. WING		11/17/2022
40000		STREET ADDRESS, CITY, STATE, ZIP CODE	
		2003 COBB STREET	
JRSING		FARMVILLE, VA 23901	
	(X1) PROVIDER/SUPPLIERCIA IDENTIFICATION NUMBER: 495339	(X1) PROVIDER/SUPPLIERCUA IDENTIFICATION NUMBER: 495339 B. WING	A. BUILDING 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET

PRINTED: 12/05/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 558		·	F 558			
F 558	Continued From page of using them they we about residents who turning who had them "If they used them for sure staff would be in would go to a two per that they were told the able to raise and lowe keep it. When asked physically turn them assist was promoting practicable level of w that it was not. OSM actively working with with alternative mean were able to use the onto. When asked if physically turn them assist was a decline in "Yes." OSM #6 stated decision was made by the previous administ On 11/16/2022 at app #6 provided a PT (ph summary for R15 date bed rails were not us therapy. OSM #6 stated the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administ of the previous administration of the p	removed, OSM #6 stated, turning we would make there to turn them, they son assist." OSM #6 stated at the resident needed to be entheir bed rail to be able to if having to have staff or becoming a two person the residents highest rell-being, OSM #6 stated #6 stated that they were nursing to provide residents as and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents is and some of the residents. The committee of the residents is and some of the residents is and some of the residents in the committee of the residents in the stated, and the stated, and the stated in the director of nursing and trator. The committee of the residents is a stated that the stated	F 558			
		<u></u>				
			(X2) MULTIPI	E CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				SURVEY :
AND PLAN	OF CORRECTION	IDEITIFICATION HOMBEN.			1	

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

2003 COBB STREET

Facility ID: VA0291

11/17/2022

495339

NAME OF PROVIDER OR SUPPLIER

HOLLY MANOR REHAB AND NURSING

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 558		F 558	E,	
	Continued From page 20			
	On 11/16/2022 at 1:04 p.m., an interview was			1 1
	conducted with OSM #2, the director of			
	maintenance. OSM #2 stated that the bed rails			
	were removed around the beginning of	l l		
	November. OSM #2 stated that as far as they	i		
	knew there was an inservice from the corporate			!
	office which advised that if the patient could not			
	raise and lower the bed rail themselves it was			
	considered a restraint. OSM #2 stated that they	ļ		
	thought there were about three residents in the building that were able to do this.			
	building that were able to do this.	1		
	On 11/16/2022 at 1:36 p.m., an interview was			
	conducted with ASM (administrative staff			
	member) #3, the assistant director of nursing.			1
	ASM #3 stated that if a resident wanted or			
	needed bed rails they assessed the resident for			
	use. ASM #3 stated that they completed a bed			
	rail safety assessment to ensure that they were	1		
	safe for the resident to use them. ASM #3 stated	l		
	that theyassessed whether the resident was able	ļ		
	to release the bed rail. ASM #3 stated that			
	whether the resident could raise and lower the			
	bed rail did not determine if they were able to			
	have them. ASM #3 stated that if there was a request from the physician, therapy, the resident			
	or the family they would evaluate the resident for			
	them. ASM #3 stated that all of the bed rails had			
	been removed and if they had a request for them			
	from staff or therapy they would go back and			
	reassess the resident. ASM #3 stated that they			l l
	had recently made changes to their process for			
	bed rails. ASM #3 stated that when they			! 1
	evaluated a resident for bed rails they would see			1
	if the resident was able to release the bed rail,			
	watch the resident roll in the bed to see if they			
	were able to hold onto the mattress or bed frame			
	and see how close to the edge of the bed they got when rolling from side to side. ASM #3 stated			
	got when rolling from side to side. Asim #5 stated	-		
		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			c
	495339	B. WING	11/17/2022
NAME OF PROVIDER OR SUPPLIER	433555	STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND NU	JRSING	2003 COBB STREET FARMVILLE, VA 23901	

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OMB NO. 0938-0391

SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 558 F 558 Continued From page 21 that a lot of the residents who had their bed rails removed used them for getting in and out of bed and turning in bed. ASM #3 stated that residents that they assessed stating that the bed rail would optimize safety and security were referred back to the director of nursing who assessed the resident also. ASM #3 stated that therapy was going in with them and helping them with adaptive devices to use instead of the bed rails. When asked about R15's bed rails, ASM #3 stated that they had spoken to all residents and explained that they were doing an assessment to determine if the bed rails were needed. ASM #3 stated that R15 never mentioned to them that they used the bed rails and that they used the arm of the recliner now. On 11/16/2022 at 2:36 p.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that for a resident to have bed rails they had to be able to raise and lower them independently. ASM #2 stated that this was part of the CMS (Centers for Medicare and Medicaid Services) regulation. ASM #2 stated that they had removed the bed rails in the facility recently because the residents were unable to raise and lower them independently. ASM #2 stated that in the building the rails were not used much for the residents to turn and reposition but as a safety net to keep them from falling. ASM #2 stated that they were practicing safety for the residents by removing the bed rails. ASM #2 stated that they thought that a grab bar could optimize safety for a resident for turning and repositioning rather than using the half side rails that were previously in place. ASM #2 stated that a grab bar would be the least restrictive and there would be less risk of entrapment. ASM #2 stated that they had some residents who were afraid that they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
8				С
	495339	3. WING		11/17/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS	S, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND N	JRSING	2003 COBB STRE FARMVILLE, V	- ·	

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F 558			F 558			
	Continued From page	e 22 going to fall out of bed				
		chiatrist come in to evaluate				- 1
		When asked about R15,	ľ			- 1
		lot of the residents were a				- 1
	two person assist price	or to the bed rails being				- 1
		vel of functioning had not				1
		ed about the staffing of one				
		g assistant) assigned on the				ļ
		person assist, ASM #2				l
		ation was for the nurse to				
	8	ing and positioning the				!
	residents.	l			Ì	1
	 On 11/16/2022 at 3:0`	7 p.m., an interview was				
		(certified nursing assistant)			1	ļ
		at R15 used the bed rail to			1	- 1
·	pull up when transfer				}	İ
		ed when they had them.				
		15 had voiced that they	İ		ì	
		back because it was harder				i
i		position themselves now.			- 1	
		15 told them that they only			1	
	wanted the right one	back. CNA #8 stated that				- 1
	now they had to assis	t R15 more physically when			l	1
		e to not having the bed rail.				i
		15 had bad knees and it				1
		ow recliner chair arm to get				
	out of bed.					
	The facility policy "Be	d Rail Risk and Safety"			}	
	documented in part, '	'b. When resident choice			ļ	
	regarding bed rails is	not consistent with the				
	facility recommendat	ions, the resident and/or				
	resident representativ	ve will be educated by a				1
		interdisciplinary team on the			1	
		dentified in the resident's			j	
	plan of care, c. The	nt representative will be				
	informed of any varia	ance from facility				
	recommendation3.	Consider restricting rail use				
			(VO) 1411 ES	CONCTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	V - 7 · · · · ·	E CONSTRUCTION		SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		000	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIET/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
				С
	495339	B. WING		11/17/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND N	JRSING		2003 COBB STREET FARMVILLE, VA 23901	

OMB NO. 0938-0391

	TERS FOR MEDICARE & MEDICAID SERVICES			. 0938-0391
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558		F 558		
	Continued From page 23 only to the times			
	necessary (e.g., while assisting staff to			
	reposition self)"	1		
	On 11/17/2022 at approximately 12:00 p.m., ASM #4, the interim administrator and ASM #2, the director of nursing were made aware of the concern.			
	No further information was presented prior to exit.			
F 561	Self-Determination	F 561	1. Residents #47 and #29 were interviewed	
SS=D	CFR(s): 483.10(f)(1)-(3)(8)		by nursing staff and interviewed by social	
	CARR 40/5) Calf data-rain-fion	1	services. The residents shower schedules	
	§483.10(f) Self-determination. The resident has the right to and the facility must		were updated to reflect the preferences	
	promote and facilitate resident self-determination		of the residents. The residents' plans of care and Kardex were reviewed and	
	through support of resident choice, including but		updated to reflect their resident-specific	
	not limited to the rights specified in paragraphs (f)		needs. Holly Manor Heath and Rehab has	
	(1) through (11) of this section.		identified that all residents are at risk	
		1	from this alleged deficient practice.	
	§483.10(f)(1) The resident has a right to choose	1	2. Nursing staff performed interviews with	
	activities, schedules (including sleeping and waking times), health care and providers of health		residents and recorded results in the	
	care services consistent with his or her interests,	1	residents' plan of care. The residents'	
	assessments, and plan of care and other		plans of care were reviewed and updated	Ш
	applicable provisions of this part.		to reflect resident-specific bathing/	
	The state of the s	1	showering needs.	
	§483.10(f)(2) The resident has a right to make		 The Director of Nursing/designee has in- serviced clinical nursing staff, including 	
	choices about aspects of his or her life in the		RNs, LPNs, CNA's regarding resident	
	facility that are significant to the resident.		preferences and allowing resident choice	
	§483.10(f)(3) The resident has a right to interact		in determining shower/bathing schedules.	
	with members of the community and participate in		The in-service includes the importance of	
	community activities both inside and outside the	1	allowing resident self-determination in	
	facility.	1	their plan of care regarding	
		1 1	bathing/shower schedule preference.	l i
	§483.10(f)(8) The resident has a right to		4. The Director of Nursing/designee will	
	participate in other activities, including social,		audit shower schedules daily for 4 weeks,	
	religious, and community activities that do not		then 3 times a week for 4 weeks and weekly for 4 weeks and then monthly for	
		1 1	2 months The Director of	
			Nursing/designee will audit ADL	
			documentation 5x a week for 4 weeks and	
			then monthly for 2 months to ensure that	
			showers are being completed per	
			resident's preference. Any issues	
			identified will be addressed immediately	4
		1	by the Director of Nursing/designee and	
			appropriate action will be taken. The	
			Director of Nursing/designee will identify	
			any trends and/or patterns, and additional education and training will be	
			auditional education and training will be	1

DEDARTM	MENT OF HEALTH AN	D HUMAN SERVICES		F		12/05/2022 APPROVED
				C	MB NO.	0938-0391
CENTERS	S FOR MEDICARE & I	MEDICAID SERVICES		provided to staff on an ongoing ba		
				Findings will be discussed with the		
1 1						1
				committee on at least a quarterly	basis.	
! !				5. Date of Compliance: 12/25/2022		
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1 1		25				
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1					**	
			(VO) MIII TO	LE CONSTRUCTION		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIET/CLIA			(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·		
					· ·	2
1		495339	B. WING		11/	17/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		
HOLLYM	ANOR REHAB AND N	URSING		FARMVILLE, VA 23901		
			ID ID	PROVIDER'S PLAN OF CORRECTION		(XS)
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				DEFICIENCY		

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F 561			F 561			
	Continued From page	e 24				
	• -	ts of other residents in the				
	facility.	is of other residents in the				
-	•	is not met as evidenced				- 1
	by:	13 Hot met as evidenced				1
	Based on observation	n resident interview				1
		rview, staff interview, clinical				1
		document review and in the				
	course of a complain					
		acility staff failed to honor a				
		ke choices about their				
		for two of 33 residents in the				
		lent#47 and Resident#29.				
					ŀ	
	The findings include:					
ľ	· ·					
	1. For Resident #47	(R47), the facility staff failed				
	to provide showers as	s per their preference.				
		IDS (minimum data set), an				
		vith an ARD (assessment			i	
		24/2022, the resident was			1	
		oderately impaired for				
		ns. Section G documented				
		endent on one staff member				
	for bathing.					
	0 44450000 -144	45 a ay a talanhana				
	On 11/15/2022 at 11:					
		cted with R47's responsible			1	
	party. R47's respons	sed to be given twice a		<u> </u>		1
		ost weeks R47 was only				
1	receiving a shower o					
		ted that they felt that this				
		nd that the aides were doing		11		
	the best that they cou	1				
	2.0 000t aloc alo, 000					
	On 11/15/2022 at 12:	07 p.m., an observation was				
	made of R47 in their	room. R47 was observed				1
100	dressed and sitting in	a wheelchair watching				
			/MAL 1 / 1 / 2 / 2 /	S CONSTRUCTION		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		É CONSTRUCTION		SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		COM	PLETED
		495339	B. WING		11/	17/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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HOLLY N	IANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION		(X5)
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02111211	OT OTT MEDIONI & MEDIONID OF TOTOE			_		
F 561		F 561			i	
	Continued From page 25					
	television. An interview was conducted with R47; R47 was able to answer yes and no questions. When asked if they preferred to get showers, R47 stated, "Yes."					
	The comprehensive care plan for R47 dated 5/5/2022 documented in part, "The resident has an ADL (activities of daily living) self-care performance deficit AEB (as evidenced by) requires extensive to total assist with ADLs; is able to feed self with supervision; SAH (subarachnoid hemorrhage) with right sided hemiparesis. Date Initiated: 05/05/2022. Revision on: 11/14/2022."				;	
	Review of the ADL-Bathing documentation for 9/1/2022-9/30/2022 for R47 documented in part, "ADL-Bathing." It documented one shower					
	provided the week of 9/18/2022 - 9/25/2022.					
	Review of the ADL-Bathing documentation for 10/1/2022-10/31/2022 for R47 documented in part, "ADL-Bathing." It documented one shower provided the week of 10/23/2022-10/30/2022.					
	Review of the clinical record failed to evidence R47 refusing showers during the dates listed above.					
	On 11/16/2022 at 9:28 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that showers were provided to residents twice a week. LPN #4 stated that they kept a shower book at the nurses station which					
	had a schedule for residents scheduled for each					
	day on the day and evening shift. LPN #4 stated					
	that staff were offering showers to all residents.					
	LPN #4 stated that resident preferences were					
	passed on to the nursing assistants in report.	<u> </u>	<u> </u>			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	495339 URSING	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	111177622
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F 561			F 56	1		
, 50.				`		
	Continued From page	e 26				ľ
				1		
						1
	On 11/16/2022 at 10:	39 a.m., an interview was				i
	conducted with CNA	(certified nursing assistant)				
		at showers were offered				
		ents. CNA #7 stated that		5		
		e resident if they wanted a				ŀ
		NA #7 stated that depending				ľ
	on the resident, some	etimes they would take a				
	shower and sometim	es they would refuse. CNA				
	#7 stated that they ha	nd a shower book that told				
	· · · · · · · · · · · · · · · · · · ·	luled on what day. CNA #7				
		lent refused the shower,				
		ow. CNA #7 stated that they				
	documented the show	wers in the computer in the				
	ADL's.					
	On 11/16/2022 at 3:0	7 p.m., an interview was				
		#8. CNA #8 stated that				
		d two times a week. CNA #8				
	stated that showers w	vere always offered to				
	residents prior to a be	ed bath being given. CNA#8			1	
	stated that if a resider	nt refused the shower they				
		d documented it. CNA #8				
		r refused their shower				
		hem. CNA#8 stated that				
'		owers on the day shift				
	normally on Tuesday	s and Thursdays and they				
		when they were working				
	because R47 preferre				ं	
	0-44400000-40-5	E n m. en intendeurung				
		5 p.m., an interview was				
	conducted with ASM				ļ	
		of nursing. ASM #2 stated				
		two CNA's on R15's unit on				
	day and evening shif	t. ASM #2 stated that at the				
		ld always be a nurse and a				ļ
	CNA on the unit. ASI					
		se was not as high for that				
		n was for the nurse to help				
	milit 20 mie expectatio	ill was for the fittings to field				
			(X2) MULTI	PLE CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,			SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	Y' BOILDIN	G	"	FLEIED
}						
		405220	p willo		14/	17/2022
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NAMEOF	-KOVIDER OR SUPPLIER			• • • •		
				2003 COBB STREET		161
HOLLY MANOR REHAB AND NURSING				FARMVILLE, VA 23901		197
- WAL 15	CHAMADY STA	TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
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				DEFICIENCY)		

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CENTER	S FOR MEDICARE & MEDICAID OF TAIGED			
F 561		F 561		
	Continued From page 27 the CNA. ASM #2			ļ
	stated that they were out on the unit each day	1		
	speaking with the staff on the floor and]		
Х	assessing the acuity of the residents to			
	determine the daily staffing needs. ASM #2			
	stated that they had received comments from			
	staff about not being able to provide showers			
	due to their workload and they or the assistant	i		
	director of nursing had stepped in and completed			
	the showers.			
	On 11/16/2022 at 4:28 p.m., an interview was			
	conducted with OSM (other staff member) #3,			
	staffing coordinator. OSM #3 stated that they			
	tried to staff R15's unit according to the census.			
	OSM #3 stated that they tried to maintain one			
	nurse and two CNA's on day and evening shift.			
	OSM #3 stated that they communicated with the			
	staff on the unit and learned which days were			
	shower days to staff the unit more.			
	On 11/17/2022 at 9:27 a.m., an interview was			
	conducted with ASM #3, the assistant director of			
	nursing. ASM #3 stated that there was a			
	schedule which documented when residents were			
	scheduled for their showers. ASM #3 stated that]		
	everyone should be offered a shower as long as] [1
	they were deemed safe.			
	The facilities of the Manual Colf Deformination			
	The facility policy, "Resident Self Determination			
	and Participation" documented in part, "1. Each resident is allowed to choose activities,			1
	schedules and health care that are consistent			
	with his or her interests, values, assessments			
	and plans of care, including: a. Daily routine,			
	such as sleeping and waking, eating, exercise			
	and bathing schedules; b. Personal care needs,			
	such as bathing methods, grooming styles and			
	dress;" The facility policy, "Shower/Tub Bath"			
	mental transfer of the second		7.7	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED C
		495339	B. WING		11/17/2022
61	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	`	D BE COMPLETION	

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CEMILL	STORMEDIOARE & MEDIOARE SERVICES				
F 561		F 561			
	Continued From page 28 documented in part,				
	"1. Qualified nursing staff will provide a bed				
-	· · · · · · · · · · · · · · · · · · ·				
	bath to the resident as needed.				
	At a minimum, the resident will be offered at least				l i
	2 full baths or showers per week. 2. To the				
	extent possible, resident preference for type and				
	frequency of baths will be taken into				
	consideration and honored"	1			
	0- 44/46/0000 -t				
	On 11/16/2022 at approximately 6:17 p.m., ASM #4, the interim administrator and ASM #2, the				
	director of nursing were made aware of the				
	•				
	concem.				
	No further information was presented prior to exit.				! !
1	The fall of the fa				1 1
	Complaint deficiency.				
	2. For Resident #29 (R29), the facility staff failed				
	to honor the resident's preference for showers.	1			
					i
	On the most recent MDS (minimum data set)		H.		
	assessment, a quarterly assessment, with an	1			1 1
	assessment reference date of 9/30/2022, the				
	resident scored a 12 out of 15 on the BIMS (brief				
	interview for mental status) score, indicating the		35		
	resident was moderately cognitively impaired for	1			l
	making daily decisions. In Section G - Functional				
	Status, the resident was coded as requiring				
15.	physical help of the bathing activity with one				1 1
	person assisting.				ł
	An interview was conducted with R29 on				
	11/17/2022 at 8:16 a.m. When asked if they				
	prefer a bath, shower or bed bath, R29 stated				
	they like a shower on their shower days.				
	nicy into a situmor off their situmor days.				
	An interview was conducted with CNA (certified				
	nursing assistant) #7 on 11/17/2022 at 8:20 a.m.	1			
	When asked how she knows what type of	1	_		
	bath/shower, R29 wants, CNA #7 stated, [R29]	<u> </u>			<u> </u>
		L (Y2) MILLITED	E CONSTRUCTION		
1	· · · · · · · · · · · · · · · · · · ·	I (AZ) WOLITE	C 00:1011100 11011	LOON DAT	T CHOVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA		A ` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
							С
١			495339	B. WING		11/	/17/2022
ŀ	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	HOLLY MANOR REHAB AND NURSING				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	*	ILD BE	(X5) COMPLETION DATE

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

CENTER	S FOR MEDICARE & MEDICAID SERVICES		 	
F 561		F 561		
	Continued From page 29 will tell you what they			
	want. The resident knows their shower days			
	and will say, shower day - shower.			
	and will say, shower ady shower.			
	The September 2022 ADL (activity of daily living)			
	document for baths documented the resident only			
	received two showers and one whirlpool, the rest			
	of the baths were documented as bed baths. The			9
	October 2022 ADL document documented the			=
	resident should have received eight showers. The			
	documentation only documented four showers			
	and four bed baths. The November 2022 ADL document documented the resident should have			;
	had five showers, it was documented the resident			
	had one shower, two bed baths and two blanks			1
	where the resident should have received a			
	shower.			
	anowor.			
	An interview was conducted with ASM			
	(administrative staff member) #3, the assistant			
	director of nursing, on 11/17/2022 at 9:25 a.m.		1	
	When asked how a staff member knows what			
	type of bath the resident wants, a shower,			
	whirlpool, or bed bath, ASM #3 stated the staff	j		
	should be asking the resident. Everyone should	ĺ		
	be asked if they want a shower.			
	The facility policy, "Shower/Tub Bath"			
	documented in part, "POLICY: The purposes of	7		10
	this procedure are to promote cleanliness,			
	provide comfort to the resident and to observe			
	the condition of the resident's skin. SPECIFIC			
	PROCEDURES / GUIDANCE: General			
	Guidelines - 1.Qualified nursing staff will provide	- 1		
	a bed bath to the resident as needed. At a			
	minimum, the resident will be offered at least 2			
	full baths or showers per week. 2.To the extent			
	possible, resident preference for type and frequency of baths will be taken into			
	nequency of Datis will be taken into		 	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA		41 · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					(С
		495339	B. WING		11/	17/2022
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY M	IANOR REHAB AND N	URSING		2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		D BE	(X5) COMPLETION DATE		

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F 561		F 561	
501		1 301	
	Continued From page 30		
	consideration and honored."		
<u> </u>			
	ASM #1, the interim administrator, and ASM #2,		
	the director of nursing were made aware of the		
	above concern on 11/17/2022 at 12:06 p.m.		"
	No further information was provided prior to exit.	5 505	407510000
F 585	Grievances	F 585	1. It is the policy of Holly Manor to 12/25/2022
55=E	CFR(s): 483.10(j)(1)-(4)		ensure that grievance logs are
	\$492.40(i) Grioveness		maintained according to CFR(s):
	§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice		483.10(j)(1)-(4). All residents have
	grievances to the facility or other agency or entity		**** * * * * * * * * * * * * * * * * * *
	that hears grievances without discrimination or		the potential to be affected by
	reprisal and without fear of discrimination or		this alleged deficient practice
	reprisal. Such grievances include those with		2. A grievance log has been
	respect to care and treatment which has been		maintained and a staff member
	furnished as well as that which has not been		has been designated as the
	furnished, the behavior of staff and of other	11	grievance officer since
22	residents, and other concerns regarding their LTC		· ·
	facility stay.		11/16/2022.
			3. The Administrator/designee has
	§483.10(j)(2) The resident has the right to and the		educated the grievance officer on
	facility must make prompt efforts by the facility to		duties and compliance with
l i	resolve grievances the resident may have, in		maintaining the grievance log
	accordance with this paragraph.		
	C402 40(1)(2) The facility must make information	ľ	according to CFR(s): 483.10(j)(1)-
	§483.10(j)(3) The facility must make information		(4).
	on how to file a grievance or complaint available to the resident.		4. The Administrator/Designee will
}	to the legident.		review the grievance log 5x per
	§483.10(j)(4) The facility must establish a		week for 4 weeks and then
	grievance policy to ensure the prompt resolution		
1	of all grievances regarding the residents' rights		monthly for 2 months to ensure
Į I	contained in this paragraph. Upon request, the		that the log is maintained as
	provider must give a copy of the grievance policy		mandated.
	to the resident. The grievance policy must		Administrator/Designee will
	include:		correct any variances identified
			· ·
	5		until substantial compliance is
			achieved. Results of audits will be
			shared with the QAPI committee.
			Any patterns or trends will be
			reported to the Quality Assurance
			and Performance Improvement
			Committee at least quarterly.
			5. Date of Compliance: 12/25/22
			41

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OTTENDED DESIGNATION			(X2) MUL	TPLE CONSTRUCTION	(VA) DATE	(X3) DATÉ SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILO	NG	COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.					
						┌	
		495339	B. WING		11/	17/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				2003 COBB STREET			
HOLLY MANOR REHAB AND NURSING				FARMVILLE, VA 23901			
				T SPOUIDEGIO DI ANI DE CORRECT	1011	Q(5)	
(X4) ID		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU		COMPLETION	
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE	
		,		DEFICIENCY)			
			F.S	OF .			
F 585			Г,	000			
	Continued From pag	e 31				į	
	(i) Notifying resident	individually or through					
		nt locations throughout the					
	facility of the right to						
		in writing; the right to file				l i	
		ously; the contact information					
		cial with whom a grievance					
		nis or her name, business					
		f email) and business phone		Ļ		1	
		le expected time frame for				l I	
		w of the grievance; the right				! i	
		cision regarding his or her				!	
	grievance; and the co						
		with whom grievances may					
		ertinent State agency,					
		t Organization, State Survey					
		ng-Term Care Ombudsman					
	program or protection	n and advocacy system; (ii)				k	
	Identifying a Grievan	ce Official who is					
	responsible for overs	seeing the grievance					
,		nd tracking grievances					
	through to their conc						
	necessary investigat						
		identiality of all information					
		vances, for example, the				<u>{</u>	
		nt for those grievances					
1	submitted anonymou						
	grievance decisions	•					
		te and federal agencies as					
]	
	necessary in light of	specific allegations; (iii) As					
	necessary, taking im	mediate action to prevent					
		ations of any resident right					
	while the alleged vio	lation is being investigated;					
	(iv) Consistent with §	483.12(c)(1), immediately					
reporting all alleged violations involving neglect, abuse, including injuries of unknown source,							
	and/or misappropria	tion of resident property, by	ŀ				
	anyone furnishing se	ervices on behalf of the					
	provider, to the admi	nistrator of the provider; and					
						<u> </u>	
CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIEF/CLIA	(X2) MUI	TIPLE CONSTRUCTION		E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	CO	MPLETED	

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		40000				5 .7
NAME OF F	PROVIDER OR SUPPLIER	495339	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	111	17/2022
MANIC OF I	NOVIDER OR GOTTELER			2003 COBB STREET		
HOLLYM	ANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D 8E	(X5) COMPLETION DATE
F 585			F 58	35		
	Continued From pag	e 32				
	as required by State I					
		ritten grievance decisions				
		grievance was received, a				
<u> </u>		of the resident's grievance,				
		estigate the grievance, a				
		nent findings or conclusions				
		t's concerns(s), a statement				
		evance was confirmed or not				ľ
:		ctive action taken or to be				
	•	s a result of the grievance, en decision was issued; (vi)				
	Taking appropriate of					
		e law if the alleged violation				
		s is confirmed by the facility				1
	or if an outside entity	having jurisdiction, such as				
		ncy, Quality Improvement				
	_	l law enforcement agency				
		or any of these residents'				
		of responsibility; and (vii)				
	_	demonstrating the result of eriod of no less than 3 years				
		the grievance decision.				
		is not met as evidenced				
	by:			=		
	•	iew and facility document				
	review, it was determ	ined the facility staff failed to				
	_	ogs from 7/20/2022 through				
		y affecting most of the 33				
	residents in the surve	y sample.				i
	The findings include:					
	11	5				
		facility on 11/14/2022 at .m. a request was made for				
	the grievance logs.	second request was made				
	on 11/15/2022 at ann	proximately 9:00 a.m. On				
		y team received a document				
		The document dated				
			(Y2) MI II TI	PLE CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IG		SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILUIN			1
						C
		495339	B. WING		11/	17/2022

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OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		
HOLLY M	ANOR REHAB AND NU	RSING		FARMVILLE, VA 23901		
(VA) ID	CI IBAMASIV ČTAT	EMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREF!X		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI		COMPLETION DATE
TAG		C IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JE ST	
+				DEFICIENCY		
F 585			F 58	85		
	Cantinual Camera	22 concerns from				
	Continued From page	I				
	1/13/2022 through 7/2	20/2022.				}
	On 11/15/2022 at 1:06	6 p.m., an interview was				
		surveyor with OSM (other				
	staff member\#4 lon	ig term care ombudsman.				
	OSM #4 stated that th	ey had received multiple			i	
	calls from residents a					
		s being removed from				
	residents beds. OSM	#4 stated that they had				
		nance had removed all of				
	the bed rails about tw	o or three weeks ago. OSM				
	#4 stated that they we	ere told that there were new				
1	regulations and the fa	cility had to be restraint free				
	so they had removed	all of the bed rails and go				ļ
		ee if the residents needed				
	the bed rails. OSM #4	4 stated that they had met				
		the administrative staff				
		it had no resolution at the			1	
	current time.				1	
i	An interview was con	ducted with ASM				
		nember) #2, the director of			l	
	nursing on 11/15/202	22 at 3:47 p.m. When asked				
	where the grievance	logs since July 2022 were,				
		naven't kept track of them."				
	When asked why, AS	M #2 did not respond.			ŀ	
	When asked who is re	esponsible for the tracking				
	of grievances, ASM #	2 stated, "Social services."				
					- 1	
'	An interview was con	ducted with OSM (other staff				
	member) #1, the dire	ctor of admissions, on				
	11/16/2022 at approx	timately 12:15 p.m. When			1	
	asked the process for	r a resident and/or family				
	member to tile a grie	vance, OSM #1 stated, the we have any complaints or				
	process nad been if V	nem to the administrator in				
	the morning meeting	, he would address it with				
	whichever departmen	nt is involved. He would do				
	the follow up on that.	When asked if a log of				
			Was the	TOUR CONSTRUCTION I		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				SURVEY PLETED
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		
						2
		495339	R WING		11/	17/2022

2003 COBB STREET FARMVILLE, VA 23901

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR REHAB AND NURSING

NAME OF PROVIDER OR SUPPLIER

PRINTED: 12/05/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 585		F 585		
	Continued From page 34 grievances is kept,			1
	OSM #1 stated she did not know. When asked			
	when the previous administrator left, OSM #1			
	stated she believed it was about a month ago.			
	An interview was conducted with ASM #4, the]		
	interim administrator, on 11/16/2022 at 1:00 p.m.	1		1
	When asked the process for grievances, ASM #4,			
	stated the process was the administrator was			1
	previously handling them. We are moving to			-
	having the social worker take over the log and			
	grievance book. It was verified with ASM #4 the	1 1		
	facility had no documentation of a log since the			
	end of July. When asked how long the	1 1		1
	administrator had been gone, ASM #4 stated,			1
	within the last 30 days.			
	The facility policy, "Resident Grievance			
	Procedure" documented in part, "It is the policy of	1		
- 1	[name of corporation] to recognize that all	1		
	residents have the right to voice grievances to the			
	facility or other agency or entity that hears			
	grievances without discrimination or			
	reprisalProcedure: 2. The facility will designate			
	a staff member as the Grievance Official who is	!!!		- 1
	responsible for: a. Overseeing the grievance			
	process. b. Receiving and tracking grievances			
	through to their conclusion. C. Leading any			1
	necessary investigation by the facility. d.			
	Maintaining the confidentiality of all information	1		
	associated with grievances, for example the identity of the resident for those grievances			
	submitted anonymously. e. Issuing written			
	grievances decisions to the resident and or			
	resident representative upon request e. The			
	facility will maintain a Grievance record for 3			
	years of written grievance decisions to include: 1.			
	the date the grievance was received. 2. A			
	summary statement of the resident/resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			C
	495339	B. WING	11/17/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP	CODE
HOLLY MANOR REHAB AND N	JRSING	2003 COBB STREET FARMVILLE, VA 23901	

