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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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	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
E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted on 11/14/22 through 11/17/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/14/22 through 11/17/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey (VA00055276- unsubstantiated, VA00055600- substantiated with deficiency, VA00055761- substantiated with deficiency, VA00056766- substantiated with deficiency, VA00056758- substantiated with deficiency). The census in this 120 certified bed facility was 90 at the time of the survey. The survey sample consisted of 33 resident reviews.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility	F 558	1. Siderail assessments were completed for residents #38, #59 and #63. Resident #15 no longer resides at the facility. Grab bars orders received from the Nurse practitioner and grab bars were applied to the residents' beds and bed controls are within reach for residents # 38, #59, and #63. The residents' care plans have been updated to reflect a current individualized plan of care. Holly Manor Heath and Rehab has identified that all residents are at risk from this alleged deficient practice.	12/25/2022

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 in-service licensed nursing staff, including LPNs and RNs, regarding honoring resident siderail preferences and ensuring that bed controls are within reach. The in-service 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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.

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F 558		F 558		

Continued From page 1 document review, and clinical record review, it was determined the facility staff failed to accommodate the needs and/or honor the resident's preferences for the use of bed side rails for four of 33 residents in the survey sample, Residents #38, #59, #63 and #15.

The findings include:

1. For Resident #38 (R38), the facility staff failed to honor the resident's preference to have bed side rails to assist them to stand at the bedside and failed to accommodate the resident's ability to reach their bed controls.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/3/2022, Resident #38 scored a 13 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 G - Functional Status, the resident was coded as requiring supervision for moving in the bed, transfers, walking in the room and walking in the corridor with one person assist. The resident was coded as requiring extensive assistance for their toileting needs. In Section H - Bladder and Bowel, the resident was coded as being frequently incontinent of both bowel and bladder.

Observation was made of R38 on 11/15/2022 at 9:15 a.m. The resident was lying in their bed. There were no side rails on the bed. The resident's bed controller was attached to the nightstand. R38 stated they can't reach the control if they are lying on their left side as the controller is on the right side of the bed and out of their reach. When asked how long it had been

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F 558		F 558		

Continued From page 2 this way, R38 stated they did that when they took the side rails off the bed.

An interview was conducted with R38 on 11/16/2022 at 8:58 a.m. When asked if they used the side rails when they had them, R38 stated they used them for turning in the bed. They stated they need them to help him get up out of the bed. R38 stated that they used them to help him stand at the bedside to use the urinal.

An interview was conducted with CNA (certified nursing assistant) #1 on 11/16/2022 at 9:00 a.m. When asked if R38 had required more assistance during ADL (activities of daily living) care since their side rails were removed, CNA #5 stated, yes, they were able to get up and stand at the bedside to urinate. [R38] now wets themselves at times. [R38] used the rails to move in bed.

The "Side Rail and Entrapment Risk Assessment" dated, 10/31/2022 documented in part, "1. Is the resident DEPENDENT in bed mobility - no. 2. Is the resident NON-AMBULATORY or only ambulates with extensive assistance - no. 3. Does the resident have alteration in safety awareness due to cognitive decline and poor decisions making - no. 4. Will the use of side rails optimize resident independence in bed mobility and transfer - no. 5. Can the resident demonstrate use of the side rails, independently or with little prompting, for bed mobility - no. 6. Does the resident have difficulty with balance or poor trunk control when in bed or transferring t/from bed - no. 7. Does the resident have a history of postural hypotension, vertigo, syncope, or dizziness - no. 8. Is the resident on any medications that may require increased safety precautions (i.e., anticoagulants, psychoactive