CENTER	S FOR MEDICARE & MEDICAID SERVICES		OMB NO	. 0938-0391
(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
	Continued From page 35 representative's grievance. 3. Steps taken to investigate the grievance. 4. A summary of the pertinent findings or conclusion regarding the expressed concern. 5. A statement as the whether the grievance was confirmed of not confirmed. 6. Any corrective action taken or to be taken by the facility as a result of the grievance. 7. The date of the written decision." ASM #1, the interim administrator, and ASM #2, were made aware of the above concern on 11/16/2022 at 6:15 p.m. No further information was provided prior to exit. Free from Misappropriation/Exploitation CFR(s): 483.12 \$483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review it was determined that the facility failed to ensure one of 33 residents were free of misappropriation of property, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to ensure they were free of misappropriation of prescribed controlled medication.	F 585	 Residents #10 was assessed and interviewed by nursing staff and interviewed by social services. The resident suffered no physical harm from the misappropriation of medications. Holly Manor has identified that all residents are at risk from this alleged deficient practice. At the time of the reported misappropriation of resident medications, the medications were replaced by the facility and the incident was sent to the appropriate governing bodies. The agency employee was investigated and their contract with Holly Manor was terminated. The Director of Nursing/designee has educated clinical staff, including RNs and LPNs regarding narcotic documentation and destruction. The education included proper narcotics delivery receipt, proper narcotics destruction, and appropriate reporting of suspected medication misappropriation. The Director of Nursing/designee will review narcotics delivery logs 5x a week for 4 weeks and then monthly for 2 months and compare the delivery logs to the narcotics stored in the facility to ensure that no medication misappropriation has occurred. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The 	
			Director of Nursing/designee will identify any trends and/or patterns, and provide	

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES): 12/05/2022 APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	. 0938-0391
CENTER	S FOR MEDICARE & I	VIEDICAID SERVICES		Fin cor	ucation as needed on an ongoindings will be discussed with the mmittee on at least a quarterly te of Compliance: 12/25/22	ng basis. ne QAPI	. 0938-0391
						1	*
			7V2) MIN	TIPLE CONSTRUCT	TON		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING			PLETED
		495339				11/	17/2022
NAME OF F	PROVIDER OR SUPPLIER	493339	B, WING		SS, CITY, STATE, ZIP CODE		
	IANOR REHAB AND N	JRSING		2003 COBB STR FARMVILLE, V	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE

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OMB NO. 0938-0391

CENTER	S FOR MEDICARE & MEDICAID SERVICES			. 0000 0001
F 602		F 602		
i	Continued From page 36			
	On the most recent MDS (minimum data set), a			
	quarterly assessment with an ARD (assessment			
	reference date) of 9/2/2022, the resident scored			i
	12 out of 15 on the BIMS (brief interview for			
ļ	mental status) assessment, indicating the			
	resident was moderately impaired for making			
	daily decisions. Section J documented R10			
	receiving scheduled pain medication and having			i
'	pain almost constantly. Section N documented	•		'
	R10 receiving opioid medications during the			
}	assessment period.			
	On 11/16/2022 at 9:19 a.m., an observation was			
	made of R10 in their room. R10 was observed in			
	bed watching television. An interview was			
	conducted with R10. R10 stated that they often			
	had pain and the nurses administered pain			
	medication to them. R10 stated that the nurses			
	took very good care of them and that their pain			
	was well controlled. R10 stated that they did not		.5	
	recall any times when the nurses did not respond			
	to their pain and attempt to make them			
	comfortable.			
				-
	Review of the FRI's (facility reported incidents)			
	documented a FRI dated 8/29/2022 involving			1
	R10. The FRI documented in part, "Incident			
	Type: Possible Resident property			
	misappropriated. Describe incident, including			
	location, and action: On 8/29/2022, the			
	pharmacist informed the Director of Nursing via			
	phone that resident [name of R10] was missing			
	one card of 30 tablets of hydrocodone-APAP 5-			
	325 mg (milligram)." (1)			
	Review of the FRI incident investigation dated			
	9/2/2022 documented in part, "Conclusion:			
	After thorough investigation of this incident the		<u> </u>	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		407220	B. WING		C 11/17/2022	
	PROVIDER OR SUPPLIER	495339	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ANOR REHAB AND N	JRSING		2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	"" I 'T' 'T' 'T' 'T' 'T' 'T' 'T' 'T' 'T' '	D BE COMPLETE	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 F 602 F 602 Continued From page 37 facility can confirm that misappropriation of the resident property, 30 doses of Hydrocodone-APAP 5-325 mg. The facility cannot definitively confirm if the medication card and the narcotic count sheet was removed by [Name of LPN (licensed practical nurse) #3]. The facility had informed the [Name of staffing agency] that [Name of LPN #3] cannot return to the facility." The completed FRI documented staff statements and in-service training report dated 8/30/2022 for "Narcotic documentation and destruction" signed by 14 staff members. The inservice training contained the facility policy "5.2" Receipt of Interim/Stat/Emergency Deliveries." The comprehensive care plan for R10 documented in part, "The resident has chronic pain r/t (related to) neuropathy. Date Initiated: 09/20/2022, Revision on: 09/20/2022." The physician orders for R10 documented in part, "Hydrocodone-APAP 5-325 MG, Give 1 tablet orally two times a day related to PAIN, UNSPECIFIED. Order Date: 06/13/2022, Start Date: 06/13/2022." The eMAR (electronic medication administration record) for R10 dated 8/1/2022-8/31/2022 documented in part, "Hydrocodone-APAP 5-325 MG. Give 1 tablet orally two times a day related to PAIN, UNSPECIFIED.* The eMAR documented R10 receiving the medication every morning and every evening except on 8/25/2022 and 8/29/2022 morning doses. On 8/25/2022 and 8/29/2022 morning doses it documented a "9" in the administration box. The eMAR documented, "Chart Codes: ...9=Other/See Progress notes..." The eMAR further documented a pain evaluation completed every shift. The pain assessment on

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEN/CLIAND PLAN OF CORRECTION IDENTIFICATION NUMBER:		41.	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495339	B. WING		1	C 17/2022
	PROVIDER OR SUPPLIER	JRSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE	(X5) COMPLETION DATE

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OMB NO. 0938-0391

02,112,11	31 OKIMEDIOARE & INEBIOARE GERMANE	= 000			
F 602		F 602		ľ	
	Continued From page 38				
	8/25/2022 and 8/29/2022 documented a pain				
	level of zero.				
	The progress notes for R10 documented in part,				
	"8/25/2022 09:41 (9:41 a.m.) Note Text:				
	Hydrocodone-APAP 5-325 MG T, Give 1 tablet				
	orally two times a day related to PAIN,		1		
	UNSPECIFIED Med (medication) not on hand."				
	The progress notes further documented,				
	"8/29/2022 13:55 (1:55 p.m.) Note Text:				
;	Hydrocodone-APAP 5-325 MG T Give 1 tablet				
	orally two times a day related to PAIN,				
	UNSPECIFIED Not available." The progress				
	note dated 8/30/2022 at 3:32 p.m. documented,				
	"Note Text: Follow up note: On 09/29/2022 this				
	nurse noted that there were no				
	Hydrocodone/Acetaminophen medication located				
	in the narcotic drawer. This nurse called				
	pharmacy to inform them that the medication				
	needed to be restocked so ensure the patient				
	could take her medication in a timely manner. The pharmacy was unable to send the	1			
	medication. This nurse noted this in the		1		
	medication progress notes. Patient was made		,		
	aware of this. Thus nurse will follow up with any				
	further information when it is received."				
	Tarble Information whometorocorros.				ļ
	On 11/16/2022 at 8:03 a.m., ASM (administrative				
	staff member) #2, the director of nursing, stated	i			
	that LPN (licensed practical nurse) #3 and the	1			1
	other agency LPN who also worked on the unit	1			
	8/24/2022, no longer worked at the facility.	1			
	On 11/16/2022 at 1:36 p.m., ASM #3, the				
	assistant director of nursing, stated that the RN				
	(registered nurse) who documented the progress				
ļ	note on 8/29/2022 no longer worked at the facility.				1
	3	1			
	On 11/16/2022 at 9:28 a.m., an interview was	<u> </u>	L	<u> </u>	<u> </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		1/9			1 1	С
		495339	B. WING		11/	17/2022
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY M	ANOR REHAB AND N	JRSING		2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		.D BE	(X5) COMPLETION DATE

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CENTERS	S FOR MEDICARE & N	MEDICAID SERVICES			OMB NO	. 0938-0391
F 602			F 602	2	- 1	
	#4. LPN #4 stated th at shift change by the ongoing nurse. LPN nurses went through matched them with that everything match anything did not matcleave the building un LPN #4 stated that wadministering any co	ntrolled medication they umber of pills that were left				
	conducted with ASM ASM #2 stated that the pharmacy stating made to refill R10's he too early. ASM #2 stated two cards of narcotic count sheets resident totaling 60 to after speaking with them that R10 should facility so they had set the missing hydrocoof the hydrocodone had missing on the day she had discovered that to counted the narcotics the day prior. ASM # shift nurse went to acmedication to R10 the called the pharmacy soon to refill the med they had interviewed the night shift prior.	5 p.m., an interview was #2, director of nursing. ley had received a call from that a request had been lydrocodone and that it was leted that the pharmacy had of hydrocodone and two leted the same time for the labels. ASM #2 stated that lete pharmacy they advised I have 30 more tablets at the laterted an investigation into lidone. ASM #2 stated that I been discovered to be lift. ASM #2 stated that they he day shift nurse who had leted that when the day liminister the scheduled lere was none there so they who advised that it was too lication. ASM #2 stated that the two nurses who worked ASM #2 stated that LPN #3 for questions and became				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION 3	COM	SURVEY PLETED
		495339	B. WING		11/	17/2022
		JRSING .	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTIO	DN .	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** F 602 F 602 Continued From page 40 more vague during the interview. ASM #2 stated that they had narrowed it down to the medication missing on the night shift. ASM #2 stated that they made LPN #3 a do not return with the agency and the other nurse who had worked with them just stopped coming to the facility. ASM #2 stated that the facility did not do any drug testing. ASM #2 stated that they had initiated education to the staff and implemented a new system for counting the drugs and the cards as well as a new way to receive narcotics from the pharmacy and add the sheets to the book. ASM #2 stated that they could not definitively determine that LPN #3 removed the hydrocodone and the count sheet because both LPN #3 and the nurse that worked with them that night on the other medication cart were vague on whether or not they gave the keys to the other during their break. ASM #2 stated that they had reported the FRI to the department of health professions along with the FRI investigation. On 11/17/2022 at 9:27 a.m., an interview was conducted with ASM #3, the assistant director of nursing. ASM #3 reviewed the in-service training report included in the FRI investigation for R10 dated 8/29/2022 and stated that they had conducted education for all licensed staff on 8/30/2022 on narcotic documentation and destruction. ASM #3 stated that the director of nursing did the investigation of the incident and they did the education attached to the FRI. ASM #3 stated that they reviewed the attached policies on receipt and disposal of controlled substances with the staff and reviewed the new process for counting narcotics with staff. ASM #3 stated that they educated staff that if there were more than two narcotic sheets and cards they were to label them 1 of 2 and 2 of 2. ASM #3 stated that the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLI	
					С	
		495339	B. WING		11/17/	//2022
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR REHAB AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 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		BE	(X5) COMPLETION DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 F 602 F 602 Continued From page 41 nurses were not allowed to leave until the count was equal and any wastes of narcotics they or the director of nursing were a part of. ASM #3 stated that they wasted all narcotics together in the medication rooms. ASM #3 stated that they had looked at every narcotic sheet in all of the narcotic books and assessed other residents but they did not have any documentation of the other residents being reviewed. On 11/17/2022 at 10:01 a.m., an interview was conducted with OSM (other staff member) #5, the human resource manager. OSM #5 stated that contracted agency staff members were trained and screened prior to working in the facility. OSM #5 stated that they had been working at the facility since May of this year and had been working to catch up files for contracted agency staff members who worked at the facility. OSM #5 stated that prior to an agency staff member coming to the facility for their first shift they received information from the agency including their background check. OSM #5 stated that contracted agency staff members received an orientation packet which contained policies at the facility and abuse, neglect and misappropriation training. OSM #5 stated that they did not have a file for LPN (licensed practical nurse) #3 and had contacted the agency on 11/16/2022 to get the requested employee documents. OSM #5 stated that they did not have any evidence of training received on abuse, neglect and misappropriation. OSM #5 provided a hire date of 8/21/2022 for LPN #3 and facility schedules documenting LPN #3 working 8/21/2022 and 8/28/2022. The facility policy "Abuse" revised 10/20/2022 documented in part, "...At a minimum, education on abuse, neglect, and exploitation will be (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIET/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 11/17/2022 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET HOLLY MANOR REHAB AND NURSING FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG **DEFICIENCY**)

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OMB NO. 0938-0391

F 602	Continued From page 42	F 602			
	provided to facility staff upon hire and annually.				
	In addition to the freedom from abuse, neglect,	i			
	mistreatment of residents, misappropriation of			1	
	property and exploitation requirements in 483.12,				
	the organization will also provide training to their				
	staff on: Activities that constitute abuse, neglect,				
	exploitation, and misappropriation of resident				
	property as set forth at 483.12Criminal record				
	checks will be obtained in accordance with state	i			
	law and/or facility policyOther residents who	:			
	may have potentially been affected or at risk will				
	be identified and a plan of care will be developed				
	or revised as appropriate to ensure their				
	safetyThe facility Quality		72		
	Assurance/Performance Improvement Committee				
	will review and provide recommendation for				
	unusual occurrencesVirginia Specific				
	Requirements:Criminal record checks will be				
	obtained on all new employees within 30 days of				
	date of hire. If contract staff is used (i.e.				
	housekeeping, dietary, rehab, etc.) the vendor				
	providing the contracted service will be asked to				
	obtain criminal record checks for all staff				
	assigned to the nursing facility and to make the				
	criminal record check information available to the				
	nursing facility in a timely manner upon				
	request"				
	On 11/17/2022 at approximately 12:05 p.m., ASM			ļ	
	#4, the interim administrator and ASM #2, the				
	director of nursing were made aware of the			ļ	
	findings.				
	mungs.				
	No further information was provided prior to exit.		all.	:	
	110 (210)01 (Hottindaoit mas provides provides and				
	(1) hydrocodone				
	Hydrocodone is used to relieve severe pain.		₹		
	Hydrocodone is only used to treat people who are		¥.		
	expected to need medication to relieve severe			1	
	pain around-the-clock for a long time and who				
	<u> </u>		··· ————		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/	A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
					1	C 17/2022
		495339	B. WING		1 11/	17/2022
	ROVIDER OR SUPPLIER ANOR REHAB AND NU	URSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		BE	(X5) COMPLETION DATE

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 602	_	F 602			
F 607 SS=D	CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and	F 607		Licensed practical nurse #3's contract was terminated and therefore a background check was not completed. Holly Manor has identified that all residents are at risk from this alleged deficient practice. The Administrator/Designee has verified that criminal background checks were performed on all employees of Holly Manor. Results of all criminal background checks were found to meet the regulations required for employment. Copies of criminal background checks are kept on file and available in the facility. The Administrator/Designee will verify that all potential employees pass a criminal background check prior to beginning employment at Holly Manor. Copies of preemployment criminal background checks will be kept on file and available in the facility. The Administrator/Designee will conduct an audit of 10 of files of potential employees to ensure that criminal background checks are performed, and the results meet the requirement for employment, prior to any potential beginning a position at Holly Manor 5x a week for 4 weeks and then monthly for 2 months. The Administrator/Designee will prohibit any employees not passing a criminal background check from being employed by Holly Manor Rehab and Nursing. The	12/25/2022
				background check from being employed by Holly Manor Rehab and Nursing. The Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement	
1			5.	Committee quarterly. Date of Compliance: 12/25/22	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
			С
495339	B. WING		11/17/2022
		STREET ADDRESS, CITY, STATE, ZIP CODE	- "
		2003 COBB STREET	
JRSING		FARMVILLE, VA 23901	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495339	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495339 8. WING	A. BUILDING 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETION DATE
F 607			F 607			
	Continued From page	. 44	,			
	· -	5 117				
	by:					ŀ
		iew, facility document				
	review, and clinical re					
		acility failed to implement the	1			
		or screening staff for one of			i	
	four agency staff revi	ewed, LPN (licensed				1
	practical nurse) #3.				l	
	The findings include:					
- 0			:			
		d to implement their abuse			l l	
		ning for LPN #3. During the				i
		ty reported incident) review				
	for Resident #10 (R10					
		esident property, it was			j	
	determined that LPN				1	i
	_	mpleted prior to working at				
	the facility.				1	
	On the most recent M	IDS (minimum data set), a				
	cuadady accessmen	t with an ARD (assessment				
		2/2022, the resident scored				95
		IMS (brief interview for				
	mental status) assess					
		tely impaired for making				
		ion J documented R10				
		pain medication and having				
		ly. Section N documented				
		medications during the				
	assessment period.	•				
	Review of the FRI's (f	acility reported incidents)			- 1	
	documented a FRI da	ated 8/29/2022 for R10. The				
	FRI documented in p	art, "Incident Type:				
	Possible Resident pro	operty misappropriated.				
		cluding location, and action:				
		armacist informed the				
		a phone that resident [name				
	of R10] was missing	one card of 30 tablets of				
			(X2) MULTIPLE	CONSTRUCTION		01101/51/
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. DOILDING			

B. WING

2003 COBB STREET FARMVILLE, VA 23901

STREET ADDRESS, CITY, STATE, ZIP CODE

11/17/2022

495339

NAME OF PROVIDER OR SUPPLIER

HOLLY MANOR REHAB AND NURSING

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607			F 607			
	Continued From pag	e 45				
	hydrocodone-APAP	5-325 mg (milligram)." (1)				
	9/2/2022 documente After thorough invest facility can confirm the resident property, 30 Hydrocodone-APAP cannot definitively co- and the narcotic cour [Name of LPN (license facility had informed	cident investigation dated d in part, "Conclusion: igation of this incident the nat misappropriation of the doses of 5-325 mg. The facility enfirm if the medication card not sheet was removed by sed practical nurse) #3]. The the [Name of staffing of LPN #3] cannot return to				
	staff member) #2, the that LPN (licensed pr other agency LPN wi	3 a.m., ASM (administrative e director of nursing, stated ractical nurse) #3 and the no also worked on the unit worked at the facility.			;	
	On 11/16/2022 at apprequest was made to administrator, LPN #					
	#4 provided copies of including a background	proximately 4:00 p.m., ASM f documents for LPN #3 and search dated 11/16/2022 on report dated 8/8/2022.				
	conducted with ASM #2 stated that they hat pharmacy stating that to refill R10's hydrocolearly. ASM #2 stated delivered two cards conarcotic count sheets	5 p.m., an interview was #2, director of nursing. ASM and received a call from the ta request had been made adone and that it was too I that the pharmacy had of hydrocodone and two at the same time for the ablets. ASM #2 stated that	8		in desired	
			(X2) MUII TIBU	E CONSTRUCTION	1	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	V-27 1110 E 117 E	C	(X3) DATE	SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495339	B. WING	s	C 11/17/2022
NAME OF PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND N	URSING		2003 COBB STREET FARMVILLE, VA 23901	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

(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 607		
F 607		F 607		
	Continued From page 46 after speaking with the			
	pharmacy they advised them that R10 should	1		
	have 30 more tablets at the facility so they had	1		
	started an investigation into the missing			
	hydrocodone. ASM #2 stated that the			1
	hydrocodone had been discovered to be missing			1
1	on the day shift. ASM #2 stated that they had			
	discovered that the day shift nurse who had			
	counted the narcotics that day had not worked			
	the day prior. ASM #2 stated that when the day			
	shift nurse went to administer the scheduled			
	medication to R10 there was none there so they			
	called the pharmacy who advised that it was too			
	soon to refill the medication. ASM #2 stated that			
	they had interviewed the two nurses who worked			
	the night shift prior. ASM #2 stated that LPN #3			
	had left a lot of room for questions and became			•
	more vague during the interview. ASM #2 stated			
	that they had narrowed it down to the medication			
 ,	missing on the night shift. ASM #2 stated that	1		
	they made LPN #3 a do not return with the			
	agency and the other nurse who had worked with	1		
	them just stopped coming to the facility. ASM #2	1		
	stated that the facility did not do any drug testing.			
	ASM #2 stated that they had initiated education			
	to the staff and implemented a new system for			
	counting the drugs and the cards as well as a			1
	new way to receive narcotics from the pharmacy			
	and add the sheets to the book. ASM #2 stated			
	that they could not definitively determine that			
	LPN #3 removed the hydrocodone and the count			
	sheet because both LPN #3 and the nurse that			
	worked with them that night on the other			
	medication cart were vague on whether or not			
	they gave the keys to the other during their			
	break. ASM #2 stated that they had reported the			
	FRI to the department of health professions			
	along with the FRI investigation.			
	On 11/17/2022 at 10:01 a.m., an interview was	<u> </u>	<u> </u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	495339	B. WING		11/17/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND N	JRSING		2003 COBB STREET FARMVILLE, VA 23901	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 607			F 607		
F 607	(other staff member) manager. OSM #5 staff members were to working in the facility had been working at year and had been working at year and had been working at year and had been working at year and had been working at year and had been working at year and the facility. OSM #5 agency staff members their first shift they reagency including the #5 stated that they did (licensed practical nuthe agency on 11/16, employee document did not have any evice check completed price provided a hire date of facility schedules do 8/21/2022 and 8/28/2001 and stated that they for documented as their part, "3.7 Background working in the facility schedules do 8/21/2022 and 8/28/2001 and stated that they for documented as their part, "3.7 Background working in the facility schedules do 8/21/2022 and 8/28/2001 and stated that they for documented as their part, "3.7 Background working in the facility schedules do 8/21/2022 at app. #5 provided page 6 countries and stated that they for any facility schedules do 8/21/2022 at app. #5 provided page 6 countries and stated that they for any facility schedules do 8/21/2022 at app. #5 provided page 6 countries and stated that they for any facility schedules and stated that they for any facility schedules and stated that they for any facility schedules and stated that they for any facility schedules and stated that they for any facility schedules and s	r coming to the facility for ceived information from the ir background check. OSM d not have a file for LPN urse) #3 and had contacted /2022 to get the requested to S. OSM #5 stated that they dence of a background or to 11/16/2022. OSM #5 of 8/21/2022 for LPN #3 and cumenting LPN #3 working	F 607		
	background and crim	ninal history check as		N =	
	on a post-offer, pre-e	cable laws. This will occur employment basis, as state			
		nn yearly evaluations. s may result in rescinding an			
	employment offer or employment"				
	documented in part,	ouse" revised 10/20/2022 "Criminal record checks			
			Lores Main To	E OQUETUUTON	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CU	A (X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
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	495339	B. WING		11/17/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HOLLY MANOR REHAB AND NURSING			2003 COBB STREET FARMVILLE, VA 23901	
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OMB NO. 0938-0391

(X4) ID PREFIX TAG	S FOR MEDICARE & MEDICAID SERVICES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 607	Continued From page 48 and/or facility policyVirginia Specific Requirements:Criminal record checks will be obtained on all new employees within 30 days of date of hire. If contract staff is used (i.e. housekeeping, dietary, rehab, etc.) the vendor providing the contracted service will be asked to obtain criminal record checks for all staff assigned to the nursing facility and to make the criminal record check information available to the nursing facility in a timely manner upon request" On 11/17/2022 at approximately 12:05 p.m., ASM #4, the interim administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. (1) hydrocodone Hydrocodone is used to relieve severe pain. Hydrocodone is only used to treat people who are expected to need medication to relieve severe pain around-the-clock for a long time and who cannot be treated with other medications or treatments. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a614045.h	F 607		5
	tml Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656	 Residents #51, #53, #54 and #63 were assessed by nursing staff and their medical records were reviewed. The residents' care plans have been updated to reflect current individualized plans of care. Holly Manor has identified that all residents are at risk from this alleged deficient practice. The Director of Nursing/designee has performed an audit of all current residents' care plans. Care plans have been updated to ensure individualized needs are addressed appropriately related to oxygen use, anticoagulant use, insulin use and anti-psychotropic medications. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified. 	12/25/2022

PRINTED: 12/05/2022 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 3. The Director of Nursing/designee has inserviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but no limited to, the importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs. 4. The Director of Nursing/designee will conduct an audit of 10 of resident care plans weekly for 4 weeks and then monthly for 2 months to ensure that interventions are appropriate and reflect the individual needs of each resident related to insulin, oxygen, anticoagulant, and antipsychotic medication usage. . The Director of Nursing/designee will also audit the care plans of any new admissions 5x a week for 4 weeks and then monthly for 2 months to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 12/25/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	TIPLE CONSTRUCTION ING	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY M	IANOR REHAB AND N	URSING		2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 656		F 656		
	Continued From page 49 medical, nursing, and			
	mental and psychosocial needs that are			
	identified in the comprehensive assessment.			
	The comprehensive care plan must describe the		Ì	
	following -			
	(i) The services that are to be furnished to attain	i		
	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 поt		İ	
	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 plan, as appropriate, in accordance with the			
	requirements set forth in paragraph (c) of this	1		
	section.			
	§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive			
	care plan, must-			
	care plan, must- (iii) Be culturally-competent and trauma-informed.			
	This REQUIREMENT is not met as evidenced	ļ		\
	by:			
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	Continued From page		:			
	Based on observatio	n, staff interview, facility				
	document review and	d clinical record review, it				
	was determined the fa	acility staff failed to develop				
ĺ		comprehensive care plan				1
l		its in the survey sample,				
	Residents #53, #51, #					
	Nealucilla #35, #31, 1	700 and 1704.				
	The findings include:					1
		the facility staff falled to				
	develop a care plan f	or the use of oxygen.				
	12					
	On the most recent M	IDS (minimum data set)		ł		
	assessment, a quarte	erly assessment, with the				
		e date of 10/15/2022, the				
		ving no short or long term				
		ection O - Special Treatment,				
		grams, the resident was				
		en while a resident at the				
	facility.					
1	Review of the compre	ehensive care plan, last				
	updated 11/14/2022,	failed to evidence				
		use of oxygen for R53.				1
	R53 was observed or	11/15/2022 at				
		.m. with oxygen on via a				
		xygen concentrator was set				
	at 2 LPM (liters per m	•				
		de on 11/15/2022 at 11:53				
	a.m. R53 was in the v	wheelchair with the oxygen				
	on at 2 LPM via a nas	sal cannula with a portable				
	tank secured to the w	heelchair.				
	Review of the physici	ian orders failed to evidence				
	a physician order for					
	a priyolalari oldor for					
	An intoniou was can	ducted with LPN (licensed				
	practical nurse) #4 of	n 11/16/2022 at 10:20 a.m.				
			(X2) MULTIPI	E CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING			SURVEY IPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	
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		495339	B. WING		11/	17/2022
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PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