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F 558	Continued From page 3 meds, medications with side effects of hypotension - Yes. Explain - htn (hypertension - high blood pressure). 9. Has the resident demonstrated a history of climbing over or around the rails - no. 10. Has the resident demonstrated a history of injury from use of the side rails including skin tears, bruising, etc.. - no. 11. Is the resident able (cognitively or functionally) to use the call bell to call for assistance - yes. 12. Has the resident or resident representative requested use of side rails - no. 13. Will the use of side rails during care provided by staff optimize resident safety and security - no... RECOMMENDATIONS: 19. Other alternative considered/trialed prior to side rails - low bed. 20. The following side rail use is recommended: no side rails indicated at this time...24. Other recommendations: Resident cannot raise or lower side rails independently." The comprehensive care plan dated 5/22/2022 failed to evidence documentation related to the use of side rails. An interview was conducted with OSM (other staff member) # 2, the director of maintenance, on 11/16/2022 at 1:04 p.m. When asked if he was involved with the removal of all the side rails, OSM #2 stated he removed the side rails the beginning of the month [November]. When asked how that come about, OSM #2 stated they had an in-service with the clinical staff, he stated he had missed it. OSM #2 stated he was told if the resident could not raise and lower the side rails, they couldn't have rails. OSM #2 stated he told them [administration] that no one could release them as the controls are on the outside of the bed rail near the frame. OSM #2 stated he was not thrilled about doing it, he felt like the facility had stepped back in time.	F 558		

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F 558	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 side rails, such as if they have an air mattress, that's one of the questions on the assessment. All rails have been removed. If there is a request by the resident, family, doctor, or therapy, we go back in and reassess the resident." When asked 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, some will use the mattress. When asked about R38, ASM #3 stated when she did the 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 resident has been using the urinal while sitting in the bed. When asked about the placement of R38's bed control and where should they be, ASM #3 stated they should be within the resident's reach. 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 requirement is located, ASM #2 stated it's part of	F 558		

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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	F 558		

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F 558	Continued From page 6 will be notified as appropriate c. The physician/practitioner will be notified and a specific order for the use of bed rails (identify how many / type of rails, which side or sides of the bed, and when they are to be in place) will be obtained." 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 provided prior to exit. 2. For Resident #59 (R59), the facility staff failed to honor the resident's preference for having side rails to assist in bed mobility. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member, in moving in the bed and for transfers. Observation was made on 11/14/2022 at 6:25 p.m. of R59 in a recliner in the resident room. The bed was observed to have one side rail on the bed. An interview was conducted with R59 on 11/15/2022 at 3:21 p.m. R59 stated they wanted both rails back on the bed. R59 stated they were able to get one rails back to put their touch-controlled specialty call bell on. A second	F 558		

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F 558	Continued From page 7 interview was conducted with R59 on 11/16/2022 at 9:16 a.m. When asked about the side rails, R59 stated when they had the other rail, on the resident's right side of the bed, they could wrap their arm over it to keep themselves over while they changed him. R59 stated they could not do that now. The "Side Rail and Entrapment Risk Assessment, dated 10/31/2022, documented in part, "1. Is the resident DEPENDENT in bed mobility - no. 2. Is the resident NON-AMBULATORY or only ambulates with extensive assistance - yes. 3. Does the resident have alteration in safety awareness due to cognitive decline and poor decisions making - no. 4. Will the use of side rails optimize resident independence in bed mobility and transfer - no. 5. Can the resident demonstrate use of the side rails, independently or with little prompting, for bed mobility - no. 6. Does the resident have difficulty with balance or poor trunk control when in bed or transferring to/from bed - yes. 7. Does the resident have a history of postural hypotension, vertigo, syncope, or dizziness - no. 8. Is the resident on any medications that may require increased safety precautions (i.e., anticoagulants, psychoactive meds, medications with side effects of hypotension - Yes. Explain - psychoactive medication. 9. Has the resident demonstrated a history of climbing over or around the rails - yes. 10. Has the resident demonstrated a history of injury from use of the side rails including skin tears, bruising, etc.. - no. 11. Is the resident able (cognitively or functionally) to use the call bell to call for assistance - yes. 12. Has the resident or resident representative requested use of side rails - yes. 13. Will the use of side rails during care provided by staff optimize resident safety	F 558		