F 656		F 656		
	Continued From page 51			-
	LPN #4 was asked to review R53's physician			1
	orders. When asked if she saw an order for the			
	use of oxygen, LPN #4 stated, no and there	İ		
	needed to be a physician order for the use of			
	oxygen. When asked if the resident is on oxygen,			
	should that be addressed in the care plan, LPN			1
	#4 stated, yes.		1	
	To dealth and the HOuse Planeton			
	The facility policy, "Care Planning - Comprehensive Person-Centered," documented			
	in part, "POLICY: 2. The facility will develop and			
	implement a comprehensive person-centered			
	care plan for each resident, that includes		i	
	measurable objectives and timeframes to meet a			
	resident's medical, nursing, and mental and			
	psychosocial needs as identified throughout the			
	comprehensive Resident Assessment Instrument			
	(RAI) process."			
	ASM (administrative staff member) #4, the interim			
	administrator, and ASM #2, the director of			
	nursing, were made aware of the above findings			
	on 11/16/2022 at 6:15 p.m.			
	No further information was provided prior to exit.			
	O. E. D. Hank 454 (DE4) the facility stoff foiled			
	2. For Resident #51 (R51), the facility staff failed to develop a comprehensive care plan to address			
	the use of an anticoagulant			
	are and or an anabougularis			
	On the most recent MDS (minimum data set)			
	assessment, a quarterly assessment, with an			
	assessment reference date of 8/23/2022, the			
	resident was coded as having no short or long			
	term memory difficulties. In Section N -			
	Medications, the resident was coded as receiving			
	an anticoagulant medication during seven days of			
	the look back period.			
		<u> </u>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		URVEY .ETED
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	495339	B. WING		11/17	/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY MANOR REHAB AND N	URSING		2003 COBB STREET FARMVILLE, VA 23901		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 656 Continued From page 52 The physician order dated, 8/27/2022 documented, "Eliquis (used to prevent blood clobs) (1) 5 mg (milligrams) 1 tablet wice dally." Review of the comprehensive care plan dated, 5/11/2022, failed to evidence documentation for the use of an anticoagulant medication. An interview was conducted with RN (registered nurse) #6; the MDS nurse, on 11/17/2022 at 8-66 a.m. When asked if a resident is on an anticoagulant, should that be addressed on the care plan, RN/8f stated, vss. RN 8f confirmed the anticoagulant use wean't on the care plan. ASM (administrative staff member) #4, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 11/17/2022 at 12:06 p.m. No further information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (1) This information was provided prior to exit. (2) This information was provided prior to exit. (3) The resident score of the above findings on 11/17/2022 to exit prior to the state of the prior to the state of the prior to the state of the prior to the state of the prior to the state of the prior to the state of the prior to the state of the prior to the state of the prior to the state of the prior to the state of the prior to the state of the p	CENTERS FOR WEDICANE &	MEDIONID SETTMOLS			OIVID 14C	. 0930-0391
The physician order dated, 8/27/2022 documented, "Eliquis (used to prevent blood clobs) (1) 5 mg (milligrams) I tablet twice daily." Review of the comprehensive care plan dated, 5/11/2022, failed to evidence documentation for the use of an anticoagulant medication. An interview was conducted with RN (registered nurse) #6, the MDS nurse, on 11/17/2022 at 8.46 a.m. When saked if a resident is on an anticoagulant, should that be addressed on the care plan, RN#6 stated, yes. RN #6 confirmed the anticoagulant use wasn't on the care plan. ASM (administrative staff member) #4, the interim administrative staff member) #4, the interim administrative staff member) #4, the interim administrative and savere of the above findings on 11/17/2022 at 12:06 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html 3. For Resident #63, the facility staff failed to develop a care plan for the use of insulin and psychotropic medications. On the most recent MDS (minimum data set) assessment, with an assessment reference date of 10/6/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental	F 656		F 656	8		
The physician order dated, 8/27/2022 documented, "Eliquis (used to prevent blood clobs) (1) 5 mg (milligrams) I tablet twice daily." Review of the comprehensive care plan dated, 5/11/2022, failed to evidence documentation for the use of an anticoagulant medication. An interview was conducted with RN (registered nurse) #6, the MDS nurse, on 11/17/2022 at 8.46 a.m. When saked if a resident is on an anticoagulant, should that be addressed on the care plan, RN#6 stated, yes. RN #6 confirmed the anticoagulant use wasn't on the care plan. ASM (administrative staff member) #4, the interim administrative staff member) #4, the interim administrative staff member) #4, the interim administrative and savere of the above findings on 11/17/2022 at 12:06 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html 3. For Resident #63, the facility staff failed to develop a care plan for the use of insulin and psychotropic medications. On the most recent MDS (minimum data set) assessment, with an assessment reference date of 10/6/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status) socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental status socker, indicating the resident scored a 15 out of 15 on the BIMS (brief interview) for mental	Continued From pag	ie 52				
documented, "Eliquis (used to prevent blood clots) (1) 5 mg (milligrams) 1 tablet twice daily." Review of the comprehensive care plan dated, 5/11/20/22, failed to evidence documentation for the use of an anticoagulant medication. An interview was conducted with RN (registered nurse) #6, the MDS nurse, on 11/17/20/22 at 8.46 a.m. When asked if a realdent is on an anticoagulant, should that be addressed on the care plan, RN#6 stated, yes. RN #6 confirmed the anticoagulant use wasn't on the care plan. ASM (administrative staff member) #4, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 11/17/20/22 at 12:06 p.m. No further information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html 3. For Resident #63, the facility staff failed to develop a care plan for the use of insulin and psychotropic medications. On the most recent MDS (minimum data set) assessment, with an assessment reference date of 10/5/20/22, the resident is sored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section N - Medications, R63 was coded as receiving seven days of insulin STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIENCIA (AB) STREET ADDRESS. CITY, STATE, ZIP CODE 2003 COBB STREET						
clots) (1) 5 mg (milligrams) 1 tablet twice daily." Review of the comprehensive care plan dated, 5/11/2022, failed to evidence documentation for the use of an anticoagulant medication. An interview was conducted with RN (registered nurse) #6, the MDS nurse, on 11/17/2022 at 8.46 a.m. When asked if a resident is on an anticoagulant, should that be addressed on the care plan, RN#6 stated, yes. RN #6 confirmed the anticoagulant use wasn't on the care plan. ASM (administrative staff member) #4, the interim administrator, and ASM #2, the director of nursing, were made aware of the above findings on 11/17/2022 at 12:06 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html 3. For Resident #63, the facility staff failed to develop a care plan for the use of insulin and psychotropic medications. On the most recent MDS (minimum data set) assessment, with an assessment reference date of 10/5/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section N - Medications, R63 was coded as receiving seven days of insulin STATEMENT OF DEFICIENCIES (X1) PROVIDER/SIPPLIENCIA (X2) MULTIPLE CONSTRUCTION A BUILDING (C 11/17/2022) NAME OF PROVIDER OR SUPPLIER			22			
Review of the comprehensive care plan dated, 5/11/2022, failed to evidence documentation for the use of an anticoagulant medication. An interview was conducted with RN (registered nurse) #6, the MDS nurse, on 11/17/2022 at 8-46 a.m. When asked if a resident is on an anticoagulant, should that be addressed on the care plan, RN#5 stated, yes. RN #6 confirmed the anticoagulant use wasn't on the care plan. ASM (administrator, and ASM #2, the director of nursing, were made aware of the above findings on 11/17/2022 at 12-06 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.h tml 3. For Resident #63, the facility staff failed to develop a care plan for the use of insulin and psychotropic medications. On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/5/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section N - Medications, R63 was coded as receiving seven days of insulin STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIENCLIA (X2) MOLTIPLE CONSTRUCTION A BUILDING CR 11/17/2022	I	· ·	751			
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	HOLLY MANOR REHAB AND N	URSING		FARMVILLE, VA 23901		

COMPLETION DATE

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

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PREFIX

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

F 656		F 656	
L 000			
	Continued From page 53 injections and seven		
	days of an anti-psychotic, antidepressant and		
	anti-anxiety medications.	1	
	The physician orders dated 9/29/2022,		
	documented, "Aripiprazole (an antipsychotic		
	medication) (1) Tablet; give 20 mg (milligrams) by		
	mouth one time a day related to BIPOLAR		
	DISORDER." The physician order dated,	(B)	
	11/11/2022, "Clonazepam Tablet (used to treat		
	seizures and panic attacks) (2) disintegrating 0.25		
	mg; give 1 tablet my mouth every day shift every		1
	Mon, Wed, Fri, related to generalized anxiety		
	disorder; give 1 hour before leaving for		
	hemodialysis."		
	The physician order dated, 9/28/2022,		
	documented, "Insulin Glargine Solution (long		
	acting insulin to treat diabetes) (3) 100 units/ML		
	(milliliters); inject 20 unit subcutaneously one tine		
	a day for diabetes. The physician order dated,		
	9/29/2022, documented, "Sertraline HCL		
	(hydrochloride) (used to treat depression,		
	obsessive compulsive disorder and panic attacks)		
	(4) tablet 50 mg; give 1 tablet by mouth in the		
	evening related to BIPOLAR DISORDER." The		767
	physician order dated, 11/1/2022, documented,		
	*Novolog Flex Pen Solution (used to treat		
	diabetes) (5) Pen-Injector 100 Unit/ML; inject as		
	per sliding scale before meals and at bedtime."		
	'		
	Review of the comprehensive care plan dated,		
	11/10/2022, failed to evidence the resident's use		
	of psychotropic medications and the use of insulin		
	to treat diabetes.		
	to none diapotos.		
	An interview was conducted with LPN (licensed		
	practical nurse) #4, the unit manager on		
	11/16/2022 at 10:10 a.m. LPN #4 stated the care		
	plan is the outline of how to care for a resident,		
	plan is the outline of flow to date for a resident		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA)		I * '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
17					С
		495339	8. WING		11/17/2022
	ROVIDER OR SUPPLIER	JRSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 656			F 6	356			
	Continued From pag	e 54 their preferences, and					
		eds. When asked who's		j			
				İ			
Ì	l .	loping the care plans, LPN					
	#4 stated it's normall	*					
		nursing, director of nursing,					
	therapy, and any dep	partment head.					
ł							
l	An interview was cor	nducted with RN (registered					
	nurse) #3, the MDS r	nurse, on 11/16/2022 at 3:58]	
·	,	resident is a diabetic and is					
		uld that be addressed on the			•		
		led, it normally is. When					
	asked if a resident is	-					
		that be addressed on the					-
		ed, yes. After reviewing the					
		ed that neither the insulin					
		dications were documented				,	
	on the care plan.						
		staff member)#4, the interim					
		SM #2, the director of					
	nursing, were made	aware of the above findings					
	on 11/17/2022 at 12:	06 p.m.					
	No further informatio	n was provided prior to exit.					
	(1) This informa	tion was obtained from the					
	following website:						
		ov/druginfo/meds/a603012.h			III		
	tml	· ·					
		tion was obtained from the					
	following website:						
		ov/druginfo/meds/a682279.h					
	tml	2.1.2.2gm10m1000000000010m1					
		tion was obtained from the					
	1.7	NON WAS ODIAINED HOITI DE					
	following website:	ov/druginfo/mode/o600027 h					
		ov/druginfo/meds/a600027.h					
	tml	sian anno afránta a diferent de e					
	1.7	tion was obtained from the					
_	following website:	<u></u>					
			(X2) MIII	ПРІ	E CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	` '				SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING ,		COM	IPLETED
							C
		495339	B. WING			11/	17/2022
NAME OF	PROVIDER OR SUPPLIER	730000	5, 11110	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 2 2 4	
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(X5)

COMPLETION

2003 COBB STREET

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FARMVILLE, VA 23901

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

HOLLY MANOR REHAB AND NURSING

(X4) ID

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391 F 656 F 656 Continued From page 55 https://medlineplus.gov/druginfo/meds/a697048.h (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605013.h tml 4. For Resident #54 (R54), the facility staff failed to develop the comprehensive care plan to include the use of antipsychotic medications. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/13/2022, the resident was assessed as being severely impaired for making daily decisions. Section N documented R54 receiving antipsychotics during the assessment period. The physician's order summary report dated 11/16/2022 documented in part, "Risperdal Tablet 0.25 MG (milligram) (risperidone) Give 1 tablet by mouth three times a day related to: Unspecified Psychosis Not Due To A Substance Or Known Physiological Condition. Order Date: 09/15/2022. Start Date: 09/15/2022." On 11/16/2022 at 3:27 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that care plans were created on admission based on the nursing assessment and then the MDS (minimum data set) team would use that to build on. LPN #5 stated that the purpose of the care plan was to have a plan of care for nursing and all staff to see the goals and interventions in place for the resident. LPN #5 stated that they would expect antipsychotics and associated behaviors to be on the care plan. On 11/16/2022 at 1:36 p.m., an interview was

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA)		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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		495339	B. WING		11/	/17/2022
'	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE	(XS) COMPLETION DATE

PRINTED: 12/05/2022 FORM APPROVED OMB NO, 0938-0391

F 656		F 656	
	Continued From page 56 conducted with ASM (administrative staff member) #3, the assistant director of nursing. ASM #3 stated that when they switched over to the new electronic medical record the former director of nursing and a group from the new facility owner came and reviewed all of the care plans at that time. ASM #3 stated that the former director of nursing worked with them, updated them and entered the new care plans into the current electronic medical record. ASM #3 stated that once they were up and running with the new system they started tweaking the care plans and adding to them. ASM #3 stated that residents on antipsychotic medication should have a care plan to address that.		
	On 11/16/2022 at 4:02 p.m., an interview was conducted with RN (registered nurse) #3, MDS coordinator. RN #3 stated that prior to switching out the electronic medical records all of the care plans were printed out and put on the nursing units so the staff had access to them. RN #3 stated that the traditional baseline care plans were put into the new electronic medical record and they have worked to get them up to date as the MDS assessments have been completed. On 11/16/2022 at 6:17 p.m., ASM #4, the interim administrator and ASM #2, the director of nursing were made aware of the findings.		
F 657 SS=D	No further information was presented prior to exit. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657	1. Residents #206 was assessed by nursing staff and their medical records were reviewed. Resident reported not using the incentive spirometer since being admitted to the facility, NP made aware, incentive spirometer discarded. Holly Manor has identified that all residents are at risk from this alleged deficient practice. 2. The Director of Nursing/designee has performed an audit of all current residents' care plans. Care plans have been updated to ensure individualized needs for incentive spirometers are addressed appropriately and that results are being tracked and addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily clinical meeting, and to update the care plans to reflect the residents need for an incentive spirometer.

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OMB NO. 0938-0391

F 657			F 657			
	Continued From page	e 57				
	(i) Developed w	rithin 7 days after				
	completion of the con	nprehensive assessment.				
		an interdisciplinary team,]	ļ
	that includes but is no	ot limited to-(A) The				
	attending physician.	nurse with responsibility for				- 1
	(B) A registered the resident.	lidise will responsibility for				
		with responsibility for the				
	resident.					
	(D) A member of	f food and nutrition services				
		t practicable, the participation				
	of the resident and th					
	representative(s). An					
		t's medical record if the sident and their resident			1	
		ermined not practicable for				
		he resident's care plan.	•			
	(F) Other appropriate	staff or professionals in				:
	•	ined by the resident's needs				
	or as requested by th					
		rised by the interdisciplinary ssment, including both the		ED.		
	team after each asse comprehensive and					
	assessments.	quarterly rovion				
		is not met as evidenced				
	by:					
		n, resident interview, staff				i.
	interview, facility doc	ument review and clinical				
	record review, the fac	cility staff failed to review and nsive care plan for one of 33				
		y sample, Resident #206.				ř.
	Testaeths in the surve	,, , , , , , , , , , , , , , , , , , , ,				
	The findings include:					
		d to review and revise				
		06) comprehensive care plan				
	for the use of an ince	intive spirometer.				
	On the most recent M	IDS (minimum data set), an				
	On the most country					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		ECONSTRUCTION		SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			IPLETED
		15				G !
		495339	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	17/2022
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PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 657			F 657			
	Continued From page	58 admission assessment				:
		ment reference date) of				
	•	t scored 15 out of 15 on the				
	BIMS (brief interview				- 10	
	indicating the resider				- 1	
					- 1	i
	impaired for making	daily decisions.				
	D0001					
		ve care plan revised on all documented information				1
					- 1	
	regarding an incentiv	e spirometer.			- 1	
	On 11/15/00 at 0:26	m P206 was shoomed				
		n.m., R206 was observed r in the bedroom. An			- 1	
		was on the resident's over				
	•					
		ew was conducted with				
1	R206. R206 stated th	-				
	spirometer every two	nouis.				
	On 11/16/22 at 3:26 r	o.m., an interview was				
		(licensed practical nurse) #5.				
		rpose of the care plan is a				
		aff to see what the goals are				1:
		place. LPN #5 stated a				k:
		hould be reviewed and				
		incentive spirometer as an				
	intervention.	incertuve spirotiteter as att				
	intervention.		i			(
	On 11/16/22 at 6:19 r	o.m., ASM (administrative				ř
		interim administrator and				
		of nursing were made aware				C.
	of the above concern	<u> </u>				
	J. 210 GEOTO OUTION	-				
	The facility policy title	ed. "Care Planning -				
	Comprehensive Pers	con-Centered" documented,				
		comprehensive care plan will				
		g: a. Services that are to be				
		maintain the resident's				
	highest practicable p				13.	
	psychosocial well-be					
	, .	_		1		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	l`'	E CONSTRUCTION		SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		СОМ	PLETED
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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CUA	V '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	495339	8. WING	STREET ADDRESS, CITY, STATE, ZIP COD		71772022	
	IANOR REHAB AND N	JRSING		2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	** I ** ** ** ** ** ** ** ** ** ** ** **	IOULD BE	(X5) COMPLETION DATE	
F 657		e 59 on was presented prior to exit.	F	657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

F 658 | Services Provided Meet Professional Standards SS=D | CFR(s): 483.21(b)(3)(i)

> §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to obtain weights as ordered by the physician, for one of 33 residents in the survey sample, Resident #22.

The findings include:

The facility staff failed to follow physician orders for initial admission weights ordered x 3 days, and weekly weight x 4 for Resident #22.

Resident #22 was admitted to the facility on 8/15/22 with diagnosis that included but were not limited to: CAD (coronary artery disease), hypertension, dementia, and anxiety.

The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 8/22/22, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the comprehensive care plan with a revision date of 8/16/22 did not include a concern PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

12/25/2022

F 658 1. The medical records of resident #22 were reviewed and weights have been obtained per physician order. The resident's care plan has been updated to reflect a current individualized plan of care. Holly Manor has identified that all residents are at risk from this alleged deficient practice.

- The Director of Nursing/designee has performed an audit of all current weight orders. Any weights not obtained per physician's orders have now been obtained and the provider and resident representative were made aware. The resident's care plans have been updated to reflect a current individualized plan of care.
- The Director of Nursing/designee has educated licensed nursing staff on obtaining resident weights per physician's order. The in-service includes the importance of obtaining weights per physician orders and recording the weights properly in the EHR.
- The Director of Nursing/designee will conduct an audit of residents with weight orders daily for 5 days a week, then 3 times a week for 4 weeks, then weekly for 4 weeks and then monthly for 2 months to ensure that weights are obtained per physician orders. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to obtain the weights and re-educate staff. The Director of Nursing/designee will Identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.

Date of Compliance: 12/25/22

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA		(X2) MUL	TIPLE CONSTRUCTION BING		E SURVEY MPLETED
		495339	B. WING		11,	/17/2022
	ROVIDER OR SUPPLIER	URSING		STREET ADDRESS, CITY, STATE, ZIP 2003 COBB STREET FARMVILLE, VA 23901	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 658			F6	358			
	O	- 60					
	Continued From pag	e 60				1	
	with weights.					- 1	
		cian orders dated 8/15/22,				- 1	i
		jht x3 days, Weekly Weight					
		hly one time a day for				1	
		ys. Per physician orders,					
		been obtained on 8/15, 8/16,				"	ľ
	8/17, 8/22, 8/29, 9/5,	9/12, 10/10 and 11/14/22.					
	A review of weights s					- 11	
		3, 10/12, 10/23 and 11/14.				- 1	1
	No weight loss was id	dentified.				- 11	
	A	destad as 44/45/00 at 0:00					
		ducted on 11/15/22 at 8:03					
		ed practical nurse) #1. When					
		r obtaining weekly weights,				Ш	
	LPN #1 stated, weekl	· -					
		NA to obtain. When asked if					
		d weights are not done, are					
		followed, LPN #1 stated, no,					
	they are not.						
	An interview was con	ducted on 11/15/22 at 4:20					
		hen asked who obtains			=		
	weights, CNA #6 state					ĺ	
		our assignment. When					
		are obtained, CNA #6				ļ	
		lly obtained on day shift and				_	
	sometimes on evenir					- 1	l
	On 11/15/22 at 5:45 F	PM, ASM (administrative				- 1	
	staff member) #1, the	administrator and ASM #2,					1
	the director of nursing	g was made aware of the				- 1	
	findings.	-					
		y's "Conformity with Laws				- 1	
		ndards" policy with no date,				1	
		operates and provides					
	services in compliant	ce with current federal, state			L		
			(X2) MUL	ΠPL	E CONSTRUCTION	()(0) 5 4	01101/61/
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	PLETED
							
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NAME OF S	ROVIDER OR SUPPLIER	495339	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	17/2022
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COMPLETION DATE

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 61 and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided.* No further information was provided prior to exit. ADL Care Provided for Dependent Residents CFR(s): 483-24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral Pylglene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document roview, dimical record review and in the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily) living care for two of 33 residents in the survey sample, Residents #61 (R61) with casing on 11/222. The findings include: 1. The facility staff failed to assist Residents #61 (R61) with casing on 11/222. On the most recort MDS (minimum data set), a quarterly assessment with an ARD (assessment reference dale) of 3/27/22, the resident scored out of 15 on the BMS (bert inverse we for mental status), indicating the resident was severely cognitively impaired for making daily decisions. Section 6 coded R61 as requiring astensive assistance of one said with the along. An occupational therapy note dated 6/15/21 documentand: "PL (Palenn) was self-leading when OTR/L (occupational therapy mel ployee) arrived The Director of wasing/designee has educated dimical staff, including Rhs, University of the seed of each resident, how to properly perform myglene/pericare, and damitying changes in resident, how to properly perform myglene/pericare, and until fright changes in resident, how to properly perform myglene/pericare, and until fright changes in resident, how to properly perform myglene/pericare, and until be addressed mineralizely by the Director of Nursing/designee and appropriate actions will be addressed mineralizely by the Director of Nursing/designee and appropriate actions will be addressed mineralizely by the Director of Nursing/designee and appropriate		OT OK MEDIOARE & MEDIOARD CERTICES	F 658			
regulations, codes and professional standards of practice that apply to our facility and types of services provided.* No further information was provided prior to exit. F 677 DL Care Provided for Dependent Residents (F 677 SP-0 CFR(s): 483.24(a)(2) \$483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hyglens; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a compleint investigation, the facility staff failed to provide ADL (activities of daily living) care for two of 32 residents in the survey sample, Residents (R61) with eating on 11/2/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference dele) of 8/2/22, the resident scored 0 out of 15 on the BINS (brief interview for mental stables), indicating the resident was severely cognitively impaired for mainting fally decisions. Section G coded R61 as requiting extensive assistance of one staff with eating. An occupational therapy note dated 6/15/21 documented, "Pt. (Pallent) was self feeding when OTRIL (occupational therapy note dated 6/15/21 documented," Pt. (Pallent) was self feeding when OTRIL (occupational therapy leading schematic and the provided plans of care, how to properly perform hyglene/perfoars, and identifying designee has decuated diminical staff, including Rhs, LPNs and CNAs staff on providing ADL care than the care given meets the needs of each resident. ApL care needs. The Director of Nursing/designee has elected to reflect a current individualized plans of care. The Director of Nursing/designee and exercity perform hyglene/perfoars, and identifying changes in resident ADL care needs. The Director of Nursing/designee ADL care and/or Peri-care, Any insures the needs of each resident. ApL care needs. The Director of Nursing/designee ADL care and/or Peri-care, Any insures the needs of ea	F 658		F 656			
regulations, codes and professional standards of practice that apply to our facility and types of services provided.* No further information was provided prior to exit. F 677 DL Care Provided for Dependent Residents F 677 SPD CFR(s): 483.24(a)(2) \$483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, dimical record review and in the course of a complaint investigation, the facility staff failed to provide ADL (activities of daily living) care for two of 33 residents in the survey sample, Residents #61 (R61) with eating on 11/2/22. On the most recent MDS (minimum data set), a quarterly assessment will an ARD (assessment reference date) of 8/2/22, the resident scored 0 out of 15 on the BMS (first lineative for maintal stabus), indicating the resident was severely cognitively impaired for making daily decisions. Section G coded R61 as requiring extensive assistance of one staff will healing. An occupational therapy note dated 6/15/21 documented, "Pt. (Patient) was self feeding when OTRIL (occupational therapy employee) arrived An occupational therapy note dated 6/15/21 documented, "Pt. (Patient) was self feeding when OTRIL (occupational therapy employee) arrived British and the sample of the sample of the care given meets the needs of each resident. Any incorrect followidualized plans of care, they work the care given meets the needs of each resident. Any incorrect followidualized plans of care, they work the care given meets the needs of each resident, frow to propelly feet a resident, frow to propelly feet a resident, frow to propelly feet a resident, frow to propelly feet a resident, frow to propelly feet a resident, frow to propelly feet a resident, frow to propelly feet a resident, frow to propelly feet a resident, frow to president and providing ability byteine AUC care and/or Peri-ca		Continued From page 61 and local laws,	1 1			
of practice that apply to our facility and types of services provided." For foreign that apply to our facility and types of services provided for Dependent Residents (Foreign and States). A notice of the services of the services of the services of the services of the services of the services of the services of the services of the services of a complaint investigation, the facility and in the course of a complaint investigation, the facility said field to provide ADL (activities of daily living reaches). The findings include: 1. The facility staff failed to assist Resident #61 (R61) with eating on 11/2/22. On the most recent MDS (minimum data set), a quarterly assessment reference date) of 827/22, the resident scored of out of 15 on the BIMS (brief liner/two for mental status), indicating the resident was severely cognitively impaired for making daily decisions. Section G coded R61 as requiring extensive assistance of one staff with eating. An occupational therapy note dated 6/15/21 documented, "Pt. (Patient) was self feeding when OTR/L (occupational therapy employee) arrived True foreign and incontreasy of the self-self self-self-self-self-self-self-self-self-						
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PRINTED: 12/05/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. Date of Compliance: 12/25/22 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUBDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CUA (X3) DATE SURVEY A. BUILDING _ AND PLAN OF CORRECTION COMPLETED 11/17/2022 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET HOLLY MANOR REHAB AND NURSING FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ĪΠ (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 677			F 677		
			12		
	Continued From 200	e 62 into room, taking tray to			
		to pour it in, getting food on			
		pt. with a towel to wipe her			
		from getting more food on it			
		h her glasses so she could	Ì		
	_	TR/L loaded fork with greens			
		again with beans/ham with a			
		it to patient. OTR/L then			-
		d handed it to patient, she			
		uth. Pt. then demonstrated			
		multiple times with Mod			
		SBA (supervision/stand-by			
		upational therapy discharge			į
	-	/21 documented, "Eating=			
	Partial/moderate assi	istance."			
		e care plan dated 6/13/22			
		has an ADL (activities of			
	daily living) self-care				
		al assistance as needed with			
	ADLs."				
	A nurse's note dated	11/2/22 documented,			
		m dining room with oatmeal			
		oted at this time. Clothes			
		in Meaningful Life program."			
	onanger and plants				
	A facility report dated	11/9/22 documented in part,			
	"TIMELINE OF EVEN				
		out 8am, (R61) was in the			
	Lee dining. (R61) wa	is served oatmeal in a bowl,			i
		lastic cup and toast and			
		SM [other staff member]			
		ile serving other residents in			ri .
,		M #9) noticed that (R61) had			18
		ne resident's) right arm, leg,			
	lap and wheelchair				1
	•	5.50			
	On 11/16/22 at 9:52 a	ı.m., an interview was			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC	CTION	(X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	 	COMPLETED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A. BUILI	LTIPLE CONSTRUCTION DING		SURVEY IPLETED C
		495339	B. WING	<u> </u>	11/	17/2022
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	***	LD BE	(X5) COMPLETION DATE

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OLIVILIY	OT OIT WILDIOAITE &	MEDIONID CEITHICE			OIND 110	. 0530-0351
F 677			F 677			
1						
					- 1	
ì					- 1	
	Continued From pag	io 63 conducted with OCM	ļ			
		e 63 conducted with OSM				
		M #9 stated that on 11/2/22				
		ıkfastin the dining room and				
	she was the only em	ployee in the room. OSM #9				
	stated that usually the	ere is nursing staff present				137
i		uring meals and she did not			- 1	
ŀ		present during breakfast on			Í	
	11/2/22. OSM #9 sta					
	J.					
		ued serving other residents.				
		vent back to R61 and the				
	resident had spilled of	oatmeal on the resident's		1		
	body and wheelchair	r. OSM #9 stated she				
	immediately got R61	's CNA and the CNA			1	ŀ
		d R61 from the dining room.				
	Intillegialery removes	a 101 from the anning room.				
	0- 444000 -440.00	la a an interview				
		a.m., an interview was				
		(certified nursing assistant)				
		61 requires assistance with				
	eating. CNA #7 state					
	sandwiches and fing	er foods but must be				
	physically assisted w	rith liquids, soups and				
	oatmeal. CNA #7 sta	ated R61's arms are				
		sident can't always bring the				
1		resident's mouth. CNA #7		D.		
	stated R61 spills a lo					
	•	ted she thought there was			-	
	no nursing staff in the	<u>-</u>				
		but she did not know why.				
		n 11/2/22, she was assisting				
		care when OSM #9 came to			- 1	_
		OSM #9 told her R61 spilled				
	oatmeal on the resid	ent's body so she finished				
	care with the other re	sident and went to the				
	dining room to get Re	61. CNA #7 stated R61 had				
	oatmeal on clothing	covering the resident's right			- 1	
		eg so she took R61 to the				
		ed the resident's clothes. On				
	11/16/22 at 3:13 p.m.					
	TITTOTEE GCOTTO PART	, an married mas		<u> </u>		
			(X2) MULTIPL	E CONSTRUCTION	Taras =	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE	SURVEY PLETED
AND PLAN C	OF CORRECTION	DENTIFICATION NOMBER.	7 551251115		0011	
		495339	B. WING		11/4	7/2022
NAME OF	PROVIDER OR SUPPLIER	1		TREET ADDRESS, CITY, STATE, ZIP CODE		
			,	003 COBB STREET		
HOLLYM	IANOR REHAB AND NU	IRSING		FARMVILLE, VA 23901		
NOLL! IV	INITOR REIMB MITS IT	21/211/2	Ι,			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(XS)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	WATE	

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F 677	Continued From page 64 conducted with ASM	F 677			
	#2, the director of nursing. ASM #2 stated	1			
	•				
	nursing staff is supposed to be present in the				
i	dining room to supervise and assist residents				
	with meals. ASM #2 stated she prefers one				
	nurse and two CNAs to be in the dining room				
	during meals but this varies depending on how				
	many residents are present and how many				
	residents need assistance.				
1					
	On 11/16/22 at 6:19 p.m., ASM #4, the interim				
	administrator and ASM #2 were made aware of				
	the above concern.				
	The facility policy titled, "Assistance with Meals"				
	documented, "Dining Room Residents:				65
	Facility staff will serve resident trays and				T:
	will help residents who require assistance with				C
	eating, 2. Residents who cannot feed themselves				
	will be fed with attention to safety, comfort, and				8
	dignity."				
	diginty.	1			į.
	No further information was presented prior to exit.				
	No fatales intomitation was presented prior to own				
	2. For Resident #22, the facility staff failed to				
	provide ADL (activities of daily living) care,				
	specifically incontinence care, for a dependent			12	
	resident.	l			-
	lesidett.				
	Resident #22 was admitted to the facility on				
	8/15/22 with diagnoses that included but were not				
	limited to: CAD (coronary artery disease),				
	hypertension, dementia, and anxiety.				
	hypertension, dementa, and anxiety.				
	The most recent MDS (minimum data set)				
	assessment, a Medicare 5-day assessment, with				
	an ARD (assessment reference date) of 8/22/22,				
	coded the resident as scoring a 09 out of 15 on				
	the BIMS (brief interview for mental status) score,				İ
	indicating the resident was moderately cognitively				
	impaired. A review of the MDS Section				
	Impaned. A testes of the stad occord		 		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLL/ IDENTIFICATION NUMBER:	M ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY IPLETED
		495339	B. WING	3	11/	17/2022
NAME OF F	PROVIDER OR SUPPLIER		100	STREET ADDRESS, CITY, STATE, ZIP CODE	_	
HOLLY M	IANOR REHAB AND N	URSING		2003 COBB STREET FARMVILLE, VA 23901		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		ULD BE	(X5) COMPLETION DATE

OCITICIO	3 FOR MEDICARE &	VIEDICAID SERVICES				OIAID 140	0330-0331
F 677	Continued From pag	e 65	F	577	· · · · · · · · · · · · · · · · · · ·		1
	G-functional status co	oded the resident as					- 1
		ssistance for bed mobility,					
		d hygiene; total dependence					
							1
	for bathing and supe	rvision for eaung.					
	A review of the comp	prehensive care plan with a					
	revision date of 8/16/	22, revealed, "FOCUS:				ľ	
		. self-care performance					
	deficit, requires assis			- 1			
	INTERVENTIONS:F			- 1			
		ng, dressing and toileting.		- 1		0.0	
	•	als. Physical assist as					i
		resident to use bell to call		- 1			
		urage resident to participate		- 1			
	to the fullest extent pe						
1		ossible with each					9
	interaction."						
		ffoot out to the containing		- 1		l	
		#22's September, October					
		ADL (activities of daily living)				- 1	
		the resident was incontinent					
	of bladder on each d	ay/evening and night shift.		1			
	An intensiow was con	iducted on 11/15/22 at 8:45		- 1			
	I	nen asked about staffing,				1	
		orse now than when we					
		ode. I have 16 residents to				- 1	
		As with 58 residents). I					
				- 1			
		with bathing, incontinence				- 1	Ē.
		larly when they were short				- 1	
		s for 58 residents) and they					
		th their care either. When					
		uency of incontinence care,					
		supposed to be every two					
		3 CNAs, we can get it done					
	2-3 times a shift. Who						
	l * * * *	r bladder incontinence on the					
		hat incontinence care was				ŀ	
		ours during her shift, CNA #1		ĺ			
	l .	t mean we did it every two					1
	hours.						
			(X2) MUL	TIPLE	CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD			(X3) DATE	SURVEY PLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BOILD	1110			
		495339	B. WING			11/1	7/2022
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
		IDONO			003 COBB STREET		
HOLLYN	IANOR REHAB AND N	DKOING		F.	ARMVILLE, VA 23901		
(X4) ID		TEMENT OF DEFICIENCIES	ID]	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
TAG	REGULATURY OR L	SC IDENTIFYING INFORMATION)	143		DEFICIENCY)		

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F 677		F 677		
	Continued From page 66			
	Condition 1 for page 00			
	0 444500 1000 MM I Intention			
	On 11/15/22 at 9:00 AM, an in-person interview			
	was conducted in Resident #22's room with the		[
	resident and Resident #22's RP (responsible			
	party). The RP stated, look at how she is, pulled			
	back the blanket and Resident #22 was naked	i i		
	except for a heavy, full urine saturated adult brief.			
	Resident #22 stated, put the blanket back over			
	me. When Resident #22 was asked when she			
	was changed last, she stated, "Sometime during			
	the night. I am wet and cold now." CNA (certified			
	nursing assistant) #1, entered the room, Resident			
	#22's RP asked the CNA, when did you last			
	change my mother? CNA #1 stated, "She has not	1		
	been changed since I started my shift. I was			
	trying to get the residents their breakfast and then			
	feed the residents. I was going to start			
	incontinence rounds next."			
	A 1 4 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
	An interview was conducted on 11/15/22 at 4:20			
	PM, with CNA #6. When asked the frequency of			
	incontinence care, CNA #6 stated, it is every two			
	hours. When asked if she is able to provide			
	incontinence care every two hours, CNA #6 stated, it depends on staffing. When we have 15			
	residents or more, no we cannot provide			
	incontinence care that frequently. When asked if the documentation under bladder incontinence on			
	the ADL form indicates that incontinence care			
			0	
	was provided every two hours during her shift, CNA #6 stated, no, it does not mean we did it			
	every two hours, it means we did it at least once			
	that shift.			
	uiat siint.			
	On 11/15/22 at 5:45 PM, ASM (administrative			
	staff member) #1, the administrator and ASM #2,			
	the director of nursing was made aware of the			
	findings.			
	-			

	F PROVIDER OR SUPPLIER MANOR REHAB AND NU SUMMARY STA	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		A. BUILD	TIPLE CONSTRUCTION DING		E SURVEY APLETED C
		495339	B. WING		11/	17/2022	
NAME OF I	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
HOLLYN	IANOR REHAB AND N	ursing		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	***************************************	LD BE	(X6) COMPLETION DATE	

Event ID:BCJ811

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F 677			F 67	7	- 1	
	Continued From page	0.67				
						1
		y's "Activities of Daily Living"				1
	policy with no date, re	evealed, "Residents will be				
	provided with care, to	eatment and services as			- 1	
	appropriate to mainta	ain or improve their ability to				
		living (ADLs). Residents				
		rry out ADLs independently				
		ces necessary to maintain				
		ning, personal and oral				
	hygiene."				- 1	
		n was provided prior to exit.				
		ards/Supervision/Devices	F 68	9		
SS=G	CFR(s): 483.25(d)(1)	(2)			1	
						16
	§483.25(d) Accidents	5 .			ļ	1
	The facility must ensu	ure that -			1	- 1
	\$483.25(d)(1) The re-	sident environment remains				6
		azards as is possible; and				
					- 1	
	8483 25(d)(2)Fach re	esident receives adequate				
		stance devices to prevent				.1
	accidents.	outilog devices to proverit				
		is not met as evidenced				
	by:	is not met as evidenced				
	•	inu facilituda que entrovieu		Past noncompliance: no plan of		
		iew, facility document review				
		view, the facility staff failed		correction required.		
		supervision to prevent injury				
•	for one of 33 residen	ts in the survey sample,				ŀ
	Resident #61, resultir	ng in harm of past non-				
	compliance.					
	The findings include:					
					- 1	
	The facility staff faile	d to supervise and assist				
	Resident #61 (R61) w	vith breakfast on 11/2/22.]	
	The resident spilled of	patmeal on themselves and				
	was diagnosed with a	a second degree burn on the				
	forearm that required					
	<u> </u>					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
					1	<u> </u>
		405000				17/2022
MANAEOF	PROVIDER OR SUPPLIER	495339	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1 117	1112022
HANC OF I	NOVIDEN ON GOLLFICK					
HOLLVE	ANOR REHAB AND NU	IPSING		2003 COBB STREET FARMVILLE, VA 23901		
HOLLT M	MITON VEUVO WITH ME	//OII10				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
IAG	REGULATURE OR E		100	DEFICIENCY)		

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F 689		F 689	
	Continued From page 68		<u> </u>
	sulfadiazine cream (1). A facility investigation		
	concluded the burn was caused by the spilled		
	oatmeal.		
	Daulieal.		
	On the most recent MDS (minimum data set), a		
	quarterly assessment with an ARD (assessment		
	reference date) of 8/27/22, the resident scored 0		
	out of 15 on the BIMS (brief interview for mental		
	status), indicating the resident was severely		
	cognitively impaired for making daily decisions.		
	Section G coded R61 as requiring extensive		
	assistance of one staff with eating.		
			1.0
	An occupational therapy note dated 6/15/21		
	documented, "Pt. (Patient) was self feeding when		
	OTR/L (occupational therapy employee) arrived		
	into room, taking tray to her mouth and trying to pour it in, getting food on lap. OTR/L provided pt.		
	with a towel to wipe her clothing off/protect it from		
	getting more food on it and provided her with her		
	glasses so she could see the tray better. OTR/L		į.
	loaded fork with greens and fed it to patient, again		
	with beans/ham with a spoon and also fed it to		
	patient. OTR/L then loaded the spoon and		1
	handed it to patient, she brought it to her mouth.		
	Pt. then demonstrated ability to self feed multiple		
	times with Mod (moderate) 1 to S/SBA		
	(supervision/stand-by assistance)." An		
	occupational therapy discharge summary dated		
į	7/8/21 documented, "Eating= Partial/moderate		
	assistance."		
	R61's comprehensive care plan dated 6/13/22		
	documented, *(R61) has an ADL (activities of		
	daily living) self-care performance deficit.		
	Interventions: Physical assistance as needed with		
	ADLs."		
			1
	A dietary service line checklist dated 11/2/22		
			1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUI IDENTIFICATION NUMBER:			A ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY MPLETED C
		495339	B. WING		11/	/17/2022
	PROVIDER OR SUPPLIER	URSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE

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F 689	1	47	F	889		П
	Continued From pag	e 69 documented the				
	oatmeal temperature	was 145 degrees.			11	:
ļ	"Resident brought fro on [the resident's] shi	11/2/22 documented, om dining room with oatmeal rt. No injuries noted at this ed and placed in Meaningful				
	was observed on res was opened, 8cm (ce W (width). Cleaned a applied Non adhesiv Was informed by day spilt hot oatmeal on (before at breakfast, cdirector of nursing) the area. Added resident was opened to be the area.	11/3/22 documented, "Area ident's right forearm. Area entimeters) L (length) x 3cm rea with wound cleaner and e gauze, wrapped with cling. I shift staff that resident had the resident's) arm the day contacted ADON (assistant lat will be on unit to assess lent to the physician binder ed. Removed bandage."				
		ated 11/3/22 documented an liazine cream 1% to be forearm every day.		1		
	state agency on 11/3, 11/03/2022, the facili had a burn noted to h	ty staff reported that (R61) er right forearm. The facility ic) assessed the the (sic) s initiated, and pain				
	Right Forearm is a Fu Exposed Support Str	2 documented, "Wound #1 ill Thickness Without uctures Burn and has lot Healed. Initial wound	<i>2</i> †		74	
			(X2) MUL	TIPLE CONSTRUCTION	000 54	CHDVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		ING	(X3) DATE COM	PLETED
					6	
		495339	B. WING			7/2022
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP	CODE	
HOLLYN	IANOR REHAB AND NU	IRSING		2003 COBB STREET FARMVILLE, VA 23901		182

COMPLETION

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

1D

PREFIX

TAG

(X4) ID

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 689		F 689	
		i i	
	Continued From page 70		
	(centimeters) length x 3.56 cm width with no		
ĺ	measureable depth"		
	A nurse's note dated 11/4/22 documented,		li i
	"Resident left facility at 4:50pm with daughter via		
	wheelchair. Daughter stated she was taking		
	resident out to eat dinner. Staff received a call at		
	8:15pm from (name of hospital), DON (director of		
	nursing) and ADON made aware."		
	Hospital emergency room documentation dated		1
	11/4/22 documented a diagnosis of a second		
	degree (partial thickness) burn.	4	
	A. F. 1914 P		
	A facility final report dated 11/9/22 documented,		8
	"TIMELINE OF EVENTS:		
	On 11/02/2022 at about 8am, (R61) was in the		
	Lee dining. (R61) was served oatmeal in a bowl,		
	cranberry juice in a plastic cup and toast and eggs on a plate by (OSM [other staff member]		S
	#9), dietary aide. While serving other residents		1
17	in the dining room, (OSM #9) noticed that (R61)		
	had spilled oatmeal on (the resident's) right arm,		
	leg, lap and wheelchair. (OSM #9) left the dining		
	room and went to the Lee unit to notify the		
	resident's aide. (OSM#9) located (CNA [certified		
	nursing assistant] #7), CNA and told her about		
	the incident. (CNA #7) went to the dining room		
	and brought (R61) back to room. (CNA #7)		
	noted that (R61) was in the Lee dining room with		
	oatmeal on mustard-colored long sleeve shirt		
	(right arm), and the top of (the resident's) green		ļ
	pants (right thigh). While wheeling (R61) to		i.
	room, (LPN [licensed practical nurse] #6), LPN		
	noted catmeal on (R61's) right side of the long-		1
	sleeved shirt. (CNA #7) informed (LPN #6) that (R61) had spilled oatmeal on self in the dining		
	room. Per (CNA #7), she took off (R61's) shirt		
	and did not see any redness or blisters. She		
	and die not see any rechess of photers. One		1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE	SURVEY IPLETED
		495339	B. WING	S		17/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2003 COBB STREET	ΣE	
HOLLY M	ANOR REHAB AND N	URSING		FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	* * * * * * * * * * * * * * * * * * * *	HOULD BE	(X5) COMPLETION DATE

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F 689			F6	589		1	
' ' ' '	Continued From pag	e 71 wiped off (R61's) arm				- 1	
		al that fell off arm. (R61)				- 1	
	did not say it was hur						
	resident) was hurting						
	(R61's) pants and shi						
		hanging (R61's) clothing,					
		he nurses' station. Per					
	(CNA #7), (R61) sper						
	(activities employee)						
		ted that (CNA #7), CNA				0	
	reported no pain or in	njury.				1	
	Numerous other staff	f were interviewed and none					
	reported any signs or	r symptoms of pain or injury			*		
	to (R61).					İ	
	At 730 pm on 11/2/22	2 (CNA #9), CNA was				1	
	preparing (R61) for b	ed, removed the long-					
		ed an open area on (the					
		No c/o (complaint of) pain					
		ed applying (R61's) night			li li		
		e assigned nurse, (LPN #4).					
		und looked like it had been				1	
	scraped, no blood on						
		able to answer how it					
	happened.	able to answer flow it					
		2/22 /LDN #7\ LDN who					
	At about 0630 on 11/3/22 (LPN #7), LPN who was providing care to (R61) asked (LPN #4) to						
		gain. At this point area					
		ke a defined blister. The					
		nd a non-adhesive dressing					1
		open area. The Assistant					
		ASM [administrative staff					
		sessed the area of concern					
		/sician to evaluate (R61's)			1		
	arm today (11/3/22)						
		/3/33 (sic) physician assistant					
		er sulfadiazine cream 1%					
	ordered, lidocaine cr	eam (a numbing agent)					
	ordered. Additional	pain medication ordered.					
	Family made aware.						
	SUMMARY OF CRIT	ICAL INFORMATION					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MÜĹ	.TP	LE CONSTRUCTION		SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	S	COM	PLETED
						1	
		405000				1 .	17/2022
	PROVIDER OF CURRY'S	495339	8. WING	_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	11/2022
NAME OF I	PROVIDER OR SUPPLIER						
					2003 COBB STREET		
HOLLY N	IANOR REHAB AND N	JRSING			FARMVILLE, VA 23901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ΙD		PROVIDER'S PLAN OF CORRECTION	N	(X5)

COMPLETION DATE

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

PREFIX

TAG

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

(X4) ID PREFIX

TAG

DEPARTMENT OF HEALTH AND HUMAN SERVICES

R61's CNA and the CNA immediately removed

On 11/16/22 at 10:38 a.m., an interview was conducted with CNA #7. CNA #7 stated R61

R61 from the dining room.

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES F 689 F 689 Continued From page 72 **OBTAINED DURING INVESTIGATION:** On 11/02/2022 (R61) spilled oatmeal on (the resident's) right arm in the Lee dining room. There was no immediate injury noted. By 11/3/22 the area had developed into a blister. Physician and family were notified and treatment was obtained. CONCLUSION: Upon conclusion of the facility's investigation, the facility can substantiate that (R61) received a burn to (the resident's) right forearm. Through interviews and statement, (R61) obtain (sic) the burn to forearm on 11/02/22, when (the resident) spilled oatmeal on (the resident's) arm while eating breakfast..." On 11/16/22 at 7:43 a.m., a CNA was observed feeding R61 and other nursing staff were observed assisting other residents in the dining room. On 11/16/22 at 9:52 a.m., an interview was conducted with OSM #9, dietary aide. OSM #9 stated that on 11/2/22 she was serving breakfast in the dining room and she was the only employee in the room. OSM #9 stated that usually there is nursing staff present in the dining room during meals and she did not know why none were present during breakfast on 11/2/22. OSM #9 stated she served R61 breakfast then continued serving other residents. OSM #9 stated she went back to R61 and the resident had spilled oatmeal on the resident's body and wheelchair. OSM #9 stated she immediately got

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		SURVEY IPLETED C
1		495339	B. WING		11/	17/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY M	ANOR REHAB AND N	URSING		2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREF TAG		.D BE	(X5) COMPLETION DATE

Facility ID: VA0291

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F 689			F 68	9		
	Continued From pag	ne 73		=		ĺ
		with eating. CNA #7 stated			}	
		indwiches and finger foods				
		lly assisted with liquids,]			
		CNA #7 stated R61's arms			1	
		ne resident can't always bring				
		the resident's mouth. CNA			11	
		a lot of food while using				
	1	ited she thought there was		1		
	no nursing staff in th	e dining room during			1	
	breakfast on 11/2/22	but she did not know why.				
	CNA #7 stated that o	n 11/2/22, she was assisting		1		
	another resident with	care when OSM #9 came to				
	her. CNA #7 stated	OSM #9 told her R61 spilled				
	oatmeal on the resid	lent's body so she finished	1			
		esident and went to the				
		61. CNA #7 stated R61 had			1	
		covering the resident's right	1			
		leg so she took R61 to the				
	-	ged the resident's clothes.]		-	
		lid not see any redness or		"		
	skin abnormalities or	n R61's right arm at that time.				
	On 11/16/22 at 11:19	a.m., an interview was				
		#6. LPN #6 stated she				
	observed R61's right	forearm on 11/2/22 when				
	CNA #7 changed R6	1's clothes and later during				
	the day around 2:00	p.m. LPN #6 stated she did			}	
	not see any redness	or discoloration of the skin at			!	
	those times.					
	On 11/16/22 at 1:01	p.m., an interview was				
		(administrative staff				
	member) #5, physici	an assistant. ASM #5 stated				
	she was notified of F	R61's burn the day after the			111	
	oatmeal spill (11/3/2	2). ASM #5 stated R61's				
		rapped with soft gauze and				
		SM #5 stated she observed				
		and there was a "decent size				
	burn." ASM #5 state	d the area was a second	L			<u> </u>
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		SURVEY
	OF CORRECTION	ÎDÉNTIFICATION NUMBER:	A. BUILDIN	G	COM	IPLETED
					(Ċ
		495339	B. WING _		11/	17/2022
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		
HOLLY N	MANOR REHAB AND N	URSING		FARMVILLE, VA 23901		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETION DATE

TAG

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

TAG

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

OLITICITA	OT OTTIME BIOTING OT	<u> </u>				
F 689			F 6	89		
	0 - 4 45	- 74 days a burn and there			- 1	
		e 74 degree burn and there			- 1	
		ister because the skin was				
		has a popped blister. ASM			- 1	
		or was molted pink mixed			1	
	with white and there v	was no visualization of				
	muscle or bone. ASN	M #5 stated she prescribed			- 1	
	treatment for the burn	and R61 was evaluated by				
	l .	e practitioner the following			- 1	
	day.	F			- 1	
	uuy.				1	
	On 44/46/22 at 1:20 r	m on intonious was				
		o.m., an interview was #9. CNA #9 stated that on				l.
		p.m., she and a nurse was				
		and noticed a wound on the				
	•	rm. CNA #9 stated it looked			ŀ	
	like the skin was peel	led back and the area was				1
·	"super red."					
		ı		1		
	On 11/16/22 at 2:22 p	o.m., an interview was			- 1	
	conducted with LPN	#4. LPN #4 stated that on				
	11/2/22, she helped (CNA #9 assist R61 into bed				
		to look at R61's arm. LPN			- 1	
		R61's right forearm did not				
! !		just red with no skin on it so			ŀ	
! !		LPN #4 stated she thought			l	
] .		against something. LPN #4				
]		ing (11/3/22), the area was				
		and day shift staff reported			i	
!		on self the previous day.			- 1	
		alled the ADON and the area			1	
	-	ADON and the physician				
	assistant.					
1						
		o.m., an interview was			-	
	conducted with ASM	#2, the director of nursing.		<u> </u>	l	
1		ng staff is supposed to be				
	present in the dining	room to supervise and assist				1
]		. ASM #2 stated she prefers				
l i		NAs to be in the dining room			- 1	
]		varies depending on how				
					7	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TPLE CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	PLETED
					(5
					11/	7/2022
		495339	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	117	17,2022
NAME OF	PROVIDER OR SUPPLIER					
		170010	ŀ	2003 COBB STREET		
HOLLYM	IANOR REHAB AND NU	TK2ING		FARMVILLE, VA 23901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NIE	
				· · · · · · · · · · · · · · · · · ·		1

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 689			F 68	9		
,	Continued From son	a 75 many rapidanta				
	Continued From pag	-				
	are present and how	many residents need			- 1	
	assistance.					1
					- 1	
		o.m., ASM #4, the interim			1	
		M #2 were made aware of				
	the above concern.					
	c and it is	1.80 ()				
		ed, "Safety and Supervision				2
		ented, "POLICY: Our facility nvironment as free from				
					- 1	
		possible. Resident safety				8
	•	assistance to prevent				
	accidents are facility- DEFINITIONS:	-wide priorities.				
		te Supervision": refers to an				3
		ins of mitigating the risk of				
	an accident.	ins of fillingaming the fish of				
		ed to provide adequate				
		nt accidents. Adequate				
		nined by assessing the				
		I number of staff required,				1
		training of the staff, and the				İ
	frequency of supervis					
		ed on the individual residents				
		identified hazards in the				
		t. Adequate supervision may				
		resident and from time to		98		
	time for the same res				- 1	
					- 1	
	The facility policy title	ed, "Assistance with Meals"				
	documented, "Dining				- 1	
	_	rve resident trays and will			- 1	
		equire assistance with eating.			- 1	
		nnot feed themselves will be				
	fed with attention to s	afety, comfort, and dignity."				
	A facility action plan					
	completion date of 1	· · · · · · · · · · · · · · · · · · ·				
	"ISSUE/CONCERN:	1. Resident received				
			(X2) MULTI	PLE CONSTRUCTION	T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	• •	G		SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	<u> </u>		
					'	2
		495339	B. WING _		11/	17/2022
NAME OF R	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		
HOLLY M	IANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901		
(VA) 10	CHAMAGV OTA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	D BE	COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE

DEFICIENCY)

Facility ID: VA0291

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F 689		F 689		
	Continued From page 76			
	significant injury during breakfastRoot Cause			
	Analysis/Related Factors- What were the			•
	reasons/related factors for the identified			(
	opportunity, risk or deficient practice? 1. Nursing			
	staff were not in the Lee Dining room when			
	incident occurred. 2. Dietary staff delivering meal			
	trays to residents without nursing staff in the Lee			
	dining room. Goals/Objectives/Expected			1
	Outcome: 1. Nursing staff will be in the dining			1
	room at all meal times on the Lee Unit. 2. Dietary			F
	staff will not deliver meals to residents in the Lee		1	
	dining room until Nursing staff is present.		1	B 11
	CORRECTION: Resident assessed by PA			65
	(physician assistant) and Siler (sic) Sulfadiazine			
	Cream 1%, and additional pain medication			
	ordered. 2. Resident assessed by Wound NP			
	(nurse practitioner) and lidocaine cream ordered			
	for resident. 3. OT (Occupational Therapy)			
	consult ordered for resident for clarification meal			
	assistance. 4. Resident care plan updated for			
	assistance with meals. 5. Residents on Lee Unit			
	had a skin assessment, no injuries noted. 6.			
	Audit of Lee residents' care plans for correct meal			li i
	assistance/supervision.			Ú.
	SYSTEM CHANGES:			
	1. The dietary will check temperature on 10 trays			V.
	for correct temperatures prior to passing the trays			
	to the residents in the dining room. 2. Dietary			
	staff will not pass any trays to the residents in the			
	Lee dining room until nursing staff are in the			
	Dining Room. 3. Nursing Staff will be present for			
	all meals in the Dining Room.			
	MONITORING/QA (Quality Assurance)			
	OVERSIGHT: Monitoring tools from Nursing and			
	Dietary will be brought to the Morning Meeting 5			
	times a week to ensure compliance X 3 weeks,			
	then weekly times 3 weeks, then monthly times 3			
	months. All findings will be brought to QAPI			
	(Quality Assurance Performance Improvement)		<u> </u>	_

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY IPLETED C
		495339	B. WING		11/	17/2022
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLYM	ANOR REHAB AND N	URSING		2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		D BE	(X5) COMPLETION DATE

Facility ID: VA0291

E 600		E 600	
F 689	Continued From page 77 monthly" All credible evidence from the above action plan was reviewed on 11/16/22.	F 689	
	No further information was presented prior to exit. This deficiency is cited at past non-compliance based on the acceptable action plan, no identified concerns with food temperatures, no other residents identified with burns, and observed residents received assistance with eating as applicable. REFERENCE:		
	(1) Silver sulfadiazine is used to prevent and treat infections of second and third degree burns. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682598.html		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690	 The medical record of resident #51 was reviewed. Incontinence care has been provided for resident #51 per facility policy since the completion of the survey. The resident's care plan and Kardex has been updated to reflect a current individualized plan of care. Holly Manor has identified that all residents are at risk from this alleged deficient practice. The Director of Nursing/designee has performed an audit of all current resident incontinence care plans to ensure accuracy and that the care given meets the needs of each resident. Any incorrect care plans and Kardex have now been corrected and clinical staff were made aware of the changes. The resident's care plans have been updated to reflect a current individualized ADL plan of care. The Director of Nursing/designee has educated clinical staff, including RNs, LPNs and CNAs staff on providing ADL care that meets the needs of each resident. The in-service includes, but is not limited to, the importance of individualized plans of care, how to properly perform hygiene/incontinence care, and identifying changes in resident ADL care needs. The Director of Nursing/designee will conduct an audit of all new and revised ADL care plans and Kardex, 5 times a
			week for 4 weeks, then 3 times a weekly for 4 weeks, weekly for 4 weeks and then monthly for 2 months to ensure that plan

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES of care meets the resident's individual ADL needs. The DON/designee will perform an observation audit of 10 residents weekly for 4 weeks and then monthly for 2 months. The observation audit will include providing incontinence care per facility protocols and individualized care plan. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to reeducate staff until significant compliance is achieved. The Director of Nursing/designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. Date of Compliance: 12/25/22 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: Ċ 11/17/2022 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET FARMVILLE, VA 23901 HOLLY MANOR REHAB AND NURSING

ID

PREFIX

TAG

(XS) COMPLETION DATE

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

PRINTED: 12/05/2022

Facility ID: VA0291

(X4) ID

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 690			F 690	<u> </u>		
	Continued From pag	e 78				
		ho enters the facility with an				
	'	r subsequently receives one				
	is assessed for remov	val of the catheter as soon as				İ
	possible unless the re	esident's clinical condition				
	demonstrates that ca	theterization is necessary;			- 1	
	and					
		ho is incontinent of bladder				
		treatment and services to			- 4	
		nfections and to restore			- "	
	continence to the exte	ent possible.				
	§483.25(e)(3) For a r	esident with fecal				
	incontinence, based				11	<u> </u>
		ssment, the facility must				
		it who is incontinent of bowel				
	receives appropriate	treatment and services to				1
	restore as much norm	nal bowel function as				1
	possible.					ŀ
		is not met as evidenced				ļ
	by:				ŀ	
		terview, facility document				
	review and clinical re				i	
		ty staff failed to provide a timely manner for one of			- 1	
		rvey sample, Resident #51				+
	(R51).	ivey sample, resident #01				
	(NoT).					
	The findings include:	:				
}		IDS (minimum data set)		12		
		erly assessment, with an			1	
		ce date of 8/23/2022, the				İ
		ns having no short or long ties. In Section H - Bladder				
		ent was coded as always				
		both bowel and bladder.				
	boning moontanoon or a					ii .
	On 11/15/2022 at 9:0	4 a.m. R51 stated, "We don't			-	e 1
	get changed." R51 sta	ated they were changes at				
			(Y2) MIN TO	LE CONSTRUCTION	1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING		(X3) DATE	SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BOILDING	· 		
)	1
		495339	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	11/	17/2022
NAME OF F	PROVIDER OR SUPPLIER					
HOLLY M	ANOR REHAB AND NU	JRSING		2003 COBB STREET FARMVILLE, VA 23901		
774 IB T		TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTIO	N I	(X5)

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

PREFIX

TAG

Facility ID: VA0291

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

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(X4) ID PREFIX

TAG

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F 690			F 690		4	1
	Continued From page	e 79				
	6:30 a.m. and not sin	ce then. R51 stated, "It's				
	now 9:00 a.m. and I h	nave moved my bowels."				
	The call bell was initia	ated by the resident. At 9:06			- 4	
		entered the room and then				
		ng the resident. The staff			- 1	
		e next room. At 9:26 a.m. the				
		till had not been changed.				1
		inged at 10:00 a.m. CNA				- 1
		istant) #14, the restorative				1
	aide.	,				
	aldo.					
	The comprehensive	care plan dated, 5/11/2022			1	
		/2022, documented in part,			1	
		ADL self care performance				
	deficit AEB (as exhibi	ited by) need for assistance				l
	with all ADLs." The "In	nterventions" documented in				
	part, "Physical assist	as needed for all ADLs."		•		- 1
	There was no docum					1
	incontinence or bowe	el and bladder.			ŀ	
		ducted with CNA #14 on				
- 2	11/15/2022 at 2:45 p.	.m. When asked if she				
		ming, CNA #14 stated she				
		ath and applied lotion on		¥.		
		neets on the bed, and stated		-1		
		ssignment, but when she			1	
		he goes in and see what the				
	resident needs. [R51]	told me they wanted a bath				
	and had soiled them:	selves. CNA #14 stated that				
		d a BM (bowel movement)				
		ront of the resident in the				
	front of the brief, she	decided to give her a bath.				
	0 4445/0000 -44-0	2 interdowwes				
		3 p.m. an interview was #1, the CNA assigned to				
	R51. When asked wh					
		a.m., CNA #1 stated there				
		the resident in the next	10			
		ndle that before she did	,	豆	ì	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l''	E CONSTRUCTION	(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING		COM	PLETED		
		495339	B. WING			17/2022
	ROVIDER OR SUPPLIER	JRSING		STREET ADDRESS, CITY, STATE, ZIP CODE 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	· · · · · · · · · · · · · · · · · · ·	OULD BE	(XS) COMPLETION DATE

Facility ID: VA0291

F 690			F	690		
	#1 stated she was as day. When asked if the stated it's usually two pull from another flo	-				
	practical nurse) #4, ti 11/16/2022 at 10:13 incontinence care is #4 stated it should be resident asks for it so of R51 waiting to be LPN #4 stated she w residentif they reque in the hallway to com the facility staff do no meals; she is trying to trays are out, we don let them eat and then The trays come on th picked up at 8:30 a.m them, they are sitting When asked why it's stool, LPN #4 stated, lead to UTIs (urinary The facility policy, "In part, "Policy: Based on the resider assessment, all resider receive appropriate to Residents that are in will receive appropria	a.m. When asked how often provided to residents, LPN every two hours unless the coner. LPN #4 was informed changed on 11/15/2022. The could normally change a st. [R51] will holler out to her the see her. LPN #4 stated of the change residents during to get a happy medium, if "t do incontinence care, we a start changing everyone. The floor at 7:30 a.m. and are in. Unless someone tells in stool, we don't know. The not good to sit wet or sit in sitting in their own stool can track infections).				
			(X2) MUL	LTIPLE CONSTRUCTION		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	DING		SURVEY PLETED
		495339	B. WING		<u> </u>	17/2022
	ROVIDER OR SUPPLIER	IRSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		Î
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE