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F 558	Continued From page 8 and security - no... RECOMMENDATIONS: 20. The following side rail use is recommended: no side rails indicated at this time...24." The "Side Rail and Entrapment Risk Assessment, dated 11/15/2022 (during survey), documented in part, "1. Is the resident DEPENDENT in bed mobility - yes. 2. Is the resident NON-AMBULATORY or only ambulates with extensive assistance - yes. 3. Does the resident have alteration in safety awareness due to cognitive decline and poor decisions making - no. 4. Will the use of side rails optimize resident independence in bed mobility and transfer - no. 5. Can the resident demonstrate use of the side rails, independently or with little prompting, for bed mobility - no. 6. Does the resident have difficulty with balance or poor trunk control when in bed or transferring to/from bed - no. 7. Does the resident have a history of postural hypotension, vertigo, syncope, or dizziness - no. 8. Is the resident on any medications that may require increased safety precautions (i.e., anticoagulants, psychoactive meds, medications with side effects of hypotension - Yes. Explain - htn. 9. Has the resident demonstrated a history of climbing over or around the rails - no. 10. Has the resident demonstrated a history of injury from use of the side rails including skin tears, bruising, etc.. - no. 11. Is the resident able (cognitively or functionally) to use the call bell to call for assistance - yes. 12. Has the resident or resident representative requested use of side rails - yes. 13. Will the use of side rails during care provided by staff optimize resident safety and security - no... RECOMMENDATIONS: 19. Other alternatives considered/trialed prior to side rails. Low bed. Positioners. 20. The following side rail use is recommended: 22. If only 1 grab bar, 1/4,	F 558		

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F 558		F 558		

Continued From page 9

1/2 or full side rails is used, identify side - left. 23. Reason for side rail use: to station soft touch call bell.

The comprehensive care plan dated 5/11/2022 documented in part, "Focus: [R59] has an ADL (activity of daily living) self-care performance deficit AEB (as exhibited by) requires assist with ADLs." The "Interventions" documented in part, "May use left upper side rail to assist with call bell placement." Revised on 11/15/2022.

An interview was conducted with LPN (licensed practical nurse) #4 on 11/16/2022 at 9:31 a.m. When asked if R59 had side rails before, LPN #4 stated, yes. When asked why they were removed, LPN #4 stated the same reason for everyone else, the resident couldn't raise or lower the side rails independently. LPN #4 stated [R59] got one back. When asked why, LPN #4 stated she was not sure but she believed it was to put his call bell on.

An interview was conducted with OSM (other staff member) # 2, the director of maintenance, on 11/16/2022 at 1:04 p.m. When asked if he was involved with the removal of all the side rails, OSM #2 stated he removed the side rails the beginning of the month (November). When asked how that come about, OSM #2 stated they had an in-service with the clinical staff, he stated he had missed it. OSM #2 stated he was told if the resident could not raise and lower the side rails, they couldn't have rails. OSM #2 stated he told them (administration) that no one could release them as the controls are on the outside of the bed rail near the frame. OSM #2 stated he was not thrilled about doing it, he felt like the facility had stepped back in time.

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F 558		F 558		

Continued From page 10

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 side rails, such as if they have an air mattress, that's one of the questions on the assessment. All rails have been removed. If there is a request by the resident, family, doctor, or therapy, we go back in and reassess the resident." When asked 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, some will use the mattress. When asked about R59, ASM #3 stated, "We've now made him more dependent." When asked if that is promoting his highest level of well -being and honoring his preference, ASM #3 stated, "If he feels that way, then no, we are not promoting his highest level of well-being."

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 requirement is located, ASM #2 stated it's part of the CMS (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

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F 558	Continued From page 11 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 provided prior to exit. 3. For Resident #63 (R63) the facility staff failed to honor the resident's preference for the use of side rails to assist in bed mobility and reduce anxiety. 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 G - Functional Status R63 was coded as requiring extensive assistance of one staff member for bed mobility and extensive assistance of two staff members for transfers. R63 was observed on 11/15/2022 at approximately 8:30 a.m., in bed. There were no side rails attached to the bed. R63 stated they want their side rails back. R63 stated, "They took them off because of some law." R63 stated they want to be able to hold onto [rails] when they turn, and they can try to reposition themselves in bed." The "Side Rail and Entrapment Risk Assessment, dated 11/1/2022, documented in part, "1. Is the resident DEPENDENT in bed mobility - yes. 2. Is	F 558		