OMB NO. 0938-0391

5.000	S POR MEDIOATE & MEDIOAD SERVICES	F 690		9.5
F 690			'I	
	Continued From page 81			
	, •			Ŷ
	ASM (administrative staff member) #2, the	ļ ,		
]		
	director of nursing, and ASM #4, the interim		"	10
	administrator, were made aware of the above	1		
	concern on 11/16/2022 at 6:15 p.m.			Į.
	No further information was provided prior to exit.	1 1		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695	 Oxygen orders have been obtained 	12/25/2022
SS=D	CFR(s): 483.25(i)	1 1	for resident #53, Incentive	
		1	spirometer orders for resident #206	
	§ 483.25(i) Respiratory care, including		•	[
	tracheostomy care and tracheal suctioning.		were not obtained, resident denied	
	The facility must ensure that a resident who		using the incentive spirometer, NP	
	needs respiratory care, including tracheostomy		aware and incentive spirometer	
		i 1	discarded. Resident #98 is no longer a	i
	care and tracheal suctioning, is provided such	1 1		
	care, consistent with professional standards of		resident of Holly Manor. The resident	
	practice, the comprehensive person-centered		plans of care were reviewed and	
	care plan, the residents' goals and preferences,	i 1	updated to include resident-specific	
	and 483.65 of this subpart.		needs. Holly Manor has identified	
	This REQUIREMENT is not met as evidenced	1 1	•	
	by:	1 1	that all residents are at risk from this	ŀ
	Based on observation, resident interview, staff	1 1	alleged deficient practice.	
	interview, facility document review, and clinical	1 1	2. An observation audit was performed	
	record review, it was determined the facility staff	1 1	to identify all residents using oxygen	
	failed to provide respiratory care and services	1 !		
	consistent with professional standards of practice	1 1	and an observation audit was	
1		1 1	performed to identify all residents	į į
	for three of 33 residents in the survey sample,	1 1	using an incentive spirometer to	
	Residents #53, #98 and #206.	1	ensure that there is a provider's	
		1 1	order for use. Any discrepancies were	
	The findings include:	1 1	·	
		1 1	immediately corrected, and orders	
	1. For Resident #53 (R53), the facility staff failed	1 1	were obtained from the provider.	
	to obtain a physician order for the use of oxygen.		3. The Director of Nursing/designee has	
		1	in-serviced licensed nurses (RNs and	
	On the most recent MDS (minimum data set)	1 1	·	
1	assessment, a quarterly assessment, with the	1 1	LPNs) regarding oxygen and incentive	1
	assessment reference date of 10/15/2022, the	i i	spirometer orders. The in-service	
	resident was coded as having no short or long		includes, but is not limited to, the	
			importance of obtaining provider	
		1	·	
]	orders for oxygen and respiratory	
			devices and clarifying respiratory	
			orders if there is any variance	
	*		between what is ordered and what is	
			stated elsewhere in the medical	
		1	record or what is being administered	
		1	to a resident.	
			4. The Director of Nursing/designee will	
			perform an observation to MD/NP	
			order audit of residents receiving	1
			oxygen, 5 times a week for 4 weeks,	
			then 3 times a week for 4 weeks,	
			then weekly for 4 week and then	
			MICH WEEKLY TOL 4 WEEK BILD LITER	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 monthly for 2 months, to ensure that oxygen is being administered as ordered by the provider. The Director of Nursing/designee will perform an observation to order audit of all residents using an incentive spirometer, 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 week and then monthly for 2 months, to ensure that oxygen is being administered as ordered by the provider., Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 12/25/22 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CUA A. BUILDING _ AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 11/17/2022 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET FARMVILLE, VA 23901 HOLLY MANOR REHAB AND NURSING SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE

PRINTED: 12/05/2022

TAG

DEFICIENCY)

REGULATORY OR LSC IDENTIFYING INFORMATION)

TAG

	.Ti	

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CENTER	S FOR MILDIOANE & I	MEDICKID SEKVICES			OND MO	. 0930-0391
F 695	-		F6	695		
	Continued From pag	10.82				
	· · -				•	
		. In Section O - Special				1
		es and Programs, the				
	resident was coded a	as using oxygen while a	ľ			
	resident at the facility	/.				
	R53 was observed or	n 11/15/2022 at				
	approximately 8:45 a	a.m. in their bed with oxygen				
i	on 2 LPM (liters per n	ninute) via a nasal cannula.	1			
	A second observation	n was made on 11/15/2022				
	at 11:53 a.m. R53 wa	as in the wheelchair with the				
		via a nasal cannula with a	ļ			1
ļ	portable tank secure					i
i .	portable latticedure.					
	Review of the physici	ian orders failed to evidence				
	a physician order for					
	a physician order for	the use of oxygen.				
	Pavious of the comes	ehensive care plan, last				
	updated 11/14/2022,					
		use of oxygen for R53.				
	documentation of the	s use of oxygen for 155.				
	A t4t	durate durith t DNI dianne				.
		ducted with LPN (licensed				
		n 11/16/2022 at 10:20 a.m.				
		review R53's physician				
		if she saw an order for the				
		#4 stated, no. When asked if				i
		physician order for the use		P.		
		ated, yes and she didn't		1		
	know why there wasr	n't an order.				
	*	xygen Administration,"			- 11	i
		"POLICY: The purpose of		i		
		rovide guidelines for safe				l
	oxygen administratio					
		IDANCE: Preparation -1.				
i	Verify that there is a p	physician's order for this				1
	procedure. Review th	e physician's orders or				
	facility protocol for ox	cygen administration."				
						1
	ASM (administrative :	staff member) #4, the interim				
			(90) 11111	TIPLE CONSTRUCTION		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,	TIPLE CONSTRUCTION		SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	СОМ	PLETED
					(
		495339	B. WING		11/	17/2022
NAME OF F	PROVIDER OR SUPPLIER	40000	2. 171113	STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	2003 COBB STREET		
HOLI Y M	ANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901		
.,				<u> </u>		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
		·		DEFICIENCY)		

Facility ID: VA0291

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

					 	
F 695			F 695			
	Continued From page	e 83 administrator, and				
	· · ·	of nursing, were made				
	· ·	concern on 11/16/2022 at				
ļ	6:15 p.m.	301100111 011 117 107 E0 E E G				
	0.15 p.m.					
	No further informatio	on was provided prior to exit.				
		(R98), the facility staff failed				
'		's order for the use of an				
	1 ' "	and failed to store the				
!		in a sanitary manner.				
]	l					
	On the most recent N	IDS (minimum data set), an				
1		ent with an ARD (assessment				
		0/20/22, the resident scored				
		IMS (brief interview for				
[ating the resident was not				
]	, ·	for making daily decisions.				
1						
]	A review of Review of	f R98's November 2022				
	physician's orders fa	iled to reveal a physician's				
	order for an incentive	e spirometer. R98's	İ			
	comprehensive care	plan dated 10/16/22				
	documented, "The re	sident has altered	i i			
	respiratory status/diff	iculty breathing r/t (related				l
!	to) respiratory failure	, COPD (chronic obstructive				
	pulmonary disease),			×		
	Administer medication	on/puffers as ordered."		~		fo!
1	On 11/15/22 at 9:12 a	a.m., R98 was observed				
		r in the bedroom. An				
	incentive spirometer	was on the resident's over				
1 1	bed table. The incen	tive spirometer mouth piece		ļ.		
	was uncovered and e	exposed to air.				
		-				
	On 11/16/22 at 10:11					
		luncovered on R98's over				
	bed table. At this tim					
		R98 stated they try to use				
		eter ten times every hour and	1		15-]
	staff had not offered	a covering for the device.				
			(X2) MI II TIPI I	CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING			E SURVEY IPLETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		l.	
		2			· · · · · ·	c
1		405220	5 WING		11/	17/2022

PRINTED: 12/05/2022 FORM APPROVED

OLIVICIN	STORWILDIOANE &	WEDICAID SERVICES			OMB MO	. 0938-0391
F 695		-	F 69	5		
	Continued From pag	ie 84				
	l communication pag	,00.				
	On 11/16/22 at 3:26	p.m., an interview was				
		(licensed practical nurse) #5.				
	LPN #5 stated reside	•				
		the use of an incentive				
	l ' -	rses can encourage use,		III		
	make sure residents					
	properly and make s	ure the device is within				
0.50		N #5 stated an incentive				
	spirometer should be	e stored in a Ziploc bag for		3		
	sanitation and cleanl	liness.				
					i	
	On 11/16/22 at 6:19 p	p.m., ASM (administrative				1
	staff member) #4, the	e interim administrator and			İ	
	ASM #2, the director	of nursing were made aware			ŀ	
	of the above concern	1.				
	The facility policy title	ed, "Incentive Spirometry"				
	documented, "To hav	ve patient perform sustained				
		without added resistance or				
	positive pressure whi	ile presenting visual				
		centive Spirometry can be				
	instructed/administer	red by an Respiratory Care				-
	Practitioner upon writ	tten physician's order." The			- 1	
	policy failed to docum	ment information regarding				
	incentive spirometer	storage.				
	No further informatio	n was presented prior to exit.				
	No farater informatio	in was presented prior to exic				
	3. For Resident #206	's (R206), the facility staff				
		sician's order the use of an				
	incentive spirometer	and failed to store the	1			
	incentive spirometer	in a sanitary manner.			l	
		IDS (minimum data set), an				:
		ent with an ARD (assessment				
		/30/22, the resident scored			- 1	[
		IMS (brief interview for			- 1	-
	mental status), indica	iting the resident was not				
		r	(X2) MIII TID	LE CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	
AND PLAN Q	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·		PLETED
						;
		495339	B. WING		11/1	7/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		
HOLLY M	ANOR REHAB AND NU	JRSING	1	FARMVILLE, VA 23901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION DATE
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BAIL	SAIL .

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

										_
F 695			F	695						
] :	Continued From page	e 85 cognitively impaired		i						
1 1	for making daily ded	• •								
1	l lot making daily doc	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
i	A review of P206's N	November 2022 physician's								
		al a physician's order for an	1							
		r. R206's comprehensive								
	-	1 11/9/22 failed to document								
	· ·	ng an incentive spirometer.	1							
	IIIIOIIIIadon legaluir	ig an incentive spirometer.								
	On 11/15/22 at 0:26	a.m., R206 was observed		- 1						
		ir in the bed room. An		- 1						
l i	=	was on the resident's over								
		ntive spirometer mouth piece								
		ching the over bed table and								
		at time, an interview was								
		6. R206 stated they use the								
		every two hours and staff								
	nad not provided a c	covering for the device.								
	On 44/46/22 at 10:03	3 a.m., R206's incentive								
	•	d on the over bed table, with								
	bed table.	overed and touching the over								
	bed table.		1							
	On 11/16/22 at 2:26	p.m., an interview was								
		(licensed practical nurse) #5.								
	LPN #5 stated reside	· · · · · · · · · · · · · · · · · · ·								
		the use of an incentive								
	•	rses can encourage use, are using the device								
		ure the device is within								
		N #5 stated an incentive								
		e stored in a Ziploc back for								
	sanitation and clean							- 1		
	Samanon and cleam	iiiless.		ľ						
	O- 44/46/00 -46:40 -	a ma A CAA /a dan in intention								
		p.m., ASM (administrative						- 1		
		e interim administrator and								
	•	of nursing were made aware								
	of the above concern	1.						- 1		
			(X2) MUL	TIPLE CONS	STRUCTION			Г		-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	ING					SURVEY PLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	n, outed							
								(>	
		495339	B. WING					11/	17/2022	Į
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CIT	Y, STATE, ZIP	CODE			1
				2003 CO	BB STREET					
HOLLY MA	ANOR REHAB AND N	JRSING		FARMV	ILLE, VA 23	901				

F 695 | Continued From page 86

(X4) ID PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

No further information was presented prior to exit.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

ID

PREFIX

TAG

F 695

COMPLETION

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

F 698 Dialysis

SS=E CFR(s): 483.25(l)

§483.25(I) Dialysis.

The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to facilitate communication with the dialysis center for one of 33 residents in the survey sample, Resident #63 (R63).

The findings include:

For Resident #63, the facility staff failed to have a communication system in place to facilitate communication between the facility and the dialysis center.

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/5/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, R63 was coded as receiving dialysis while a resident at the facility.

An interview was conducted with R63 on

F 698

Dialysis assessments and communication with the dialysis center has been established for resident #63. The resident's plan of care was reviewed and updated to reflect their resident-specific needs related to dialysis. Holly Manor has identified that all receiving dialysis residents are at risk from this alleged deficient practice.

- The Director of Nursing/designee has identified all current residents receiving hemodialysis and has established resident assessments and communication with the dialysis center. Nursing staff has ensured that care plan interventions are appropriate and address resident specific care needs.
- The Director of Nursing/designee has educated licensed clinical staff regarding dialysis assessment and communication with dialysis centers. The education includes, but is not limited to, the importance of assessing residents' pre- dialysis and post-dialysis, and the importance of sending and receiving resident information to and from the dialysis center.
- 4. The Director of Nursing/designee will review residents receiving hemodialysis weekly for 4 weeks and then monthly for 2 months to ensure that proper assessments were performed, and that communication has been sent to and received from dialysis centers. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.

5. Date of Compliance: 12/25/22

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:		A ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
_		405000				· ·	C	
		495339	B. WING			11/	17/2022	
	PROVIDER OR SUPPLIER IANOR REHAB AND N	URSING		200:	REET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

F 698

PRINTED: 12/05/2022 **FORM APPROVED** OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

72	Continued From pag	e 87 ximately 8:45 a.m. When		4		
	asked if they took an give to the dialysis st	y papers or a notebook to aff when they go to dialysis, stated they go to dialysis on				
	titled, "Dialysis Asses The form was filled in dialysis center. A req	I record revealed one form ssment" dated 11/4/2022. In by both the facility and the uest was made on onal "Dialysis Assessment"				9
	documented in part, ESRD (end stage rer hemodialysis at [nam of town] M, W, F (Mo The "Interventions" dithe vascular access i pressure, call the dia determine the need fitransported emergendepartment). Pre-Po Encourage resident tidalysis appointment M, W, F. Auscultation Venous) fistula (pulsuadequate blood flow blood or take B/P (blograft."	ofly to the ED (emergency st dialysis weights. or go for the scheduled so. Resident receives dialysis hipalpation of the AV (arterial e, bruit and thrill) to assure per protocols. Do not draw bood pressure) in arm with				
	practical nurse) #6 or When asked where the book for R63 was, LP believe they had one paperwork goes with	ducted with LPN (licensed n 11/16/2022 at 7:39 a.m. ne dialysis communication N #6 stated she did not . When asked what the resident to dialysis, LPN neet, medication list, and the			ļ	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		1	IPLETED C
		495339	B. WING	\$3	1	17/2022
	PROVIDER ÖR SUPPLIER Å	IRSING	2	TREET ADDRESS, CITY, STATE, ZIP CODE 003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE

F 698

F 698			F 69	8		
	Continued From pag form. When asked v stored when the resi dialysis, LPN #6 stat chart, but she comes	ed she puts them in the s back after she is off. aducted with LPN #4, the unit 2022 at 9:21 a.m. When				
	residents who go to dialysis assessment medications and lun dialysis assessment resident's return fron given to medical recomost of the time they it back. We send the	dialysis, LPN #4 stated, the form, current list of ch. When asked where the sheet is filed upon the dialysis, LPN #4 stated, it's bord to scan in. LPN #4 stated (dialysis center) don't send the but they won't send it		ů.		
	center for the forms, around 4:30 p.m. to seem as the waybe if we sent a bound when asked what the form was, LPN #4 standication changes trying to communicate with her and it's them	she does not call the dialysis [the resident] gets back 5:00 p.m. LPN #4 stated inder, that might work better. e purpose of the assessment ated it's to put the vitals, or observations on. We are te with them what's going on telling us what they did; luring the process. LPN #4				ă
	was asked, if you do communicating with An interview was con (administrative staff)	n't get the form back is that them, LPN #4 stated, no.				
	there is a communicate resident. When asked form was, ASM #2 state their care. They [dialy out their form and se	ation form we send with the d what the purpose of the ated it's so we can monitor rsis center] usually don't fill nd it back here, and the staff ere has to be continuity of				1
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMI	PLETED
		495339	B, WING			7/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	OULD BE	(XS) COMPLETION DATE

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F 698		F 698			
' "	Continued From page 90	1 030			
1 1	Continued From page 89				
	The facility relies Want Olean Devel Disease				
	The facility policy, "End Stage Renal Disease - Care of Resident," documented in part, "3.				
	Agreement between the facility and the				
	contracted ESRD facility will include all aspects of				
i I	how the resident's care will be managed including	ĺ			
	but not limited to:b. communication process				
	between the nursing facility and the dialysis				
	center that will reflect ongoing communication,				
1 1	coordination and collaboration."		•		
	ACM 444 the interior administrator and ACM 442				
1 1	ASM #4, the interim administrator, and ASM #2 were made aware of the above concern on				
1 1	11/16/2022 at 6:15 p.m.				
	Triolege at 6.10 p.m.				
	No further information was provided prior to exit.			i	1
	Bedrails	F 700	1.	Informed consent for siderail rail usage	12/25/2022
SS=D	CFR(s): 483.25(n)(1)-(4)			has been obtained and siderail rail	
i	C400 05(-) D D 1			assessments have been completed for	
1 1	§483.25(n) Bed Rails.			residents #68. Informed consent for	
1 1	The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If			siderails not obtained #20, siderails	
	a bed or side rail is used, the facility must ensure			removed. The residents' care plans have	
	correct installation, use, and maintenance of bed			been updated to reflect a current	
	rails, including but not limited to the following			individualized plan of care related to siderall usage. Holly Manor Heath and	
	elements.			Rehab has identified that all residents are	
				at risk from this alleged deficient practice.	
	§483.25(n)(1) Assess the resident for risk of		2.		
	entrapment from bed rails prior to installation.			performed an audit of all current	
1				residents using side rails to ensure that	
	§483.25(n)(2) Review the risks and benefits of			informed consent is obtained, and the	
	bed rails with the resident or resident representative and obtain informed consent prior			siderail assessment has been completed.	
	to installation.			Any variances that were found have been	
ľ	to matamation.			corrected.	
	§483.25(n)(3) Ensure that the bed's dimensions		3.	• • •	
	are appropriate for the resident's size and weight.			serviced licensed clinical staff, including	
				RNs, LPNs and Nursing/Clinical leadership	
				staff regarding the importance of	
				discussing risks versus benefits of sideralls	
				with residents and their representatives,	
				and the importance of completing siderail	
				assessments. The in-service includes, but not limited to, the importance of accurate	
				assessments, completing siderail	
	75			assessment, and obtaining informed	
				consent for siderall usage.	
			4.		
				newly admitted residents, 5 times a week	
				for 4 weeks, then 3 times a week for 4	
				weeks, then weekly for 4 weeks, then	
				weekly for 4 weeks and then monthly for	
				2 months to ensure that siderall	
				assessments have been completed,	

Facility ID: VA0291

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES): 12/05/202 // APPROVE
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		informed consent has been obtained siderail usage, and that the reside medical record reflects the indivication choices of each resident. Any issuidentified will be addressed immediate by the Director of Nursing/designappropriate actions will be taken Director of Nursing/designee will any trends and/or patterns and a education and training will be paran ongoing basis. Findings will be discussed with the QAPI committed least a quarterly basis. 5. Date of Compliance: 12/25/22	ned for ent dual ues ediately nee and b. The I identify dditional ovided on	. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		PLETED
NAME OF I	PROVIDER OR SUPPLIER	495339	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	11/1	17/2022
HOLLY M	IANOR REHAB AND NU			2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES F 700 F 700 Continued From page 90 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement bed rail requirements for two of 33 residents in the survey sample, Residents #68 and #20. The findings include: 1. The facility staff failed to review the risks and benefits of the use of bed rails with Resident #68 (R68) (and/or the resident's representative) and falled obtain informed consent. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/13/22, R68's cognitive skills for daily decision making were coded as moderately impaired. A review of R68's clinical record revealed a side rail (bed rail) and entrapment risk assessment dated 9/9/22 that documented the use of side rails during care provided by staff would optimize resident safety and security, and the use of 1/2 upper rails was recommended. Further review of R68's clinical record failed to reveal documentation that the facility staff reviewed the risks and benefits of bed rails with R68 (and/or the resident's representative) and obtained informed consent. On 11/15/22 at 8:47 a.m. and 11/16/22 at 10:08 a.m., R68 was observed lying in bed with bilateral 1/4 bed rails in the upright position.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA)		(X2) MUI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	1 1 1	
		495339	B. WING		C 11/17/2022	2
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR REHAB AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE) ETION E

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

							01110	. 0000 000 1
F 700	59		F.	700		-		
	Continued From pag	je 91						
			1					
i	On 11/16/22 at 3:26	p.m., an interview was	1					
	conducted with LPN	(licensed practical nurse) #5	1]
l	(the nurse who com	pleted the side rail						
	assessment). LPN#	f5 stated she did not review						l
 	the risks and benefit	s of bed rails and obtain						
]	informed consent fro	om R68 or the resident's						
[]	representative, LPN	#5 stated the unit manager		- 1				
	may have done this.		1	l				
		a.m., an interview was		1				
		registered nurse) #4, R68's						
		SM (administrative staff	1	l l				
		sistant director of nursing.						
		stated they had not reviewed						
		s of bed rails and obtain om R68 or the resident's						
		i #3 stated ASM #2, the						
	director of nursing m							
	director of fluiding in	ay nave done uns.		- 1			İ	
	On 11/17/22 at 10:24	a.m., an interview was						
		#2. ASM #2 stated she had		1				
		s and benefits of bed rails		1				!
		consent from R68 or the						' I
	resident's representa	itive.		-				
	•							
	On 11/17/22 at 12:55	p.m., ASM #4, the interim						
	administrator and AS	SM #2 were made aware of	50					1
	the above concern.		1					
				- 1				ŀ
		ed, "Bed Rail Risk and						-
	Safety* documented							
ľ		nim or her as appropriate for	İ					
		, the following procedures						
	will be followed:	ent/resident representative	1					- 1
	on the risks and obta	•						
		r resident representative's	1					[
	consent for use of the		1					
	CONSCIENCE GOO OF AIR	o bed fails will be	1					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTR	RUCTION		(X3) DATE	SUBVEY
4	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				PLETED
							1 6	,
		495339	D WING					7/2022
NAME OF P	ROVIDER OR SUPPLIER	490333	B. WING	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	1 17	1/2022
				2003 COBB	, ,			
HOLLY MA	ANOR REHAB AND NU	JRSING			LE, VA 23901			
/W/L18s T	OLIMATA VASA	TEMENT OF DEFICIENCIES			•	N OF CORRECTO		0/5:
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	< a	PROVIDER'S PLA EACH CORRECTIVI)	N OF CORRECTION SHOULD		(X5) COMPLETION
740	DECILIATORY OF LE	OF IDENTIFYING INFOOMATIONS	TAG	l cò	OCCOPACE	TO THE ADDROO	OLATE	DATE

DEFICIENCY)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

F 700	Castinuad From non	. 02	F7	'00			
	Continued From pag						:
	documented in the m	nedical record."					
	2. For Resident #20 (evidence a consent a	on was presented prior to exit. (R20), the facility failed to and a bed rail assessment or bed rails while they were in				į	
	assessment, a quarte	MDS (minimum data set) erly assessment, with an ce date of 7/25/2022, the ed as being moderately daily decisions.					
	R20 was made in the	to a.m., an observation of eir room. R20 was observed with bilateral upper half bed		<i>-</i>			
	11:23 a.m., 11/15/20	.m., revealed R20 in bed with					
	The comprehensive	care plan for R20 failed to					
		tion of the use of bed rails.					
	The physician orders documentation for the	for R20 failed to evidence e use of bed rails.					
	The side rail and entr	apment risk assessment					
		R20 documented in part,					
		endent in bed mobility? side rails optimize resident					
	independence in bed	I mobility and transfer?					
		demonstrate use of the					
	for bed mobility? No.	ntly or with little prompting, Has the resident or ve requested use of side					
			(X2) MIII	TIPLE CONSTRUCTION	1 0 1	· · · · ·	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		' '	NG		СОМ	SURVEY PLETED	
		495339	B. WING				17/2022
NAME OF P	ROVIDER OR SUPPLIER	400000	3	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				2003 COBB STREET			
HOLLY M	ANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901			

COMPLETION

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(D

PREFIX

TAG

(X4) ID PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

F 700	I	_	E 7	700			
F 700			"	700			
	Continued From pag	je 93					
	No. Will the use of s	ide rails during care provided					
		ident safety and security?	l				
		de rail use is recommended.		- 1			
			1	- 1			
	No side rails indicate						
	· · · · · · · · · · · · · · · · · · ·	Resident is unable to raise	ľ				
	and lower side rails i	independently"					
							ŀ
	On 11/16/2022 at 9:2	28 a.m., an interview was		- 1			
	conducted with LPN	(licensed practical nurse) #4.				i	
	•	vere not sure why R20 had	1				
		ated that R20 could not pull					
		could not hold onto them					
	·		ľ				
		reviewed the bed rail			***		
		and stated that it appeared					
		posed to have the bed rails					
i	on the bed.						
			i				
	On 11/16/2022 at 1:3	6 p.m., an interview was					
	conducted with ASM						
		istant director of nursing.					
		ney completed a bed rail					
		ensure that they were safe					
	-						
		e them. ASM #3 stated that					
	•	er the resident was able to		- 1			
24	release the bed rail.	ASM #3 stated that they had					
	recently made chang	jes to their process for bed					
	rails. ASM #3 stated	that when they evaluated a					
	resident for bed rails						
		release the bed rail, watch					i i
i		bed to see if they were able					
		ress or bed frame and see					
		e of the bed they got when					
	rolling from side to si	de.]	1
		ed Rail Risk and Safety"					}
	documented in part, '	"This organization will take					
	measures to develop	and implement a strategy to					
		lity of resident entrapment					
		sing bed rails. This will					
	and an injury minio we						
OTATELIES:	OF DESIGNATION	(V4) DDAMBEDIA IDDI IEDRI IA	(X2) MUL1	TIPLE	CONSTRUCTION	(22) 54	enonan
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	ING		(X3) DATE	PLETED
				_			
		\$4°				()
		495339	B. WING			11/	17/2022
NAME OF P	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				200	3 COBB STREET		
HOLLY M	ANOR REHAB AND NU	JRSING			RMVILLE, VA 23901		
					·		
(X4) ID		TEMENT OF DEFICIENCIES	ID	. T	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX TAG	^	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
TAG	REGULATURT OR L	SC IDENTIFYING INFORMATION)	IAG		DEFICIENCY)	UPATE	

F 700	· · · · · · · · · · · · · · · · · · ·	F 700			
	Continued From page 94 include an evaluation of				
	residents who have a need for or desire to use	1			
	bed rails and that may have characteristics that				
	place them at special risk for entrapment1.				
	Any resident being considered for using a bed				l
	with bed rail(s) is evaluated by the facility's	1			
	• • • • • • • • • • • • • • • • • • • •	1 1			
	interdisciplinary team to determine whether the resident's functional status and bed mobility is				
1	•				
	improved through the use of bed rail(s), to				
i	identify any bed rail that might constitute physical restraint, and to identify individual characteristics				
	•				
	that may increase the risk of entrapment by bed rails or mattress"				:
	rails of mattress				
1	On 11/16/2022 at 6:17 p.m., ASM #4, the interim	1 1			
	administrator and ASM #2, the director of nursing				
1	were made aware of the concern.				
İ	Word made aware of the compositi				
	No further information was presented prior to exit.				
F 725	Sufficient Nursing Staff	F 725	1.	Residents #22 was assessed and	12/25/2022
SS=D	•	1		interviewed by nursing staff and	
i i				interviewed by social services. The	
]	§483.35(a) Sufficient Staff.			resident's concerns about staffing were	
i I	The facility must have sufficient nursing staff with	1		addressed. The president's plan of care	
•	the appropriate competencies and skills sets to			was reviewed and updated to reflect their	
1	provide nursing and related services to assure	000		resident-specific needs. It is the policy of	
	resident safety and attain or maintain the highest			Holly Manor to ensure that the facility has	
	practicable physical, mental, and psychosocial			sufficient nursing staff to meet the needs	
	well-being of each resident, as determined by	1 1		of the residents. All residents have the	
	resident assessments and individual plans of care	1		potential to be affected by this alleged	
i	and considering the number, acuity and			deficient practice.	
	diagnoses of the facility's resident population in	1 1	2.		
	accordance with the facility assessment required		4.	nursing staff have been addressed in a	
	at §483.70(e).			December 2022 resident council meeting.	
				The steps of this plan of correction, as	
	§483.35(a)(1) The facility must provide services			well as the 2567, were shared with	
	by sufficient numbers of each of the following			resident council and their input was	
	types of personnel on a 24-hour basis to provide			encouraged and received. The	
	nursing care to all residents in accordance with			DON/Designee has performed an audit of	
				CNA staffing ratios on Lee unit to ensure	
				that there is sufficient staff to meet the	
·				needs of the resident population. Any	
				deficient practices identified by the	
				results of the audit have been addressed	
				appropriately by Director of	
1				Nursing/designee.	
			3.		
			J.	serviced administrative staff, nursing	
				management staff, and scheduling staff	
				regarding maintaining staffing levels	
				sufficient to meet resident care needs.	
				The in-service includes, but is not limited	
				to, safe staffing ratios, what to do if there	
		1		is insufficient staff, and how to schedule	
				sufficient nursing staff.	
				Sometic Huising State.	

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES): 12/05/2022 MAPPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0.0938-0391
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES		4.	The Director of Nursing/designee meet with staffing coordinator 50 for four weeks and then monthly months to review staffing pattern ensure sufficient nursing staff are in the facility. The Director of Nursing/designee will meet with administrator and HR director we 4 weeks and then monthly for 2 nto review hiring and recruitment monitor the success of, and strenger recruitment efforts. The Director Nursing/designee will identify an and/or patterns, and additional end training will be provided to stan ongoing basis. Findings will be discussed with the QAPI committed least a quarterly basis. Date of Compliance: 12/25/22	will c weekly for 2 ns and e always the ekly for nonths goals to gthen, of y trends ducation eaff on	0.0938-0391
	:						
			L	1			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
495339		8. WING		11/17/2022			
NAME OF PROVIDER OR SUPPLIER				STREET AD	DRESS, CITY, STATE, ZIP CODE		
HOLLY MANOR REHAB AND NURSING			I	2003 COBB FARMVILI	STREET LE, VA 23901		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	1	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROPR DEFICIENCY)	RRECTIVE ACTION SHOULD BE COMPLETE CAMPLET CAM		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMP NO	1. 0930-0391
F 725			F.	725			
' '		10 OF				1	
ľ	Continued From pag	Je 30					
	resident care plans:						
	(i) Eventuber	a waiwad undar naraaraah (a)					
		n waived under paragraph (e)					
	of this section, licens						
	(ii) Other nursin	g personnel, including but not					
	limited to nurse aide	\$					
	0.400.05(-)(0).5						
		t when waived under					
	paragraph (e) of this	section, the facility must	1		3		
	designate a licensed	nurse to serve as a charge					
	nurse on each tour o						
		is not met as evidenced					
		is not met as evidences				1	
	by:		l l				
	Based on staff inten	view, resident observation,					
	facility document rev	riew and clinical record					
	*	nined that the facility staff					·
		icient staffing to meet					
			ļ.				
	1	ne of 33 residents, Resident	1				
	#22.		!				:
	1		i				,
	The findings include:	•					
	i	•					
	The facility staff faile	d to provide aufficient staffing					
	· -	d to provide sufficient staffing					
	to meet resident nee	ds.	1				
	A request was made	during the entrance	1				
	conference on 11/14/22 at approximately 6:45						
		* *	1				
		trative staff member) #2, the				1	
		provide "as worked" staffing					
	schedules from 10/1	4/22-11/14/22. When asked				1	
	during the entrance of	conference if there were any	i				
	_	// #2 stated, "No, there are				- 1	
		WHZ Stated, 110, there die					
	no waivers."					1	
	As a part of the suffic	cient staffing facility task and		- 1]
	a complaint investiga	ation the as worked staffing					
		11/14/22 sheets for Lee Unit					
		Unit has 60 available beds	ĺ				
	with 58 beds occupie	a duning survey.	1				
			1				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		СОМ	PLETED
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						1 '	
		495339	B. WING			11/	17/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
2003 COBB STREET							
HOLLY MANOR REHAB AND NURSING FARMVILLE, VA 23901							
DOLLI M	INITOR REFIND AND NO	ANGING			Little appoint the many t		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP	RIATE	DATE
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F 725			F 70	el .			
F /25			F 72	اد:			
l	Continued From pag	re 96					'
ľ							
		Jnit as worked nursing					
		2-11/14/22 revealed, 2 CNAs	1				
	(certified nursing ass	sistants) scheduled on day	i	•			
		shift: 10/11, 10/13, 10/16,					
i			ĺ				
i i		11/2, 11/6, 11/13 and night					
		0/14, 10/16, 10/22, 11/2,					
	11/12, 11/13 and 11/	14/22. Ratios on these dates					
	were approximately	24 residents to one CNA.		i			
	,,		l				
	A review of the Lee I	Jnit has worked nursing		1			ľ
				1			
		2-11/14/22 revealed, 3 CNA		1			
	(certified nursing ass	sistant) scheduled on day					
.23	shift: 10/10, 10/11, 10	0/17, 10/22, 10/24, 10/29,	l				
1211		/7, 11/11, 11/12, 11/13 and	Į.	1			i
		10/10, 10/12, 10/15, 10/19,					
	_	· · · · · · · · · · · · · · · · · · ·					
		10/23, 10/25, 10/27, 10/29,					[
	11/1, 11/3, 11/4, 11/7	', 11/9, 11/10, 11/11, 11/12					
	and night shift: 10/12	, 10/13, 10/15, 10/17, 10/19,					
	10/20, 10/21, 10/23,	10/27, 10/28, 10/29, 11/3,		1			
		, 11/10, and 11/11/22.		1			
				1			
		s were approximately 16		1			l
1	residents to one CNA	٨.					I
i							ľ
	An interview was con	ducted at 8:45 AM with CNA					
ŀ	#1. When asked abo	out staffing, CNA #1 stated, it					
		nen we were in full COVID					
		sidents to care for today (3					
				1			
		nts). I cannot care for them		Ì			1
- 1	with bathing, incontin			.			ı
	particularly when the	y were short on night shift (2		İ			
	CNAs for 58 resident	s) and they could not keep					
		ner." When asked what the					
		ers are, CNA #1 stated, a lot					
		NAs, when we should have					
- 1		s not approved until that				ļ	
		agency staff. Some of us					
	have children and ha	ve to plan ahead for					
	childcare to work the	overtime.					
		w =	(V2) 14111 T	HE CONCIDENCE			
+ · · · · · · · · · · · · · · · · · · ·	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	PLE CONSTRUCTION		(X3) DATE	
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		СОМ	PLETED
						ا ر	、
						l	
		495339	B. WING			11/1	7/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
				2003 COBB STREET			
HOLLY M	ANOR REHAB AND NU	IRSING		FARMVILLE, VA 23901			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX		TIVE ACTION SHOULD		COMPLETION DATE
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OMB NO. 0938-0391

	OT OTTIME DISTRICE OF	1120101110 0111111020				
F 725			F 7	25		
	Continued From pag	0.07				
		AM, an interview was				
	*****	nt #22's room with the				
		nt #22's RP, (responsible				
		d, look at how she is, pulled				İ
		sident #22 was naked except				
	• •	orief. Resident #22 stated,				
	•	over me. When Resident				
		she was changed last, she				
	•	uring the night. I am wet and				
	cold now." CNA (cert	ified nursing assistant) #1,				
	entered the room, Re	sident #22's daughter asked				
] [the CNA, when did ye	ou last change my mother.				
	CNA #1 stated, "She	has not been changed since				
	I started my shift. I w	as trying to get the residents				
	their breakfast and th	en feed the residents. I was	i			
	going to start incontin	nence rounds next."				
	-					
	An interview was cor	iducted on 11/15/22 at 2:43				
	PM, with OSM, #3, th	e scheduling coordinator.			- 35	39
		e staffing pattern is for each				
	unit, OSM #3 stated,					
		nd 1 CNA (certified nursing				
		enings and 1 RN and 2				
	•	ce has 1 RN and 2 CNAs on				
		RN and 1 CNA on nights.				
		CNAs on days/evenings				
		s on nights. When asked				
i		es are filled, OSM #3 stated,				
	•	ly open shifts. I send out a				
		Overtime is approved. We				
		nd we pull staff between				
ļ		We have hired some CNAs				
		this coming week." When				
	• -	-				
[are that the facility triggered		III.		
	•	the third quarter of 2022,		***		
	OSIVI #3 stated, IVO,	I was not aware of that."				
	An intoniou was con	ducted on 11/15/22 at 10:15				
		director of nursing. When				
	MINI MINI MOINI #2, UIB	director of hursing. Which				
	A	DO OVIDEDIGUES PERSON	(X2) MULT	PLE CONSTRUCTION	(V2) DATE	SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	NG		PLETED
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1						_
	0	495339	B. WING_		11/	17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	2003 COBB STREET		

(X5)

COMPLETION DATE

ID

PREFIX

TAG

FARMVILLE, VA 23901

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

HOLLY MANOR REHAB AND NURSING

(X4) ID

PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Continued From page 98 asked about the staffing on Lee unit with 16 residents to 1 CNA, ASM #2 stated, we also have restorative aides. When asked if the restorative aides have an assignment, ASM #2 stated, no, they help out. On 11/15/22 at 5:45 PM, ASM (administrative staff member) #1, the administrative staff member) #1, the administrative and ASM #2, the director of nursing was made aware of the findings. According to the facility's "Facility Assessment" dated 9/2022, revealed, "Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Staff direct care staff: Lee Wing- LPN (licensed practical nurses) 1:30 ratio days/evenings, 1:60 ratio on nights; CNAs 1:10 ratio days/evenings, 1:15 on nights." According to the facility's "Staffing" policy with no date, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with the resident care plans and the		OT ORTHEDIOXICE & WIEDIOXID SERVICES	,	Olvid INC	. 0936-0391
staffing on Lee unit with 16 residents to 1 CNA, ASM #2 stated, we also have restorative aides. When asked if the restorative aides have an assignment, ASM #2 stated, no, they help out. On 11/15/22 at 5:45 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility's "Facility Assessment" dated 9/2022, revealed, "Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Staff direct care staff: Lee Wing- LPN (licensed practical nurses) 1:30 ratio days/evenings, 1:50 ratio on nights; CNAs 1:10 ratio days/evenings, 1:15 on nights." According to the facility's "Staffing" policy with no date, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in	F 725		F 725		
facility assessment." No further information was provided prior to exit.	F 730	Continued From page 98 asked about the staffing on Lee unit with 16 residents to 1 CNA, ASM #2 stated, we also have restorative aides. When asked if the restorative aides have an assignment, ASM #2 stated, no, they help out. On 11/15/22 at 5:45 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. According to the facility's "Facility Assessment" dated 9/2022, revealed, "Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Staff direct care staff: Lee Wing-LPN (licensed practical nurses) 1:30 ratio days/evenings, 1:60 ratio on nights; CNAs 1:10 ratio days/evenings, 1:15 on nights." According to the facility's "Staffing" policy with no date, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with the resident care plans and the facility assessment." No further information was provided prior to exit. Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education		performance reviews for CNAs #2, #3, and #5. Holly Manor has determined that all residents have the potential to be affected by this alleged deficient practice. 2. The Director of Nursing/designee has completed an audit of 12-month performance reviews for all CNAs currently employed by the facility. Any variances found have been corrected and all currently employed CNAs have had a 12-month performance review completed. 3. The Director of Nursing/designee has inserviced nursing management and Human Resources staff on the importance of conducting annual CNA performance reviews. The education included, but was not limited to, procedure for conducting the annual performance review and maintaining documentation of the review in the employee personnel record. 4. The Director of Nursing/Designee will	12/25/2022

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES		FORM APPROVE				
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039			
			1	performance reviews weekly for	4 weeks			
				and then monthly for 2 months to	ensure			
				that the reviews are completed. I	Γhe			
				Director of Nursing/designee will	identify			
			any trends and/or patterns and a	dditional				
			education and training will be provided on					
			an ongoing basis. Findings will be	an ongoing basis. Findings will be				
			discussed with the QAPI committ	ee on at				
		ļ	least a quarterly basis.	least a quarterly basis.				
			5. Date of Compliance: 12/25/22					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA				(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED		
					(3		
		495339	B. WING		11/	17 <i>[</i> 2022		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
				2003 COBB STREET				
HOLLYM	IANOR REHAB AND N	JRSING		FARMVILLE, VA 23901				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE		
IAG	REGULATURE UK L	SC IDENTIF THIS INFORMATION)	IAG	DEFICIENCY)	in in			
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PRINTED: 12/05/2022

F 730	Continued From page 99 reviews. In-service	F 730		-
	training must comply with the requirements of			
	§483.95(g).			
	This REQUIREMENT is not met as evidenced			
	by:			
	Based on staff interview, clinical record review			
	and facility document review, it was determined			
	the facility staff failed to provide performance			
	evaluations and mandatory training for three of			1
	five CNA's (certified nursing assistants) reviewed			
	CNA #2, #3, and #5.			
	The findings include:			
	During the Sufficient and Competent Staffing			
	facility task review on 11/15/22 at 3:00 PM there was no evidence of performance evaluations for			
	three of five CNA's (certified nursing assistants)			
	reviewed.			
	104104104			
	On 11/15/22 at 9:00 AM, ASM (administrative			
	staff member) #1, the regional director of			
	operations was provided with the list of five	i		
	CNA's with a request for evidence of performance			
	review.			
	On 44/45/00 at 40/20 DM ASM #4 #5 and and			
	On 11/15/22 at 12:30 PM, ASM #1, the regional director of operations, provided the employee			
	files requested. Upon review, the following was			
	revealed:			
	1. CNA #2 with a date of hire of 11/17/20			
	had an initial orientation evaluation in 3/2021.			
	There was no performance evaluation in the last		_	
	12 months.			
	2. CNA #3 with a date of hire of 3/16/92			
	evidenced the last evaluation in 3/2020. There			
	was no performance evaluation in the last 12			
	months.		,	
	3. CNA #5 with a date of hire of 8/18/97,			
	evidenced the last evaluation in 7/2020. There			
	was no performance evaluation in the last 12			

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
							С	
ı			495339	B. WING		11/	17/2022	
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR REHAB AND NURSING					STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		BE	(X5) COMPLETION DATE	

F 730		F 730	**	i i
F /30		[[[]	33	
	Continued From page 100	1		
	months.			
	On 11/15/22 at 3:00 PM, OSM #5, the human			
	resources manager stated, "We do not have any	!		
	more performance reviews. I have been auditing			
	the files, there are many missing items and I have	1		
	been working on getting the files correct."			
	been working on getting the mes someon			
	On 11/15/22 at 5:45 PM, ASM (administrative	1		
1	staff member) #1, the administrator and ASM #2,			
	the director of nursing was made aware of the			
	findings.			
	inidings.	1		
	A			
	A review of the facility's policy "Performance			
ľ	Evaluations" policy with no date, revealed, "The	1 1		
	job performance of each employee shall be			
	reviewed and evaluated at least annually."	1 1		
		1 1	19	
	No further information was provided prior to exit.			40/05/0000
	Drug Regimen is Free from Unnecessary Drugs	F 757	1. Resident #16's drug regime was reviewed	12/25/2022
SS=E	CFR(s): 483.45(d)(1)-(6)	1 1	by Nurse Practitioner. A new order was	
		1 1	received by Nurse Practitioner for the	
	§483.45(d) Unnecessary Drugs-General. Each	1 1	Hydrochlorothiazide.	
	resident's drug regimen must be free from	1 1	2. The Director of Nursing/designee will	
	unnecessary drugs. An unnecessary drug is	1 1	completed an audit of all residents who	
	any drug when used-	1 1	have an order for Hydrochlorothiazide to	
		1 1	ensure parameters are being followed as	
	§483.45(d)(1) In excessive dose (including	l i	written. Any variances found have been	
	duplicate drug therapy); or	1 1	reviewed by the Nurse Practitioner.	
l i		1 1	3. The Director of Nursing/Designee will in-	
i	§483.45(d)(2) For excessive duration; or	1	serviced nurses on the importance of	
	§483.45(d)(3) Without adequate monitoring; or	l 1	administering medications in a safe and	
			effective manner. The education included,	
	§483.45(d)(4) Without adequate indications for its		but was not limited to, obtaining and	
	use; or	1 1	recording vital signs or other monitoring	
1	· ·	1 1	parameters ordered prior to medication	
	§483.45(d)(5) In the presence of adverse]	administration.	
		1	4. The Director of Nursing/Designee will	
		1	perform an audit of residents with an	
1] [order for Hydrochlorothiazide 5 times a	
		1	week for 4 weeks, then 3 times a week for	
		ļ l	4 weeks, then weekly for 4 weeks and	
			then monthly for 2 months to ensure any	
		1	parameters on the physician order are	
			being followed. The Director of	
]]	Nursing/designee will identify any trends	
			and/or patterns and additional education	
		1	and training will be provided on an	
]	ongoing basis. Findings will be discussed	
			with the QAPI committee on at least a	
			·	
			quarterly basis.	
		[]	5. Date of compliance: 12/25/22	

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	. 0938-0391
		I	(X2) MULT	IPLE CONSTRUCTION		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	(X3) DATE COM	SURVEY PLETED
					(
		495339	B. WING		11/1	17/2022
NAME OF	PROVIDER OR SUPPLIER		Ī	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		
HOLLY M	MANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

F 757			F7	257		
F/3/			' '	31		l
	Continued From pag	e 101 consequences which]		
	indicate the dose she	ould be reduced or				
	discontinued; or					
1			i			
1	§483.45(d)(6) Any co	ombinations of the reasons		1		1
ļ.		(d)(1) through (5) of this				
	section.	(-)(-) = = -3 (-) = = = = =				
		F to				
		is not met as evidenced	1	 		•
	by:			ł		
l :	Based on staff inten	view, facility document	1			
	review, and clinical r	ecord review it was	l			
•	'	facility staff failed to ensure	1			
1			Ĭ			
		the survey sample was free				ļ
	of unnecessary med	ications, Resident #16.				1
	The findings include	•				
	The midnigs medde	•				
	C D141440 /D4	IC) the feelite staff felled to				
		16), the facility staff failed to				
	hold the Hydrochlord	othiazide (1) as ordered when	1			
	the resident's systolic	c blood pressure (2) was less	1			
		uring October 2022 and five				
	times during Novem					
	unies during Novem	001 2022.				
		/IDS (minimum data set), a				
	significant change as	ssessment with an ARD	l			
	(assessment referen	ce date) of 7/26/2022, the				
		ut of 15 on the BIMS (brief				
]			
l i	interview for mental		1			
	indicating the resider	nt was cognitively intact for	1			
	making daily decisio	ns. R16 was coded as	ł			
	receiving a diuretic d	luring the look back period				
	and having high bloc					
	and having mgn bloc	or pressure.				
		5 546 1 1 1 1 1 1				
		for R16 documented in part,	l			
	"Hydrochlorothiazide	12.5 MG (milligram) * Give 1	ĺ			
	tablet orally every da	y shift related to Essential				
		on. HOLD IF SBP (systolic				
		ess than) 140. Order Date:				
	06/13/2022. Start Da				0.6	
	JUNIONZUZZ. GLAREDO	16. VJ/ 17/2024.				
		·		L		
			Lozor	BRIS OCUCTOROL		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MULT	TPLE CONSTRUCTION	(X3) DATE	SURVEY
• •	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COM	IPLETED
					<u> </u>	c
					- 1	_
		495339	B. WING			17/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				2003 COBB STREET		
HOLLYM	ANOR REHAB AND NU	IRSING		FARMVILLE, VA 23901		
HOLLI W	CHALLIFICD VID III					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	QI QI	PROVIDER'S PLAN OF COR		(2(5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX			COMPLETION DATE
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PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F /5/			F /5	' [
	Continued From pag	je 102					
	A review of R16's MA	AR (medication					
	administration record	d) for October 2022 revealed					
	the following blood p	pressures: 10/12/2022		ľ			
	Morning 137/82; 10/	19/2022 Morning 134/70;					
	10/21/2022 Morning	132/71; 10/22/2022 Morning					
	121/68; 10/23/2022 I	Morning 121/68; 10/24/2022					
		25/2022 Morning 128/72;					
-	10/26/2022 Morning	119/73; 10/27/2022 Morning					
	122/75; and 10/28/20	022 Morning 126/73, Further					
	review of the Octobe	r 2022 MAR revealed that					
	Hydrochlorothiazide	12.5 mg was administered to					
	R16 on each of the d	ates listed above when the					
	systolic blood pressu	re was less than 140.					
	A review of R16's MA	AR (medication					
		d) for November 2022					
		ig blood pressures: 11/1/2022					
		5/2022 Morning 137/72;					
	•	38/74; 11/10/2022 Morning					
		022 Morning 135/64. Further					
		ber 2022 MAR revealed that					
		12.5 mg was administered to				- 1	
		ates listed above when the					
		ire was less than 140.					
	On 11/16/2022 at 9:28 a.m., an interview was						
		(licensed practical nurse) #4.					
	LPN #4 stated that du						
		edication was checked					
	•	ce and documented after					
		#4 stated that there were					
ŀ		at required vital signs to be					
	checked prior to adm						
	parameters in the ord						
		#4 reviewed the order for					
	*	for R16 and stated that					
	•	r that the medication should				æ	
		blood pressure was less					
	man 140. LPN #4 re	viewed the MAR for R16	<u> </u>				
STATEMENT!	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		OX3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G			PLETED
						1 ,	3
		*****					_
NAME OF S	POVINCE OF CLIEBLIES	495339	B. WING	STREET ADDRESS, CITY, S	TATE ZIP CODE	11/	17/2022
NAME OF P	PROVIDER OR SUPPLIER				INIE, ZIF CODE		
HOLLYM	ANOR REHAB AND NU	IRSING		2003 COBB STREET FARMVILLE, VA 23901			
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ID

PREFIX

TAG

Facility ID: VA0291

(X5)

COMPLETION

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

(X4) ID PREFIX

TAG

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES F 757 Continued From page 103 dated October 2022 and November 2022 and stated that the medication had been administered on the dates above and should have been held because the systolic blood pressure was below 140. The facility policy "General Guidelines for Medication Administration" revised 8/2020 documented in part, "Medications are administered as prescribed in accordance with good nursing principles and practices only by persons legally authorized to administer...Medications are administered in accordance with written orders of the prescriber..." On 11/17/2022 at 12:00 p.m., ASM (administrative staff member) #4, the interim administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. (1) "Hydrochlorothiazide is used alone or in combination with other medications to treat high blood pressure. Hydrochlorothiazide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease and to treat edema caused by using certain medications including estrogen and corticosteroids. Hydrochlorothiazide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine." This information is taken from the website: https://medlineplus.gov/druginfo/meds/a682571.h tml (X2) MULTIPLE CONSTRUCTION PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES A. BUILDING COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 11/17/2022 B. WING 495339 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET FARMVILLE, VA 23901 HOLLY MANOR REHAB AND NURSING PROVIDER'S PLAN OF CORRECTION (X5)

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

COMPLETION

PREFIX

TAG

(X4) ID

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 757

Continued From page 104

(2) "Systolic pressure is the pressure when the ventricles pump blood out of the heart. Diastolic pressure is the pressure between heartbeats when the heart is filling with blood...For most adults, a normal blood pressure is less than 120 over 80 millimeters of mercury (mm Hg), which is written as your systolic pressure reading over your diastolic pressure reading - 120/80 mm Hg. Your blood pressure is considered high when you have consistent systolic readings of 130 mm Hg or higher or diastolic readings of 80 mm Hg or higher." This information is taken from the website:

https://www.nhlbi.nih.gov/health/high-blood-press ure#:~:text=Systolic%20pressure%20is%20the% 20pressure,day%20based%20on%20your%20act

F 760

Residents are Free of Significant Med Errors SS=E | CFR(s): 483.45(f)(2)

> The facility must ensure that its-§483.45(f)(2) Residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, and clinical record review it was determined that the facility staff failed to administer medications in a manner free of significant errors for one of 33 residents in the survey sample. Resident #16.

The findings include:

For Resident #16 (R16), the facility staff failed to hold the Hydrochlorothiazide (1) as ordered when the resident's systolic blood pressure (2) was less

F 757

1. Resident #16's drug regime was reviewed 12/25/2022 by Nurse Practitioner. Resident # 16 Responsible Party made aware of medication errors. Nurse

Practitioner made aware of the medication's errors. A new order was received from Nurse Practitioner for the Hydrochlorothiazide.

- 2. The Director of Nursing/designee has completed an audit of all residents who have an order for Hydrochlorothiazide to ensure parameters are being followed as written. Any variances found have been reviewed by the Nurse Practitioner.
 - 3. The Director of Nursing/Designee has inserviced individual nurses on the importance of administering medications in a safe and effective manner for resident # 16. The education for the licensed nursing staff included, but was not limited to, administering medications as prescribed in accordance with good nursing principles and practices and administering medications in accordance with written orders of the prescriber.
 - 4. The Director of Nursing/Designee will perform an audit of residents with an order for Hydrochlorothiazide, 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 4 weeks and then monthly for 2 months to ensure any parameters on the physician order are being followed. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an

F 760

If continuation sheet Page 117 of 166

DEPARTI	MENT OF HEALTH AN	ND HUMAN SERVICES): 12/05/2022 I APPROVED
		MEDICAID SERVICES			•	OMB NO	. 0938-0391
1				- 1	ongoing basis. Findings will be dis		
					with the QAPI committee on at le		
1					quarterly basis.		
				ŀ	5. Date of compliance: 12/25/22		
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ISTRUCTION		SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			PLETED
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		495339	B. WING			11/	17/2022
NAME OF I	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		•
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HOLLYM	IANOR REHAB AND N	URSING		FARM	VILLE, VA 23901		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1D	\top	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	۲	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	I IAG		DEFICIENCY)		

Event ID:BCJ811

PRINTED: 12/05/2022 FORM APPROVED

OLIVILIV	S FOR MEDICARE &	MIEDICAID SERVICES			OMP NO	. 0938-0391
F 760			F 76	0		
	la	4004 444 4				
	Continued From pag	ge 105 than 140 ten times				
1	during October 2022	and five times during				1
1	November 2022.				- 1	
	November 2022.					
i	1					
l	On the most recent N	ADS (minimum data set), a				
l	1	ssessment with an ARD	1			
l			1		ľ	1
		ice date) of 7/26/2022, the				
	resident scored 14 o	ut of 15 on the BIMS (brief				
	interview for mental	status) assessment				
l		nt was cognitively intact for				
l	•				- 1	ì
l .		ns. R16 was coded as		- 3	- 1	
ĺ	receiving a diuretic d	luring the look back period				
	and having high bloc	od pressure.			- 1	
					- 1	1
	l				J	
	The physician orders	s for R16 documented in part,			1	
1	"Hydrochlorothiazide	12.5 MG (milligram) * Give 1			1	1
	1 -	y shift related to Essential			- 1	
					- 1	
l		ion. HOLD IF SBP (systolic	1		l l	ŀ
ľ		ess than) 140. Order Date:				
	06/13/2022. Start Da	ate: 06/14/2022."		,		
	A review of R16's MA	NP (madication				
		I) for October 2022 revealed				
	the following blood p	ressures: 10/12/2022				
	Morning 137/82: 10/1	19/2022 Morning 134/70;				- 1
	_	132/71; 10/22/2022 Morning				
		Morning 121/68; 10/24/2022				
	Morning 122/66; 10/2	25/2022 Morning 128/72;				
	10/26/2022 Morning	119/73; 10/27/2022 Morning			- 1	
		022 Morning 126/73. Further		İ]	
	1	r 2022 MAR revealed that	1			i
			l		ı	
		12.5 mg was administered	l		- 1	
	R16 on each of the d	ates listed above when the	l	İ	i i	
	systolic blood pressu	re was less than 140.	l		İ	
	-,			i e		
	A	D (en e di entire				
	A review of R16's MA	•	ľ			
		l) for November 2022				
	revealed the followin	g blood pressures: 11/1/2022				
		5/2022 Morning 137/72;	-		_	
		38/74; 11/10/2022 Morning				
	THOIZOZZ MORNING T	OUT TE THIOLOGE MORNING	1	1		
			מת ונווא (כצ)	LE CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l ` '		(X3) DATE	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	СОМІ	PLETED
					1	
	<u></u>	495339	B. WING		<u> 11/1</u>	7/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2003 COBB STREET		
HOLLYM	IANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901		
.,						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLÉTION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	CIATE	DOLE
			1	DEFICIENCY)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/05/2022 **FORM APPROVED**

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 F 760 F 760 Continued From page 106 125/59; and 11/12/2022 Morning 135/64. Further review of the November 2022 MAR revealed that Hydrochlorothiazide 12.5 mg was administered R16 on each of the dates listed above when the systolic blood pressure was less than 140. On 11/16/2022 at 9:28 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that during medication administration the medication was checked against the order twice and documented after administration. LPN #4 stated that there were some medications that required vital signs to be checked prior to administration and had parameters in the orders to follow for administration. LPN #4 reviewed the order for Hydrochlorothiazide for R16 and stated that according to the order that the medication should be held if the systolic blood pressure was less than 140. LPN #4 reviewed the MAR for R16 dated October 2022 and November 2022 and stated that the medication had been administered on the dates above and should have been held because the systolic blood pressure was below 140. The facility policy "General Guidelines for Medication Administration* revised 8/2020 documented in part, "Medications are administered as prescribed in accordance with good nursing principles and practices only by persons legally authorized to administer...Medications are administered in accordance with written orders of the prescriber..." On 11/17/2022 at 12:00 p.m., ASM (administrative staff member) #4, the interim administrator and ASM #2, the director of nursing

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С
1		495339	B. WING		11/17/2022
	PROVIDER OR SUPPLIER	URSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		BE COMPLETION

F 760		F 760			
1,00	Continued From page 107 were				
ı	· -				
	made aware of the findings.				
	No further information was provided prior to exit				
	No further information was provided prior to exit.				
	(1) "Hydrochlorothiazide is used alone or in				
	combination with other medications to treat high				
	blood pressure. Hydrochlorothiazide is used to				
	treat edema (fluid retention; excess fluid held in				
	body tissues) caused by various medical				
	problems, including heart, kidney, and liver				
	disease and to treat edema caused by using				
	certain medications including estrogen and				
	corticosteroids. Hydrochlorothiazide is in a class				
	of medications called diuretics ('water pills'). It				
	works by causing the kidneys to get rid of				
	unneeded water and salt from the body into the				
	urine." This information is taken from the				
	website:				
	https://medlineplus.gov/druginfo/meds/a682571.h				
	tml				
	(O) MO - A-11			- 1	
	(2) "Systolic pressure is the pressure when				
	the ventricles pump blood out of the heart. Diastolic pressure is the pressure between				
	heartbeats when the heart is filling with				
	bloodFor most adults, a normal blood pressure			- 1	
	is less than 120 over 80 millimeters of mercury				
	(mm Hg), which is written as your systolic				
1	pressure reading over your diastolic pressure				
	reading - 120/80 mm Hg. Your blood pressure is				
	considered high when you have consistent				
	systolic readings of 130 mm Hg or higher or				
	diastolic readings of 80 mm Hg or higher." This				
	information is taken from the website:				
	https://www.nhlbi.nih.gov/health/high-blood-press				
	ure#:~:text=Systolic%20pressure%20is%20the%				
	20pressure,day%20based%20on%20your%20act			-	
	ivities.				
					_
	· · · · · · · · · · · · · · · · · · ·	(X2) MULTIPLE	CONSTRUCTION	 	
STATEMENT	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	A BUILDING			SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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		495339	B. WING		11.	/17/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HOLLY MANOR REHAB AND NURSING				2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	PROVIDER'S PLAN OF CORRECT IX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION	
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG			DATE	
F 801	Continued From pag	e 108	F	801			

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391 hab and | 12/25/2022 |

F 801 Qualified Dietary Staff SS=F CFR(s): 483.60(a)(1)(2)

§483.60(a) Staffing

The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)

This includes:

§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-

- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
- (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
- (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the

F 801

- It is the policy of Holly Manor Rehab and Nursing to ensure that the facility has a qualified dietary staff to meet the nutritional needs of the residents.
- A Registered Dietician who fulfills the requirements set forth in CFR(s): 483.60(a)(1)(2) has been employed at Holly Manor Rehab and Nursing on a fulltime basis since June 15, 2022.
- The Administrator/designee has inserviced Human Resources staff on the qualifications of a Registered Dietician for a skilled nursing facility. The inservice includes, but is not limited to, the specific regulations set forth in CFR(s):
 483.60(a)(1)(2), and the importance of a Registered Dietician in order to meet the nutritional needs of the resident population of Holly Manor Rehab and Nursing.
- The Administrator/designee will meet
 Human Resources and Registered
 Dietician staff weekly for 4 weeks then
 monthly for 2 months to ensure that a
 qualified Registered Dietician remains
 employed at Holly Manor Rehab and
 Nursing. The Administrator/designee will
 identify any trends and/or patterns, and
 additional education and training will be
 provided to staff on an ongoing basis.
 Findings will be discussed with the QAPI
 committee on at least a quarterly basis.
 Date of Compliance: 12/25/22

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING COMPLETED AND PLAN OF CORRECTION 11/17/2022 B. WING 495339 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET FARMVILLE, VA 23901 HOLLY MANOR REHAB AND NURSING PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE PREFIX *(EACH DEFICIENCY MUST BE PRECEDED BY FULL* PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**)