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F 558	Continued From page 12 the resident NON-AMBULATORY or only ambulates with extensive assistance - yes. 3. Does the resident have alteration in safety awareness due to cognitive decline and poor decisions making - no. 4. Will the use of side rails optimize resident independence in bed mobility and transfer - no. 5. Can the resident demonstrate use of the side rails, independently or with little prompting, for bed mobility - no. 6. Does the resident have difficulty with balance or poor trunk control when in bed or transferring to/from bed - no. 7. Does the resident have a history of postural hypotension, vertigo, syncope, or dizziness - no. 8. Is the resident on any medications that may require increased safety precautions (i.e., anticoagulants, psychoactive meds, medications with side effects of hypotension - no. 9. Has the resident demonstrated a history of climbing over or around the rails - no. 10. Has the resident demonstrated a history of injury from use of the side rails including skin tears, bruising, etc.. - yes. 11. Is the resident able (cognitively or functionally) to use the call bell to call for assistance - yes. 12. Has the resident or resident representative requested use of side rails - no. 13. Will the use of side rails during care provided by staff optimize resident safety and security - no... RECOMMENDATIONS: 24. Resident is unable to raise and lower side rails independently." The comprehensive care plan revised on 11/14/2022 failed to evidence documentation related to the use of side rails. An interview was conducted with LPN (licensed practical nurse) # 4, the unit manager, on 11/16/2022 at 9:33 a.m. When asked why R63 didn't have side rails, LPN #4 stated the resident	F 558		

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F 558	Continued From page 13 had them, but they were removed. When asked why, LPN #4 stated the resident was unable to raise and lower them, so they are considered a restraint. When asked if [R63] can move in the bed by themselves, LPN #4 stated they can wiggle, they were using the rails to hold themselves over and pull themselves up. When asked if side rails would assist in bed mobility for R63, LPN #63 stated, yes. An interview was conducted with CNA (certified nursing assistant) #7 on 11/16/2022 at 11:00 a.m. When asked about the 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 rails helped to hold them over to be cleaned. Now it's harder to provide care. CNA #7 stated, [R63] has anxiety and is afraid to fall out of the bed. [R63] now pushes against the wall and that sometimes is a disadvantage. CNA #7 stated she pushed the bed against the wall but [R63] still has a fear of falling out of the bed. An interview was conducted with OSM (other staff member) # 2, the director of maintenance, on 11/16/2022 at 1:04 p.m. When asked if he was involved with the removal of all the side rails, OSM #2 stated he removed the side rails the beginning of the month (November). When asked how that come about, OSM #2 stated they had an in-service with the clinical staff, he stated he had missed it. OSM #2 stated he was told if the resident could not raise and lower the side rails, they couldn't have rails. OSM #2 stated he told them (administration) that no one could release them as the controls are on the outside of the bed rail near the frame. OSM #2 stated he was not thrilled about doing it, he felt like the facility had stepped back in time.	F 558		

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F 558		F 558		

Continued From page 14

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 side rails, such as if they have an air mattress, that's one of the questions on the assessment. All rails have been removed. If there is a request by the resident, family, doctor, or therapy, we go back in and reassess the resident." When asked 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, some will use the mattress. When asked about R63, ASM #3 stated, they are a two person assist, that is the safest way to reposition them. When asked doesn't their fear factor and anxiety come into play with the assessment, ASM #3 stated, "Yes, it does. The resident will be reassessed for the use of side rails."

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 requirement is located, ASM #2 stated it's part of 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

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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.	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 558		F 558		

Continued From page 16

On 10/15/2022 at 11:30 a.m., an interview was conducted with R15 in their room. R15 was observed sitting in a recliner in their room. R15 stated that they had bed rails on their bed until a couple of weeks ago when someone came in and took them off. R15 stated that they were told that there was a state regulation that said that no one could have them. R15 stated that they used the bed rails every day prior to them being removed and wanted them back. R15 stated that they used them in bed when turning and repositioning and when transferring out of bed they used the right bed rail to hold onto to push themselves up. R15 stated that now they were trying to use the arm of the recliner and it was further from the bed and much lower than the bed rail was. R15 stated that it made their transfer much harder for them now.

The side rail and entrapment risk assessment for R15 dated 11/1/2022 documented in part, "...Will the use of side rails optimize resident independence in bed mobility and transfer? Yes. Explain if Yes. Resident pulls on side rail to assist when sitting up or turning. Can the resident demonstrate use of the side rails, independently or with little prompting, for bed mobility? Yes...Has the resident or resident representative requested use of side rails? Yes...Will the use of side rails during care provided by staff optimize resident safety and security? No...Has the bed inspection been completed and demonstrated that the bed is safe functionally and rails and mattress do not create risk for entrapment? Yes. Other alternatives considered/trialed prior to side rails: Low Bed...No side rails indicated at this time...Other recommendations: Resident unable to raise and lower side rails independently...The

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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."