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F 801			F 801			
	O *	- 400				
		e 109 requirements of				
		and (II) of this section.				
	(iv) For dietitians hire	d or contracted with prior to				
	November 28, 2016,	meets these requirements				
	no later than 5 years	after November 28, 2016 or				
	as required by state I					
	[' '		1			
	8483 60(a)(2) If a qui	alified dietitian or other	1			
		trition professional is not				
,		he facility must designate a	ŀ			
		e director of food and				
	nutrition services.		}			[
	.,	od and nutrition services	ĺ			
	* * *	neet one of the following				
1	qualifications-	nections of alle following				
	l '	etary manager; or				
	, <i>,</i>	od service manager; or(C) Has				
		ication for food service				
	_	fety from a national certifying				
	body; or					
		s or higher degree in food				İ
		t or in hospitality, if the				
		s food service or restaurant	83			
	_	in accredited institution of	ŀ			
	higher learning; or					
	(E) Has 2 or more ye	ears of experience in the		(*)		
	position of director of	food and nutrition services				
	in a nursing facility se	etting and has completed a				
	course of study in foo	od safety and management,				
	by no later than Octol	ber 1, 2023, that includes				
	topics integral to mar	naging dietary operations	ļ			
	including, but not lim	ited to, foodborne illness,				
	sanitation procedure					
	purchasing/receiving					Ш
		e established standards for				
. 11		ers or dietary managers,				
		nents for food service				3
	managers or dietary					
			0/01 4 / 11 / 44 -	E O O NOTE HOTON		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	l	E CONSTRUCTION		SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED
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(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
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PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 801			F8	101		
	Continued From page	e 110				
1		tly scheduled consultations				
	from a qualified dietit					
	qualified nutrition pro					
		is not met as evidenced				
	by:					
	Based on staff interv	iew, facility document review				
		complaint investigation, the				
	_	continuously employ a				
		D) or qualified nutritional		i	!	
	professional.					
	The Single-on includes					
	The findings include:					
	The facility staff faile	d to employ a registered				
		nutritional professional from				
	4/30/22 until 6/15/22.	-				
		d to the state agency on				
	_	was no registered dietitian				
	employed by the faci	lity since 5/1/22.				
	A review of facility do	cuments/timesheets				
		employment on 6/15/22.				
	levened a 110 began	omploymont on a rozza.				
1	On 11/16/22 at 5:52 p	o.m., an interview was				
	conducted with ASM					
X		rim administrator. ASM #4				
		left the facility right before				
		another company. ASM #4				
	stated another RD wa	is not employed until				
	6/15/22.					
	On 11/17/22 at 12:35	p.m., ASM #4 stated the				
		of employment was 4/30/22				
		utritional profession was				
	employed at the facil	•				
	6/15/22).					
						1
	On 11/17/22 at 12:55	p.m., ASM #4 and ASM #2,	L			<u> </u>
		and the same that the same to	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING		(PLETED
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		495339	B. WING		11/	17/2022
NAME OF	PROVIDER OR SUPPLIER	45003	D. 14114G	STREET ADDRESS, CITY, STATE, ZIP		
	· · · · · · · · · · · · · · · · · · ·			2003 COBB STREET		
HOLLYN	IANOR REHAB AND NU	IRSING		FARMVILLE, VA 23901		

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X5) COMPLETION DATE

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(X4) ID

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

F 801		F 801		
	Continued From page 111 the director of			
	nursing, were made aware of the above			
ļ <u>1</u>	concern.			
	The facility policy titled, "Dietician (Dietitian)"			
	documented, "POLICY: A qualified, competent,			
! !	and skilled Dietitian will help oversee the food and			
	nutrition services in the facility.			
	DEFINITIONS:			
	"Qualified Dietitian Or Other Clinically Qualified			
	Nutrition Professional is one who: Holds a			
	bachelor's or higher degree granted by a			
]]	regionally accredited college or university in the			
1 1	United States (or an equivalent foreign degree)			
	with completion of the academic requirements of	0.		
1 1	a program in nutrition or dietetics accredited by		120	
	an appropriate national accreditation organization			
	recognized for this purpose. Has completed at			
	least 900 hours of supervised dietetics practice			
	under the supervision of a registered dietitian or			
11	nutrition professional. Is licensed or certified as a			ŀ
	dietitian or nutrition professional by the State in			
	which the services are performed"			
1	No further information was presented prior to exit.			
	Constaint definiency			
E 812	Complaint deficiency. Food Procurement, Store/Prepare/Serve-Sanitary	F 812	1. Certified Dietary Manager/Cook has 12/2	5/2022
	CFR(s): 483.60(i)(1)(2)	, 5,2	performed a walk-through inspection and	
00 -	07 1 (d): 400.00(i)(1)(2)	ĺ	discarded expired items, has ensured all	ł
	§483.60(i) Food safety requirements.		products were properly stored and	l
	The facility must -		dishwasher is in good repair. It is the	
	•		policy of Holly Manor Rehab and Nursing	- 1
	§483.60(i)(1) - Procure food from sources		to ensure food is procured, stored, and	
	approved or considered satisfactory by federal,		prepared in a sanitary manner and	
	state or local authorities.		dishwasher is in good repair. Auto-Chlor	
	(i) This may include food items obtained directly		performed inspection of dishwasher.	1
	from local producers, subject to applicable State		Residents receiving meals from the	
	and local laws or regulations.		kitchen have the potential to be affected	ŀ
			by this alleged deficient practice.	
			The Certified Dietary Manager/designee	i
			has performed morning and evening	
			walk-through inspections of both facility	
			kitchens to ensure expired items have	
			been discarded, products properly stored,	
			and dishwasher is in good repair. Any	1
			items found out of compliance have been	
			corrected.	
			3. The Certified Dietary Manager/designee	
		ļ	has re-educated dietary staff on	
			discarding expired items, the proper	
			storage of items, and dishwasher machine	
			use as per policy.	
			4. Certified Dietary Manager/designee will	
			perform AM/PM walk-through audits 5x	ŀ

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES		FORM APPROVED			
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	. 0938-0391
					per week for 4 weeks and then we	ekly for	i
				1	2 months to ensure expired items	have	
					been discarded, products properly	stored,	
					and dishwasher is in good repair.	Any	
]		variances identified will be immed	' '	
					corrected and further education w		
İ					provided to staff regarding prever	ition of	
			ĺ		these variances. Certified Dietary		
					Manager will present audit finding any trends/patterns to the QAPI	gs and	
					committee on a quarterly basis.		
					5. Date of Compliance: 12/25/2022		
			L				
CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			PLETED
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		495339	B. WING			11/	17/2022
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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HOLLY	IANOR REHAB AND N	JRSING		F	ARMVILLE, VA 23901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
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		·				
F 812			F 812	2	1	
	Continued From page	0.112				
	Continued From pag					
		es not prohibit or prevent				
		produce grown in facility				
		ompliance with applicable				- 1
		od-handling practices. (iii)				
		not preclude residents from				
	consuming foods not	t procured by the facility.				ĺ
	8.400.00(i)/0) Ohnun	managa diatributa and				
		prepare, distribute and ance with professional				- 1
	standards for food se	•			ļ	
		is not met as evidenced				
	by:	13 Hot met as evidenced				i
i		ns, staff interview, and				i
		iew, it was determined that			J	
	· ·	to properly store food				
	-	n refrigerator, discard			1	
		aintain the dishwasher in			1	
		two kitchens in the facility.				
	good topan in one of	tivo kilonono in alo racinty.				i
ŀ	The findings include:			""		
	On 11/14/2022 at 6:3	7 p.m., an observation of the				
	kitchen on the Grace	unit was conducted with				
	OSM (other staff mer	mber) #8, dietary cook.				
		alk in refrigerator revealed a				
	12 pound container of	of homestyle potato salad				
	with a use by date of	10/25/2022 on the lid. The		li li		1
	container was observ	ed to be unopened. OSM				
ŀ		ainer and stated that the				
		and needed to be thrown				
	•	d that the container was				
		servation of the walk in		E		
) pound box of diced grilled				
		on the freezer floor, a 16.72				
		eady four cheese pizzas				
		floor and a 10 pound box of				
		freezer floor. OSM #8				
		ot have a lot of room in the boxes should not be stored				
	meezer, nowever uie	boxes should not be stored				
CTATT::	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA* IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>		PLETED
	5					c
		405000	6 140016			17/2022
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HAME OF F	MOVIDER ON OUR FEIGH					
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HOLLY MANOR REHAB AND NURSING				·		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
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CENTER	S FOR MEDICALE & MEDICALD DELIVICES			. 0000 000 .
F 812		F 812		
	Continued From page 113 on the floor.			
	• •			
	Observation of the dishwasher on the Grace unit			
	revealed a plaque on the outside of the	1		
	dishwasher documenting a minimum water			
	temperature of 120. Observation of three			
	dishwasher cycles revealed the highest			
	temperature observed on the dishwasher			
	temperature gauge to be 116 during the cycles.	1		
	OSM #8 was asked to confirm the temperature			
	during the dishwashing cycle and stated that			
	they could not see the gauge very well because			
	it was low to the ground and very small. OSM #8			
i	stated that the gauge did not appear to be	1		
	getting to the temperature and they would report			
1	this to the supervisor. OSM #8 stated that the	1		
	dishwasher had recently been repaired and they			
	frequently had issues with it.			
	Trequently flad issues with it.			
	On 11/15/2022 at 8:42 a.m., an observation of			
	the Grace unit dishwasher was made with OSM			
	#2, the director of maintenance and OSM #7, the			
	assistant dietary manager. OSM #2 stated that	1 1		
	the dishwasher was leased from the vendor and			
	they had multiple problems with getting service	1	ļ	
	from them. OSM #7 proceeded to run the			
ł	dishwasher and observed the temperature gauge		28	
	staying below 120 during the cycle. OSM #2			
	stated that the dietary staff had a thermometer	\$P		
	that could be used to check the temperature			
	during the wash if the gauge was not showing the			
	required temperature. OSM #2 and OSM #7			
	were made aware of the observations on			
	11/14/2022 and OSM #7 stated that they would			
	educate their staff on reading the gauge and			
	using the thermometer to confirm the water			
	temperature. OSM #2 provided a thermometer			
	and checked the water temperature during the			
	dishwasher cycle which showed 122.4 on the	V		
1	thermometer and 115 on the dishwasher			
	temperature gauge. OSM #2 stated that it			'
	tomporatare gauge. Comine contra and the			
	DOCUMENT TO THE PROPERTY OF TH	(X2) MULTIPLE CONSTRUCTION	(X3) DATE	SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) IDENTIFICATION	PROVIDER/SUPPLIER/CLIA ON NUMBER:	l`'	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
38							C	
			495339	B. WING		11/	/17/2022	
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR REHAB AND NURSING					STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREF TAG		D BE	(X5) COMPLETION DATE	

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 812			F 812				
	Continued From pag	e 114 appeared that the					
	temperature gauge v	vas not accurate on					
	machine and they no	eded to call the vendor to					
	come in. A request v	vas made to OSM					
	#2 and OSM #7 for th	ne manufacturers					
		nd the past three months of	1				
	temperature logs for	the dishwasher.					
	Review of the temper	rature logs dated 9/1/2022-					
		by OSM #2 documented the					
		ture at 120 degrees or above					
	daily for breakfast, lu	nch and dinner.					
	On 11/15/2022 at app	proximately 1:30 p.m., OSM					
	#2 provided instruction						
		cumented in part, "Water					
	supply temp 140 [deg			20			
		[degrees] F Minimum Water					
	Temperature)"			,			
	The facility policy "Di	shwashing Machine Use"					
		"Food Service staff required					
		ashing machine will be					
	•	dishwashing machine use	1		i		
		a designee proficient in all					
	aspects of proper use	e and sanitation7. The emperatures using the					
	•	each dishwashing machine					
		the results in a facility					
		erator will monitor the gauge					
		hwashing machine cycle.					
	Inadequate temperat	ures will be reported to the					
	supervisor and corre	cted immediately"		,			
		7 p.m., ASM (administrative					
		e interim administrator and of nursing were made aware			28		
	of the findings.	or harsing were made aware					
	a.oa.iigoi						
					 		_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, , , , , , ,	E CONSTRUCTION		SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		I COM	PLETED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA		TIPLE CONSTRUCTION JING		(X3) DATE SURVEY COMPLETED	
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		495339	B. WING		11/	17/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HOLLYM	IANOR REHAB AND N	JRSING		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		D BE	(X5) COMPLETION DATE	
F 812	· · ·	e 115 on was provided prior to exit.	F	812			

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F 839 Staff Qualifications SS=E CFR(s): 483.70(f)(1)(2)

> §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a fulltime, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.

§483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to evidence maintenance of required certification for five of five CNA (certified nursing assistant) record reviews.

The findings include:

The facility staff failed to provide the evidence of required certification for five of five CNAs that were employed for greater than on year, CNA #1, CNA #2, CNA #3, CNA #4 and CNA #5.

During the Sufficient and Competent Staffing facility task review on 11/15/22 at 3:00 PM revealed that the following CNA certifications were verified after expiration from the Virginia Department of Health Professions (DHP) as follows:

1. CNA #1 with a date of hire of 6/1/15, the previous certification expired 8/31/22, however

Professional certifications have been verified and copies are on file in the facility for CNA #1, CNA #2, CNA #3, CNA #4 and CNA #5.

F 839

- 2. An audit has been performed on all CNA professional certifications. All CNAs have copies of their current professional certifications in their personnel record.
- 3. The Administrator/Designee has inserviced Human Resource Director on the importance of verification of professional certifications upon hire and maintaining copies of the professional verification in the personnel records.
- 4. The Administrator/Designee will conduct an audit of 10% of CNA personnel records weekly for 4 weeks and then monthly x2 months to ensure that their professional certifications are current and valid. The Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.
- 5. Date of Compliance: 12/25/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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l			495339	B. WING			11/	17/2022
r	NAME OF PROVIDER OR SUPPLIER				STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	HOLLY MANOR REHAB AND NURSING					COBB STREET RMVILLE, VA 23901		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

F 839			F 83	39					
	Onetime d Francisco	446							
	obtained from the DF	e 116 verification was not							
		a date of hire of 11/17/20, the							
		expired 3/31/22, however						- 1	
	, ,	btained from the DHP until							
	4/18/22.								ŀ
		a date of hire of 3/16/92, the							
		expired 8/31/22, however							
		btained from DHP until 9/8/22. a date of hire of 5/27/13, the							
		expired 8/31/22, however							
		btained from DHP until							
	10/6/22.								
		a date of hire of 8/18/97, the							
	•	expired 12/31/21, however							
	verification was not o	btained from DHP until							
	4/10/22.								
	On 11/15/22 at 3:00 F	M, OSM #5, the human					100		
	resources manager s	tated, we do not have any						.	
		views. I have been auditing						Ш	
		any missing items and I have						10	
		ing the files correct. I know be pulled from the Virginia							
		Professions site prior to the							
	end of the month of e	-							
		PM, ASM (administrative administrator and ASM #2,							
		was made aware of the							
	findings.	, was made aware or are		ŀ					
	J			-					
	A review of the facility								
		stration of Personnel" policy							
		d, "A copy of the current or registration must be filed							
		rsonnel record. A copy of						ļ	
	the recertification mu								
			(X2) MUI TI	PLE CONS	TRUCTION				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN						SURVEY PLETED
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i		495339	B. WING						17/2022
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HOLLYM	ANOR REHAB AND NU	IRSING		FARMV	ILLE, VA 239	101			

(X5)

COMPLETION DATE

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

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PREFIX

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

CENTERS	S FOR MEDICARE & MEDICAID SERVICES		OND NO	. 0936-0391
F 839	Continued From page 117 expiration of current licensure, certification or registration." No further information was provided prior to exit. QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) \$483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: \$483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; \$483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; \$483.75(a)(3) Present its QAPI plan to a State	F 839	 It is the policy of Holly Manor to maintain systems and processes to ensure that the quality assurance/performance improvement programs identifies and addresses issues and/or risks and implements corrective action plans as necessary according to CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(1). All residents have the potential to be affected by this alleged deficient practice A QAPI program has been maintained since August 2022. The Regional Director of Operations has educated the Administrator on duties and compliance with maintaining the QAPI program according to CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(I). The Regional Support Staff/Designee will review the QAPI program documentation monthly for 6 months to ensure that the QAPI program is maintained as mandated. Administrator/Designee will correct any variances identified until substantial compliance is achieved. Results of audits will be shared with the QAPI committee. Any patterns or trends will be reported to the Quality Assurance and Performance 	12/25/2022
	identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the		4. The Regional Support Staff/Designee will review the QAPI program documentation monthly for 6 months to ensure that the QAPI program is maintained as mandated. Administrator/Designee will correct any variances identified until substantial compliance is achieved. Results of audits will be shared with the QAPI committee.	
	§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			4 ' ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		495339	B. WING		11/17	7/2022	
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR REHAB AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	· · · · · · · · · · · · · · · · · · ·	.D BE	(X5) COMPLETION DATE	

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	OT OTTIME DIONIA A	MEDIONID GERVICES			OND 140. 0330-0331
F 865	Continued From page ongoing QAPI prograthe facility's complianted State Survey Agency upon request. §483.75(b) Program facility must design in ongoing, compreher full range of care and facility. It must: §483.75(b)(1) Address management practice facility. It must:	e 118 evidence of its am's implementation and noe with requirements to a r. Federal surveyor or CMS design and scope. A is QAPI program to be asive, and to address the diservices provided by the ses all systems of care and ses; e clinical care, quality of life,	F &	365	OMB NO. 0330-0331
	to define and measu facility goals that refl facility operations tha	the best available evidence re indicators of quality and ect processes of care and at have been shown to be outcomes for residents of a			
	§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.			Ξ	
	(or organized group full legal authority and	ice and leadership. and/or executive leadership or individual who assumes d responsibility for operation onsible and accountable for		III	
		oing QAPI program is d, and maintained and priorities.			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUIDENTIFICATION NUMBER:	Al`í	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495339	B. WING		C 11/17/2022
	PROVIDER OR SUPPLIER ANOR REHAB AND N	JRSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901	_ 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPLETION

DEFICIENCY)

Facility ID: VA0291

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F 865		F 865			
	Continued From page 119				
	§483.75(f)(2) The QAPI program is sustained				
	during transitions in leadership and staffing;				
	§483.75(f)(3) The QAPI program is adequately				
	resourced, including ensuring staff time,				
	equipment, and technical training as needed;				
	3				
	§483.75(f)(4) The QAPI program identifies and				
	prioritizes problems and opportunities that reflect				
	organizational process, functions, and services				
	provided to residents based on performance				
	indicator data, and resident and staff input, and				
	other information.				
	§483.75(f)(5) Corrective actions address gaps in				
	systems, and are evaluated for effectiveness; and				
	8	l			
]	§483.75(f)(6) Clear expectations are set around				
	safety, quality, rights, choice, and respect.				
	§483.75(h) Disclosure of information. A State				
	or the Secretary may not require disclosure of				
	the records of such committee except in so far				
	as such disclosure is related to the			,	1
	compliance of such committee with the				
	requirements of this section.				
	§483.75(i) Sanctions.				1
	Good faith attempts by the committee to identify				
	and correct quality deficiencies will not be used as				
	a basis for sanctions.		*		
	This REQUIREMENT is not met as evidenced				
	by:				
	Based on staff interview and facility document				
	review, the facility staff failed to implement a				
	QAPI (Quality Assurance and Performance				
	Improvement) program potentially affecting all		ð:		
	residents in the survey sample.				
	The findings include:		<u></u> .		<u> </u>
		(V2) MILITER	E CONSTRUCTION		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		71			C	•
		495339	B. WING		11/1	17/2022
	PROVIDER OR SUPPLIER	JRSING	<u>-</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		D BE	(X5) COMPLETION DATE	

Event ID:BCJ811

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F 865		F 865		
	Continued From page 120			
	The facility staff failed to provide evidence of a QAPI program prior to August 2022.			
	On 11/17/22 at 10:24 a.m., ASM (administrative staff member) #2, the director of nursing (hired on 7/25/22), stated she could not provide evidence of any QAPI program/documentation prior to August 2022. ASM #2 stated the QAPI program is supposed to consist of identifying issues through concerns from department heads and their staff, the concerns should be taken to the QAPI meetings, the QAPI team should develop action plans, staff should be educated, processes should be implemented, the plan should be evaluated, and if the plan is not working then new interventions should be started. On 11/17/22 at 12:55 p.m., ASM #4, the interim administrator and ASM #2 were made aware of the above concern.			
	The facility policy titled, "Quality Assurance Performance Improvement (QAPI) Committee" documented, "The facility will maintain systems and processes to ensure that the quality assurance/performance improvement program identifies and addresses issues and/or risks and that implements corrective action plans as necessary"			
F 867 SS=F	No further information was presented prior to exit. QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867	 It is the policy of Holly Manor to maintain systems and processes to ensure that the quality assurance/performance improvement programs identifies and addresses issues and/or risks and implements corrective action plans as necessary according to CFR(s): 483.75(c)(d)(e)(g)(2)(I)(ii). All residents have the potential to be affected by this alleged deficient practice A QAPI program has been maintained since August 2022. The Regional Director of Operations has educated the Administrator on duties and compliance with maintaining the QAPI program according to CFR(s): 483.75(c)(d)(e)(g)(2)(I)(ii). The Regional Support Staff/Designee will review the QAPI program documentation monthly for 6 months to ensure that the QAPI program is maintained as mandated. Administrator/Designee will correct any 	12/25/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES variances identified until substantial compliance is achieved. Results of audits will be shared with the QAPI committee. Any patterns or trends will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly. Date of Compliance: 12/25/22 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIDENTIFICATION NUMBER: PROVIDER/SUPPLIER/CUA COMPLETED A. BUILDING _ AND PLAN OF CORRECTION C 11/17/2022 495339 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901 HOLLY MANOR REHAB AND NURSING PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ΙD (X5) 7X41 ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)

PRINTED: 12/05/2022

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F 867	" "		F 867		
	procedures for feedb	ack, data collections			
	systems, and monito	ring, including adverse			
	event monitoring. Th	e policies and			
	procedures must incl	lude, at a minimum, the			
	following:				
	_				
	§483.75(c)(1) Facility	maintenance of effective		ľ	
	systems to obtain an	d use of feedback and input			
	from direct care staff	, other staff, residents, and			
		ves, including how such			
		sed to identify problems that		1	
		lume, or problem-prone, and			
	opportunities for imp	rovement.			
		maintenance of effective		₹	
		ollect, and use data and			
		departments, including but			
		lity assessment required at			
	, ,	ding how such information			
		pp and monitor performance			į
	indicators.				
	6483 75(c)/3) Facility	development, monitoring,			
		rformance indicators,		_	
		ology and frequency for such			
	development, monito				
	development, monte	mig, and evaluation.			
	8483 75(c)(4) Facility	adverse event monitoring,		11	
		s by which the facility will			
	_	y, report, track, investigate,			
		a and information relating to			i i
		facility, including how the			
		ita to develop activities to			
	prevent adverse ever	-	1		
	•			790	
	§483.75(d) Program	systematic analysis and			
	systemic action.				
Į					
				FOONOTHOTON	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	l ` <i>'</i>	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
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HOLLY M	ANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901	7
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	IĐ	PROVIDER'S PLAN OF CORRECTION	
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F 867	400	F 867	
	Continued From page 122		
	§483.75(d)(1) The facility must take actions		
	aimed at performance improvement and, after		
	implementing those actions, measure its success,		
	and track performance to ensure that		
	improvements are realized and sustained.		
	§483.75(d)(2) The facility will develop and		
ľ	implement policies addressing:		
	(i) How they will use a systematic approach		
	to determine underlying causes of problems		
	impacting larger systems;		
	(ii) How they will develop corrective actions		·
	that will be designed to effect change at the		
	systems level to prevent quality of care, quality of		
	life, or safety problems; and		
	(iii) How the facility will monitor the		
	effectiveness of its performance improvement		
	activities to ensure that improvements are		
	sustained.		
	§483.75(e) Program activities.		
	0.000 TS(. Ma) The Security countries and adjusted for its		
	§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on		
	high-risk, high-volume, or problem-prone areas;		
	consider the incidence, prevalence, and severity		
	of problems in those areas; and affect health		
19	outcomes, resident safety, resident autonomy,		
	resident choice, and quality of care.		
	Todicolit Ollologi alla quality of care		
	§483.75(e)(2) Performance improvement		
	activities must track medical errors and adverse		
1	resident events, analyze their causes, and		
	implement preventive actions and mechanisms		
1	that include feedback and learning throughout the		
	facility.		
	§483.75(e)(3) As part of their performance		
	improvement activities, the facility must conduct		
	,	<u> </u>	 L

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA)		l ` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	BE COMPLETION	

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F 867			F 867			
	0	400 distinct conferences				1
		e 123 distinct performance				
	improvement project					
	frequency of improve	ement projects conducted				
	by the facility must re	eflect the scope and				
	complexity of the fac-	ility's services and				
		as reflected in the facility				
	assessment required					
		- ' '				ļ.
		s must include at least				
		at focuses on high risk or				į
		s identified through the				ŀ
	data collection and a	nalysis described in				
	paragraphs (c) and (c	d) of this section.				
		· l		0		
	6483 75(a) Quality as	ssessment and assurance.		707		
	3400:10(g) dadanty ac	ooooni on ana accaratico.				
	0400 75/m\/0\ The av	elibe accessment and				
		uality assessment and				
	6	e reports to the facility's				. 11
	governing body, or de				53	× .
	functioning as a gove	eming body regarding its				
	activities, including in	nplementation of the QAPI				
		der paragraphs (a) through				
	(e) of this section. The					
	(0) 01 1110 00000111 111	0 00111111100				
	(ii) Develop and impl	ement appropriate plans of			ı	
		tified quality deficiencies;			i	
		· · · · · · · · · · · · · · · · · · ·				
		and analyze data, including				
		the QAPI program and data				
		egimen reviews, and act on				
	available data to mal			İ		
	This REQUIREMENT	is not met as evidenced				
	by:					
		riew and facility document				- 1
		aff failed to implement				- 1
	policies and procedu					
i						
		ormance Improvement)				
		ata systems and monitoring				1
		all residents in the survey				ì
	sample.					
	The findings include:				ļ	
			(X2) MULTIPI	E CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(· -, · · · · · · · ·			SURVEY PLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	· · · · · · · · ·		
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	190	495339	B. WING		11/	17/2022
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HOLLY N	IANOR REHAB AND NU	JRSING		FARMVILLE, VA 23901		
7/4/15	CHAMADV STA	TEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	Į.	(X5)
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				DEFICIENCY)		

F 867		F 867	- "	
	Continued From page 124			
	The facility staff failed to implement policies and			
	procedures for a systematic approach to			
	determine underlying causes of problems		2	
	impacting larger systems, corrective action and			
	monitoring of the effectiveness of performance			
	improvement activities prior to August 2022.			
	Improvement addition prior to ragast 2022.			
	On 11/17/22 at 10:24 a.m., ASM (administrative			
	staff member) #2, the director of nursing (hired			
	on 7/25/22), stated she could not provide			
	evidence of any QAPI program/documentation			
	prior to August 2022. ASM #2 stated the QAPI			
	program is supposed to consist of identifying			
	issues through concerns from department heads			
	and their staff, the concerns should be taken to			
	the QAPI meetings, the QAPI team should			
	develop action plans, staff should be educated,		i	
	processes should be implemented, the plan			
	should be evaluated, and if the plan is not			
	working then new interventions should be started.		i	
	In regards to determining underlying causes of			
	problems impacting larger systems, corrective			
	action and monitoring of the effectiveness of			
	performance improvement activities, ASM #2			
	stated the QAPI team completes a root cause			
	analysis, implements the action plan, includes			
	floor staff when working the action plan then			
İ	follows up and verifies the results.			
	0 444700 14085 u u 4084#4 #h a intenim			
	On 11/17/22 at 12:55 p.m., ASM #4, the interim			
	administrator and ASM #2 were made aware of			
	the above concern.			
	The facility policy titled, "Quality Assurance and			
	Performance Improvement (QAPI) Program-			
Ì	Governance and Leadership" documented, "4.			
,	The responsibilities of the QAPI committee are to:			
	a. Collect and analyze performance indicator data			
	di namenamenta amanta amanta manana amanta a			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION JING		E SURVEY MPLETED
			:			С
		495339	B. WING		11/	/17/2022
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY MANOR REHAB AND NURSING				2003 COBB STREET FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	• • • • • • • • • • • • • • • • • • • •	ULD BE COMPLETION	

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F 867			F 867			
F 867	monitor and improve processes that support services; c. Identify a outcomes and/or car during the QAPI processes to help ident point to underlying sydepartments, consulting the ment systems to issues in quality of care	n. b. Identify, evaluate,	F 867			
F 868 SS=F	implementation, more performance improves specific goals" No further information QAA Committee	ordinate the development, intoring, and evaluation of ement projects to achieve on was presented prior to exit. (i)-(iii)(2)(i); 483.80(c)	F 868			
	§483.75(g) Quality as §483.75(g) Quality as §483.75(g)(1) A facil assessment and ass at a minimum of: (i) The director (ii) The Medical designee;(iii) At least facility's staff, at least administrator, owner	ssessment and assurance. ssessment and assurance. ity must maintain a quality urance committee consisting of nursing services; Director or his/her t three other members of the t one of who must be the , a board member or other riship role; and (iv) The		- 47	N	1
	assurance committee governing body, or d	uality assessment and ereports to the facility's esignated person(s) erning body regarding its	Ш			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIEVOLIA IDENTIFICATION NUMBER:	l ' '	E CONSTRUCTION	COM	SURVEY PLETED
		495339	B. WING			17/2022
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F 868		F 868		
_				
}	Continued From page 126 activities, including			
	implementation of the QAPI program required			
	under paragraphs (a) through (e) of this section.		- F	
	, - , , , , , , , , , , , , , , , , , , ,			
	The committee must: (i) Meet at least quarterly			
	and as needed to coordinate and evaluate			
	activities under the QAPI program, such as			
	identifying issues with respect to which quality			
	assessment and assurance activities, including			
1	performance improvement projects required			
	under the QAPI program, are necessary.			
			3	
	§483.80(c) Infection preventionist participation on			
	quality assessment and assurance committee.			
	The individual designated as the IP, or at least			
	one of the individuals if there is more than one IP,			
	must be a member of the facility's quality			
	assessment and assurance committee and report			
	to the committee on the IPCP on a regular basis.			
	This REQUIREMENT is not met as evidenced			
	by:			
	Based on staff interview and facility document			
	review, the facility staff failed to conduct required		i	
	QAPI (Quality Assurance and Performance			
	Improvement) meetings potentially affecting all			
	residents in the survey sample.			
			1	
	The findings include			
	The facility staff failed to evidence quarterly QAPI			
	meetings were conducted prior to August 2022.			
	- 444700 44004 4014 (-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1			
	On 11/17/22 at 10:24 a.m., ASM (administrative			
	staff member) #2, the director of nursing (hired			
	on 7/25/22), stated she could not provide			
	evidence of any QAPI meetings prior to August			
	2022. ASM #2 stated the QAPI committee			
	should meet quarterly and consists of the social			
	worker, director of nursing, administrator, dietary		į į	
	manager, activities director, laundry manager, a			
			ACUATRICATION	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA)		M ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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		495339	B. WING			/17/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR REHAB AND NURSING FARMVILLE, VA 23901					ODE	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE

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Continued From page 127 CNA (certified nursing assistant) and the medical director. On 11/17/22 at 12:55 p.m., ASM #4, the interim administrator and ASM #2 were made aware of the above concern. The facility policy titled, "Quality Assurance Performance Improvement (QAPI) Committee" documented, "4. The facility will maintain a QAPI committee consisting at a minimum of: a. The director of nursing service; b. The medical director or his or her designee; c. The facility Infection Preventionist; d. At least three other members of the facility's staff, at least one of whom must be the administrator, owner, a board member or other individual in a leadership role6. The committee will meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program" No further information was presented prior to exit. Infection Prevention & Control SSS=F 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	5/2020
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comfortable environment and to help prevent the a. Training: Holly Manor Healthcare	
diseases and infections. prevention program to include	
surveillance, tracking, and	
§483.80(a) Infection prevention and control trending of infection. Licensed	
program.	
The facility must establish an infection prevention nursing staff (RN and LPNs)	
and control program (IPCP) that must include, at including the nursing	
a minimum, the following elements: administration have been	
educated on the infection	
prevention program to include	
surveillance, tracking and	
trending infections. Staff	
competency validated by the	
Director of Nursing and/or	
Infection Preventionist	
2.) Holly Manor will have two licensed	
nursing staff with Infection	
Preventionist Implementation: The	
facility has implemented an	
appropriate infection and intervention	
plan consistent with the requirements	
of 42 CFR 483.80 for the affected	

new or changed cough and sore throat.

c. The facility has developed and implemented an infection sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection. Nursing leaders trained

on how to use tools.

d. Facility staff educated on using PPE related to droplet precaution. Demonstration and knowledge check testing completed on

3.) Systemic changes:

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facility staff. Infection Preventionist completed training in CDC training in order to help facilitate enhanced compliance with infection control and prevention. Completion date of CDC training 12/15/2022.

- 4.) The charge nurse or designee will complete documentation on all residents and staff infections on the facility infection tracking log. Compliance and review of the infection control log will be completed by the infection Preventionist 5 times a week. Monitoring:
 - g. Facility will always ensure adequate supplies of PPE readily available to all staff and applicable to their duties and responsibilities. The facility will calculate PPE usage weekly and with any significate changes that may occur. Any disruption to the chain of supply, the State Agency will be notified immediately, upon facility notice of such disruption.
 - h. The Infection Preventionist and Director of nursing will review the infection prevention, line listing when applicable, tracking and trending by reviewing antibiotic usage, and antibiotic timeout assessments five times a week and more often as necessary. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control infection. Such monitoring will continue until the facility has been infection free for at least four weeks. i. The Infection preventionist, Director of Nursing and other nursing leadership will conduct rounds throughout the facility to ensure the facility staff is using PPE appropriately and ensure infection control procedures are followed on each unit. Ad hoc education will be provided to staff who are not correctly utilizing equipment and/or infection control practices. Monitoring will be 5 times

a week for 4 weeks, then 3 times a

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES week for 4 weeks, then weekly for 4 weeks, then monthly times 2 months. Findings will be discussed with the QAPI committee on at least a quarterly basis. 6) An RCA (Root Cause Analysis) was completed Infection with assistance from the Preventionist. Quality Assurance Performance Improvement (QAPI) committee and Governing Body. The RCA was incorporated into the intervention plan 7) Date of compliance: 12/15/22 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES A. BUILDING _ COMPLETED AND PLAN OF CORRECTION С 11/17/2022 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET **HOLLY MANOR REHAB AND NURSING** FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

DEFICIENCY)

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CENTER	S FOR MEDICARE & N	MEDICAID SERVICES			OMB MO. 0330-0391
F 880	Continued From page	e 128	F 880		
	reporting, investigatir and communicable d staff, volunteers, visit providing services un arrangement based u	upon the facility assessment to §483.70(e) and following			
	procedures for the pr but are not limited to: (i) A system of	surveillance designed to			
	infections before the persons in the facility (ii) When and to communicable disea	•			
	precautions to be foll infections; (iv)When a used for a resident; in (A) The type and dura	d transmission-based owed to prevent spread of and how isolation should be acluding but not limited to: ation of the isolation, affectious agent or organism		_	
	(B) A requirement that least restrictive possi circumstances. (v) The circumstance	at the isolation should be the ble for the resident under the s under which the facility		11	
	disease or infected s contact with residents contact will transmit t	procedures to be followed			
_					
			1 //0(1411) 500-	E CONSTRUCTION	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495339	B. WING		11/17/2022
NAME OF	PROVIDER OR SUPPLIER	49999		TREET ADDRESS, CITY, STATE, ZIP CODE	
	IANOR REHAB AND N	URSING	2	003 COBB STREET FARMVILLE, VA 23901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE COMPLETION

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F 880		F 880	
	Continued From page 129		
	§483.80(a)(4) A system for recording incidents		
	identified under the facility's IPCP and the		
	corrective actions taken by the facility.		
	\$492.90(a) Linana		
	§483.80(e) Linens. Personnel must handle, store, process, and		
	transport linens so as to prevent the spread of		
	infection.		
	§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		ļ
	by:		ļ
	Based on staff interview and facility document		
	review, it was determined the facility staff failed to		
	implement an ongoing infection prevention and		
	control program (IPCP) potentially affecting all residents in the survey sample.]	
	Tesidents in the survey sample.		
Ï	The findings include:		
	There were no infection control tracking logs		
	available for review.		
	Upon entrance on 11/14/2022 a request was		
	made for the infection control tracking logs. A second request was made on 11/16/2022.	 	
	Second request was made on 11/10/2022.		
	ASM (administrative staff member) #2, the		
	director of nursing, stated on 11/16/2022 at 5:25	- W	ļ
	p.m. the facility has no infection control tracking		
	logs before August 2022. They presented a		
	notebook with the floor plans of the facility. It had colored lines on rooms with infections.		
	Colored lines of rooms was allocatorio.		
	On 11/17/2022 at 10:08 a.m. an interview was		
	conducted with ASM #2, and ASM #3, the		
	assistant director of nursing. When asked if they	<u></u>	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA)		(X2) MUI	TIPLE CONSTRUCTION JING		(X3) DATE SURVEY COMPLETED	
l							С
۱			495339	B. WING		11.	/17/2022
ŀ	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HOLLY MANOR REHAB AND NURSING					2003 COBB STREET FARMVILLE, VA 23901	_	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	*	LD BE	(X6) COMPLETION DATE

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F 880	Continued From page	120	F 880			i
	Continued From page			275		5
		e infections in the facility				
		s, source, culture results				
		SM #2 stated, no. When				
		tracking and trending				
		ty, ASM #2 stated they				
		what organism is being				
		is a pattern on a particular				
		shift. When asked where				
		SM #2 stated she hadn't				
		trending of infections				
		end of July. When asked if				{
		cking and trending logs,				
	ASM #3 stated, in the					
	acting director of nurs	sing, she did not see any				
	logs.					
	The facility policy, "Su	urveillance for \Infections"				
	documented in part, "					
		ee] will conduct ongoing				
		hcare-associated infections				
		emiologically significant				ŀ
	infections that have s	- · · · · · · · · · · · · · · · · · · ·				
		s comes and that may				1
		-based precautions and				l [
		erventionsGathering				
		The infection preventionist				
		on control personnel is				
1	responsible for gathe					1 {
	surveillance dataDa					
		idents with infections that				
		efinition of infection for				
	surveillance, collect to			ļ		
		fying information (i.e.,				, ,
		, room number, unit and				! !
		a. Diagnosis, b. Admission				1
	date, date of onset of	infection (may list onset of				
		or date of positive diagnostic				
]	test), c. Infection site	(be as specific as possible,				
	e.g., cutaneous infec	tions should be listed as				
		oot, " pneumonia as right		<u></u>		<u> </u>
			(X2) MIII TIPI	E CONSTRUCTION	1.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY MPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		l	1
						c
		495339	B. WING			/17/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
1			1 2	1003 CORR STREET		

FARMVILLE, VA 23901

Facility ID: VA0291

ID

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X5)

COMPLETION

HOLLY MANOR REHAB AND NURSING

(X4) ID PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 880		F 880		
F 881	Continued From page 131 upper lobe, etc.) d. Pathogens. e. Invasive procedures or risk factors (i.e., surgery, indwelling tubes, Foley, fractured hip, malnutrition, altered mental status). f. Pertinent remarks (additional relevant information; (temperature, other symptoms of specific infection, white blood cell count, etc.) Also, record if the resident is admitted to the hospital or expires). g. Treatment measures and precautions (interventions and steps taken that may reduce risk). h. Using the current suggested criteria for healthcare-associated infections, determine if the resident has a healthcare-associated infectionMonthly - 1. Collect information from individual resident infection reports and enter line listing of infections by resident for the entire month. 2. Summarize monthly date for each nursing unit buy site and by pathogen (e.g., facility-wide Monthly Infection Report by Site, Facility-Wide Monthly Infection Report by Pathogen, or similar form). ASM #3, the director of nursing, and ASM #4, the interim administrator, were made aware of the above concerns on 11/17/2022 at 12:06 p.m. No further information was obtained prior to exit. Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a	F 880		2/25/2022
			to, the importance of antibiotic stewardship in infection control, and the individual responsibilities of nurses in	

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM	APPROVED
CENTER	S FOR MEDICARE & N	MEDICAID SERVICES			OMB NO	. 0938-0391
				with the antibiotic stewardship pro	ogram.	
				Results of audits will be shared wi	ith the	
				QAPI committee. Any patterns or t	trends	
				will be reported to the Quality Ass	urance	
				and Performance Improvement		
				Committee at least quarterly.		
				5. Date of Compliance: 12/25/22		
				•		-
						-
	<u> </u>				i	
			(X2) MULTIPLE	E CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		(X3) DATE	SURVEY PLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BOILDING			
						· I
		495339	B. WING		11/1	7/2022
NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				003 COBB STREET		
HOLLYM	ANOR REHAB AND NU	JRSING	F	ARMVILLE, VA 23901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I		COMPLETION DATE
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F 881			F 8	881			
	Continued From pag	a 132					
	· -						1
ļ	system to monitor an						T
		is not met as evidenced					
	by:						
		view and facility document					
		ined the facility staff failed to	ŀ				
		antibiotic stewardship					
	program.						
•	The findings include:	:					
	,						
		entation of any antibiotic	1				
	stewardship program	1.	ľ	_			
	414	44.0000					
		/14/2022 a request was	1				
		f an antibiotic stewardship					ľ
	program.						
	On 11/16/2022 at 5:2	5 p.m. ASM (administrative					
		e director of nursing, stated					
;		cumentation of an antibiotic	l				
		. ASM #2 stated there was					
		ance) documentation prior to					
		M #2 stated she had called					
		stated they (pharmacist) was					
	not allowed to be inve	- "					THE STATE OF THE S
	stewardship program						
	diotraraomp program	20.0.0.					
	An interview was con	ducted on 11/17/2022 at					
	10:08 a.m. with ASM						
		ursing. When asked the					
		otic stewardship program,				Ш	
	ASM #2 stated we se	e if the infections meet the	7.00				
	McGreer's definition	of an infection. We look at					
		a involved, ensure a start,					
		antibiotics, and make sure					
	_	for the infection. When					
		ne use of antibiotics in the				_	
		d they review them in their					
	morning meetings. W	hen asked if the medical					
			(X2) MUL	TIPLE	CONSTRUCTION		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING			SURVEY PLETED
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NAME OF S	POVINED OR SUPPLIED	495339	B. WING	- 91	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	17/2022
IVAME UF F	PROVIDER OR SUPPLIER						
HOLLY M	ANOR REHAB AND NU	IRSING			003 COBB STREET ARMVILLE, VA 23901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION DATE
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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES F 881 F 881 Continued From page 133 director was involved in the antibiotic stewardship program, ASM #2 stated the previous one (medical director) was involved. When asked if the pharmacist was involved in the program, ASM #2 stated, no. When asked if there has been a quality assurance (QA) meeting since she started, ASM #2 stated, yes, two. When asked if the antibiotic stewardship program was discussed it the QA meetings, ASM #2 stated, no. An interview was conducted with ASM #7, the consulting pharmacist for the facility, on 11/17/2022 at 11:04 a.m. When asked if he was involved with the antibiotic stewardship program, ASM #7 stated the previous administration and the current administration have not invited them to the QA meetings. The previous administration held things close to the chest and did not want any outsiders involved. ASM #7 stated the pharmacy is involved with other nursing homes for the antibiotic stewardship program but not at this facility. ASM #7 stated he reviews the antibiotic use when doing his reviews of the medication in use for residents. The facility policy, "Antibiotic Stewardship Program" documented in part, "Policy: The organization is committed to providing sufficient resources to establish and maintain systems and processes for a facility-wide system to monitor the use of antibiotics through an interdisciplinary Antibiotic Stewardship Program...The Antibiotic Stewardship team will analyze infection data (included type of infection or symptoms being treated, antibiotic utilization and adverse outcomes, etc.) monthly and feedback will be provided to the QAPI (quality assurance program improvement) Committee regarding antibiotic stewardship practices...1. The facility will (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 11/17/2022 495339 **B. WING** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET FARMVILLE, VA 23901 HOLLY MANOR REHAB AND NURSING SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID

COMPLETION

DATE

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

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(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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	F 881		F 881		
		Continued From page 134		-	
		establish and maintain and interdisciplinary			
		Antibiotic Stewardship Program that will at a		i	
		minimum include participation by the medical			
		director, prescribing physicians/non-physician			
		practitioners, consulting pharmacist,			
	ı	administrator, nursing leadership, and infection control preventionist. 2. The Antibiotic			
		Stewardship team will meet monthly to review			
		antimicrobial regimens for appropriate: a. Drug			
		[does, duration, route of administration, etc.]. b.	:		
		Indication for use [i.e., type of infection,			
	i	symptoms, prophylactic use, etc.]. d. cultures and			
		sensitivities obtained during review period. e.			
		Person centered precautions/isolation status. f.			
		Clinical assessments. g. Resident response to		=	
		antimicrobial therapy including the development of a secondary infection, allergy, adverse			
		outcomes such as diarrhea, rash, gastritis, etc.			
	i				
		ASM #2, and ASM #4, the interim administrator,	-		
		were made aware of the above findings on			
		11/17/2022 at 12:06 p.m.			
		No fivether information was accorded unless to out		_	
	F 882	No further information was provided prior to exit. Infection Preventionist Qualifications/Role	F 882	1 It is the policy of Helly Manes Debah and	12/25/2022
		CFR(s): 483.80(b)(1)-(4)	1 002	It is the policy of Holly Manor Rehab and Nursing to ensure that the facility has a	122012022
		(=). /=====(=)(*/ (*/		qualified Infection Preventionist.	
		§483.80(b) Infection preventionist The facility		A qualified Infection Preventionist who	
		must designate one or more individual(s) as the		fulfills the requirements has been	
	1	infection preventionist(s) (IP) (s) who are		employed at Holly Manor Rehab and	
		responsible for the facility's IPCP. The IP must:		Nursing on a full-time basis since 7/25/22.	
		§483.80(b)(1) Have primary professional training		3. A new qualified Infection Preventionist	
		in nursing, medical technology, microbiology,		has been designated and the Director of	
		epidemiology, or other related field;		Nursing has trained the individual in	
		37,		responsibilities.	
		§483.80(b)(2) Be qualified by education, training,		The Administrator/Designee will audit IPCP weekly for 4 weeks and then	
				monthly for 2 months to ensure that a	
				qualified Infection Preventionist remains	
				employed at Holly Manor Rehab and	
			1	Nursing. The Administrator/designee will	
				identify any trends and/or patterns, and	
				additional education and training will be	
	ŀ			provided to staff on an ongoing basis.	
				Findings will be discussed with the QAPI	
				committee on at least a quarterly basis.	
				5. Date of Compliance: 12/25/22	
_					

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA

(X1) PROVIDER/SLIDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

(X3) DATE SURVEY

COMPLETED

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

11/17/2022 495339 **B. WING** NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR REHAB AND NURSING FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **DEFICIENCY**) F 882 F 882 Continued From page 135 experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced Based on staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to continuously employ an infection preventionist (IP) potentially affecting all residents in the survey sample. The findings include: The facility staff falled to employ an infection preventionist from 6/18/22 until 7/25/22. A complaint submitted to the state agency on 6/29/22 alleged that as of 6/18/22, there was no one in the facility certified to fill the role of infection preventionist. On 11/16/22 at 5:32 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated she could not provide evidence that the facility employed an infection preventionist with required credentials from the time the former director of nursing left (6/18/22) until she was hired (7/25/22). On 11/17/22 at 12:55 p.m., ASM #4, the interim administrator and ASM #2 were made aware of the above concern. The facility policy titled, "Infection Preventionist" (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 11/17/2022 495339 B. WING

PRINTED: 12/05/2022 **FORM APPROVED**

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR REHAB AND NURSING FARMVILLE, VA 23901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 882 F 882 Continued From page 136 documented, "The Infection Preventionist is responsible for coordinating the implementation and updating of our established infection prevention and control policies and practices..." No further information was presented prior to exit. Complaint deficiency. F 888 COVID-19 Vaccination of Facility Staff F 888 12/25/2022 1. A staff matrix was created to track and SS=C CFR(s): 483.80(i)(1)-(3)(i)-(x) document the COVID-19 vaccination status of contract staff. §483.80(i) The Infection Preventionist/designee has COVID-19 Vaccination of facility staff. The facility reviewed COVID-19 vaccination status for must develop and implement policies and all contract staff of Holly Manor Rehab procedures to ensure that all staff are fully and Nursing. All current contract staff are vaccinated for COVID-19. For purposes of this either vaccinated or have a valid section, staff are considered fully vaccinated if it exemption from vaccination and the has been 2 weeks or more since they completed information has been documented on the a primary vaccination series for COVID-19. The matrix completion of a primary vaccination series for The Administrator/Designee has in-COVID-19 is defined here as the administration of serviced Infection Preventionist on a single-dose vaccine, or the administration of all COVID-19 vaccination for staff. The required doses of a multi-dose vaccine. education includes but is not limited to the importance of tracking and §483.80(i)(1) Regardless of clinical responsibility documenting the COVID-19 vaccination or resident contact, the policies and procedures status of contract staff. must apply to the following facility staff, who The Infection Preventionist /Designee will provide any care, treatment, or other services for perform an audit of vaccination status of the facility and/or its residents: contract staff weekly for 4 weeks and (i) Facility employees; then monthly x2 months to ensure Licensed practitioners; (ii) employees are fully vaccinated or have a Students, trainees, and volunteers; and(iv) (iii) valid exemption documented on the staff Individuals who provide care, treatment, or other matrix. The Infection Preventionist services for the facility and/or its residents, under /Designee will identify any patterns or contract or by other arrangement. trends and report to the Quality §483.80(i)(2) The policies and procedures of this Assurance and Performance Improvement section do not apply to the following facility staff: Committee at least quarterly. Date of Compliance: 12/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HOLLY M	ANOR REHAB AND NU	IRSING		2003 COBB STREET FARMVILLE, VA 23901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 888			F 88	8			
	Continued From page	e 137					
	telemedicine service and who do not have residents and other s (1) of this section; and (ii) Staff who pro- facility that are perfor the facility setting and	ovide support services for the med exclusively outside of a who do not have any direct and other staff specified in			5.		
	include, at a minimur (i) A process for ensignar paragraph (i)(1) of the staff who have pendippeen granted, exemprequirements of this swhom COVID-19 vac delayed, as recommedinical precautions a received, at a minimur vaccine, or the first devaccination series for vaccine prior to staff treatment, or other series residents; (iii) A process for implementation of accinated for COVID-19, for all servaccination status of paragraph (i)(1) of the (v) A process for trace documenting the COVID-19 of the COVID-19 o	r a multi-dose COVID-19 providing any care, provices for the facility and/or r ensuring the Iditional precautions, the transmission and spread staff who are not fully 0-19; (iv) A process for documenting the COVID-19 all staff specified in is section;					
			(X2) MULTI	PLE CONSTRUCTION	(V2) DAT	CLIDVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		IG	(X3) DATE COM	PLETED	
					C		
		495339	B. WING		11/1	7/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET			

FARMVILLE, VA 23901

HOLLY MANOR REHAB AND NURSING

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

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F 888	-		F 888			
	Continued From pag	e 138 as				
	recommended by the					
	•					
	`	which staff may request an				
	· -	staff COVID-19 vaccination on an applicable Federal law;				
	II	or tracking and securely				
		ation provided by those staff			-	1
		, and for whom the facility has				
100	granted, an exemption	· •				i
		on requirements; (viii) A				
		that all documentation,				
	which confirms recog	gnized clinical				
		COVID-19 vaccines and				
	which supports staff					67
		cination, has been signed				
		sed practitioner, who is not				
1		sting the exemption, and				
		heir respective scope of				
		y, and in accordance with, and local laws, and for			1	
	further ensuring that				111	
		mation specifying which of				
	• -	D-19 vaccines are clinically				
		e staff member to receive				
	and the recognized of	linical reasons for the		•		
	contraindications; an	d				
		e authenticating practitioner				
	recommending that t				- 1	
	exempted from the fa					
		ents for staff based on the				
	-	ontraindications; (ix) A the tracking and secure		_		
		e vaccination status of staff			- 51	
	for whom COVID-19					
		as recommended by the				
	CDC, due to clinical;	precautions and				
	considerations, inclu-	ding, but not limited to,	1			
		illness secondary to	- 1			
	COVID-19, and indivi	iduals who received				
			(VO) MIN TOP!	CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		ECONSTRUCTION	(X3) DATE	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		495339	B. WING		11/1	7/2022
NAME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		

HOLLY MANOR REHAB AND NURSING

2003 COBB STREET FARMVILLE, VA 23901

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OMB NO. 0938-0391

CENTERS	S FOR MEDICARE & N	MEDICAID SERVICES			OMB NO.	0938-0391
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ::	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MIE	1
F 888		-	F 888			
						į
	Continued From pag	e 139 monoclonal				
		scent plasma for COVID-	 			
	19 treatment; and					
	·	s for staff who are not fully				
	vaccinated for COVID					
	Vaccinated for COVIL	7-19.				
	Effective 60 Days Aft	er Publication:				
		ocess for ensuring that all				
		agraph (i)(1) of this section				- 1
		or COVID-19, except for				
		been granted exemptions to				
		rements of this section, or				
		COVID-19 vaccination must			ľ	i
		ed, as recommended by the				
	CDC, due to clinical					
1	considerations;					1
		is not met as evidenced				1
	by:	1011011110120 0112011000				
		riew and facility document				
		aff failed implement their				
		ack and document the COVID-				
		for contract employees.	1			
	10 10001110110111011	,,,				
	The findings include:					
	• • • • • • • • • • • • • • • • • • • •					
	Upon entrance on 11	/14/2022, a request was				
	made of the list of co	ntracted staff or vendors that	1		- 1	
		to provide services and care				
	to the residents.	·			1	-2
	A second request wa	s made on 11/15/2022. The				
	staff matrix, COVID -	19 Staff Vaccination Status			- 1	
	for Providers was pre	sented.	i		- 1	
					1	
	An interview was con					
		nember) #4, the interim				1
		16/2022 at 5:25 p.m. When				
		y documentation of vendors			- 1	ŀ
	or contract employee	vaccination status, ASM #4				
			(Y2) MUII TIDI S	CONSTRUCTION	r	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	' '	CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		ŀ	
					C	
		405000	0.140010		ı 11/1	7/2022

STREET ADDRESS, CITY, STATE, ZIP CODE

2003 COBB STREET FARMVILLE, VA 23901

NAME OF PROVIDER OR SUPPLIER

HOLLY MANOR REHAB AND NURSING

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2022 FORM APPROVED

OMB NO. 0938-0391

PREFIX TAG	(EACH DEFICIENC	ALEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 888	folders on the agence [certified nursing ass providers. When ask documentation of the building of their vacc	ed if they had hospice staff coming in the ination status, ASM #4 tated they do not have a list	F 888			
	director of nursing, o When asked why the	-		*	•	
	facility to provide ser facility did not have a employees. The age a file, and their vacci	ncy nurses and CNAs have nation status is in the file.				
	building, ASM #2 sta asking their vaccinati entering the building	or a vendor entering the ted the facility should be ion status prior to them . If the vendor is not to wear an N-95 mask,				
1	which the facility wou	uld provide. When asked if OVID of the vendors, ASM			1	
ı	Staff" documented in committed to maintain protocols to minimize	OVID-19 Vaccination for part, "Policy: The facility is ining infection control e transmission of COVID -19	. :			
	develop and implem that meet each reside	om COVID-19, the facility will ent policies and procedures				
	needs and will offer staff"Staff - means in the facility on a regweek) basis, includin	vaccines to all residents and those individuals who work jular (that is, at least once a g individuals who may not be				
	physically in LTC (lor	ng term care) facility for a	<u> </u>			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		SURVEY
		495339	8 WING		11/	17/2022

NAME OF PROVIDER OR SUPPLIER

HOLLY MANOR REHAB AND NURSING

2003 COBB STREET

FARMVILLE, VA 23901

STREET ADDRESS, CITY, STATE, ZIP CODE

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) F 888 F 888 Continued From page 141 period of time due to illness, disability or scheduled time off, but who are expected to return to work. This also includes individuals under contract or arrangement, including hospice and dialysis staff, physical therapist, occupational therapist, mental health professionals, or volunteers, who are in the facility on a regular basis, as the vaccine is available." ASM #2 and ASM #4, were made aware of the above concern on 11/17/2022 at 12:06 p.m. No further information was provided prior to exit. 12/25/2022 F 940 Employee #8 has been trained on the F 940 | Training Requirements SS=D electronic medical record system and CFR(s): 483.95 employee #11 is no longer employed by §483.95 Training Requirements the facility. A facility must develop, implement, and maintain 2. The Administrator/designee has an effective training program for all new and performed an audit on the education existing staff; individuals providing services under records of CNA and licensed nurses to a contractual arrangement; and volunteers. ensure training on the electronic medical consistent with their expected roles. A facility record has been completed. All current must determine the amount and types of training CNA and licensed nurses have been necessary based on a facility assessment as trained on the electronic medical record. specified at § 483.70(e). Training topics must 3. The Administrator/Designee has ininclude but are not limited toserviced Human Resource Director and This REQUIREMENT is not met as evidenced nurse management team on the bv: importance of training CNA and licensed Based on staff interview, facility document review nurses on the electronic medical record and in the course of a complaint investigation, the and the record keeping of the employee facility staff failed to maintain an effective training program for two of 5 employee reviews. 4. The Administrator/Designee will conduct an audit of the education records of 10% The findings include: of the CNA and licensed nurses weekly x4 weeks and monthly x2 months to ensure The facility staff failed to train LPN (licensed that upon hire all new CNA and licensed practical nurse) #8 and CNA (certified nursing nurses have received education on the assistant) #11 regarding the new electronic electronic medical record. The Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. Date of Compliance: 12/25/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED

PRINTED: 12/05/2022 FORM APPROVED OMB NO. 0938-0391

C B. WING 11/17/2022 495339 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET **HOLLY MANOR REHAB AND NURSING** FARMVILLE, VA 23901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 940 F 940 Continued From page 142 medical record system. A complaint submitted to the state agency on 6/29/22 alleged concern over the amount of time employees received regarding the new electronic medical record system. The facility transitioned to a new electronic medical record system on 6/15/22. A review of CNA and licensed nurse training/orientation checklists revealed CNAs and nurses were supposed to be trained regarding the new electronic medical record system. A review of five employee records failed to reveal evidence that LPN #8 (hired on 6/6/20 and last worked on 11/10/22) and CNA #11 (hired on 9/3/21 and last worked on 10/21/22) received training regarding the new electronic medical record system. On 11/16/22 at 2:55 p.m., an interview was conducted with ASM (administrative staff member) #4, the interim administrator. ASM #4 stated all CNAs and nurses are supposed to receive training regarding the electronic medical record system before they work so they can be prepared to document. On 11/16/22 at 6:19 p.m., ASM #4 and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit. Complaint deficiency. 12/25/2022 Abuse, Neglect, and Exploitation Training F 943 Employees #5, #3, #12, #13 and #9 have F 943 SS=E now received abuse and dementia management training. The Administrator/designee has performed an audit on employee education records to ensure abuse and dementia management training has been completed within the year. All current

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** employees have the abuse and dementia management training. 3. The Administrator/Designee has inserviced Human Resources staff on the importance of employee training on abuse and dementia management. The education included, but was not limited to, the importance of the training being provided to staff upon hire and annually and record keeping of the training. The Administrator/Designee will conduct an audit of all new hire's education records weekly x4 weeks and monthly x2 months to ensure that upon hire they have received education and training on abuse, neglect, mistreatment of residents, misappropriation of property and exploitation and dementia management. The Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. Date of Compliance: 12/25/22 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING _ COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 11/17/2022 495339 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET FARMVILLE, VA 23901 **HOLLY MANOR REHAB AND NURSING**

PREFIX

TAG

0(5)

COMPLETION

DATE

PRINTED: 12/05/2022

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X4) ID

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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						01110 110	. 0000-0001
F 943			F 9	943			
i	Continued From non	. 142					100
	Continued From pag						1374
	CFR(s): 483.95(c)(1)	-(3)					ŀ
	8483 95(c) Ahuse no	eglect, and exploitation.					
	In addition to the free						
				- 1			
		tion requirements in §		- 1			
1	483.12, facilities mus	st also provide training to					
!	their staff that at a mi	nimum educates staff on-					
							i
	\$493 0E/oV(1) Antiviti	as that assettints above					
		es that constitute abuse,					
		and misappropriation of					
	resident property as	set forth at § 483.12.					
í l	\$483.95(c)(2) Proced	dures for reporting incidents		- 1			
[of abuse, neglect, ex			- 1			
				- 1			
	misappropriation of r	esident property		- 1			
				- 1			
1	§483.95(c)(3) Demei	ntia management and		l			
	resident abuse preve						
m		is not met as evidenced		ľ			
1		is not met as evidenced					
	by:						
		view, facility document review					
	and in the course of a	a complaint investigation, the					
	facility staff failed to	provide abuse and dementia					
1		g for five of six agency					
		g for five of six agency		ļ			
	employee reviews.			- 1			
	The findings include:						
		=				- 1	
	The facility staff failed	d to provide abuse and		ı			
		ent training to RN (registered					
		sed practical nurse) #3,		- 1		- 1	
	•	g assistant) #12, CNA #13	ı	1		i	
	and LPN #9.						
			ı				
	A complaint submitte	d to the state agency on					ľ
		ncern regarding agency staff					
	_	room regarding agency start					
	training.						
	RN #5 was hired on 9	9/2/22.]			
OTATE MEN'T	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SLIDVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			PLETED
				-		1	i
						(7
		495339	B. WING			11/	17/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
mand of the field of the field				-			
THE AMERICAN POPULAR AND AUTOMATICA					03 COBB STREET		
HOLLY M	ANOR REHAB AND NU	JKSING		F/	ARMVILLE, VA 23901		
(XA) ID	SHMMADV STA	TEMENT OF DEFICIENCIES	ID	I	PROVIDER'S PLAN OF CORRECTION	v 1	(X5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFI)	χĺ	(EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR		DATE
		•			DEFICIENCY)		

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02111214	S FOR WEDIOANE & WEDIOAND CENTICES			
F 943	Continued From page 145	F 943		
	The facility policy titled, "Abuse" documented in	!		
	part, "At a minimum, education on abuse,			
	neglect, and exploitation will be provided to facility		5	
	staff upon hire and annually. In addition to the	!		
	freedom from abuse, neglect, mistreatment of	1		
	residents, misappropriation of property and			
	exploitation requirements in 483.12, the	 		
	organization will also provide training to their staff			l i
	on:Dementia management and resident abuse			
	prevention"			
	On 11/17/22 at 12:55 p.m., ASM #4 and ASM #2,			
	the director of nursing were made aware of the			1
İ	above concern.			
	above concorn.			
1	No further information was presented prior to exit.			
1		!		
1	Complaint deficiency.			
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