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 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."

On 11/15/2022 at 1:06 p.m., an interview was

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F 558	Continued From page 18 conducted with OSM (other staff member) #4, long term care ombudsman. OSM #4 stated that they had received multiple calls from residents and family members regarding the bed rails being removed from 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 restraint free so they had removed all of the bed rails and go through the steps to see if the residents needed the bed rails. OSM #4 stated that they had met with the residents and the administrative staff about this concern but had no resolution at the current time. 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 hazard. 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. 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 without the bed rails. OSM #6 stated that if the resident was high functioning and not using the	F 558		

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F 558	Continued From page 19 bed rails or not capable of using them they were removed. When asked about residents who used the bed rails for turning who had them removed, OSM #6 stated, "If they used them for turning we would make sure staff would be in there to turn them, they would go to a two person assist." OSM #6 stated that they were told that the resident needed to be able to raise and lower their bed rail to be able to keep it. When asked if having to have staff physically turn them or becoming a two person assist was promoting the residents highest practicable level of well-being, OSM #6 stated that it was not. OSM #6 stated that they were actively working with nursing to provide residents with alternative means and some of the residents were able to use the side of the mattress to hold onto. When asked if having to have staff physically turn them or becoming a two person assist was a decline in function, OSM #6 stated, "Yes." OSM #6 stated that the bed rail removal decision was made by the director of nursing and the previous administrator. On 11/16/2022 at approximately 12:30 p.m., OSM #6 provided a PT (physical therapy) discharge summary for R15 dated 9/15/2022 and stated that bed rails were not used at the time R15 was in therapy. OSM #6 stated that R15 was able to perform bed mobility with supervision. The PT discharge summary documented in part, "...Skilled interventions Provided: Skilled treatment interventions included instructing and training patient in positioning maneuvers, strength training, proper body mechanics, safe transfer techniques and gait training with safe use of RW (rollator walker) in order to facilitate functional mobility..."	F 558		

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F 558	Continued From page 20 On 11/16/2022 at 1:04 p.m., an interview was conducted with OSM #2, the director of maintenance. OSM #2 stated that the bed rails were removed around the beginning of November. OSM #2 stated that as far as they 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 thought there were about three residents in the building that were able to do this. On 11/16/2022 at 1:36 p.m., an interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing. 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 safe for the resident to use them. ASM #3 stated that theyassessed whether the resident was able 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 had recently made changes to their process for bed rails. ASM #3 stated that when they evaluated a resident for bed rails they would see 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	F 558		

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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	F 558		

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F 558	Continued From page 22 going to fall out of bed and they had the psychiatrist come in to evaluate them for their fears. When asked about R15, ASM #2 stated that a lot of the residents were a two person assist prior to the bed rails being removed and their level of functioning had not changed. When asked about the staffing of one CNA (certified nursing assistant) assigned on the unit for R15 for a two person assist, ASM #2 stated that the expectation was for the nurse to assist the CNA in turning and positioning the residents. On 11/16/2022 at 3:07 p.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that R15 used the bed rail to pull up when transferring out of bed and to position and turn in bed when they had them. CNA #8 stated that R15 had voiced that they wanted the bed rails back because it was harder to get out of bed and position themselves now. CNA #8 stated that R15 told them that they only wanted the right one back. CNA #8 stated that now they had to assist R15 more physically when getting out of bed due to not having the bed rail. CNA #8 stated that R15 had bad knees and it was hard to use the low recliner chair arm to get out of bed. The facility policy "Bed Rail Risk and Safety" documented in part, "...b. When resident choice regarding bed rails is not consistent with the facility recommendations, the resident and/or resident representative will be educated by a representative of the interdisciplinary team on the risks and resolution identified in the resident's plan of care. c. The resident's attending physician and resident representative will be informed of any variance from facility recommendation...3. Consider restricting rail use	F 558		

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F 558	Continued From page 23 only to the times necessary (e.g., while assisting staff to reposition self)..." 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 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561	1. Residents #47 and #29 were interviewed by nursing staff and interviewed by social services. The residents shower schedules were updated to reflect the preferences of the residents. The residents' plans of care and Kardex were reviewed and updated to reflect their resident-specific needs. Holly Manor Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2. Nursing staff performed interviews with residents and recorded results in the residents' plan of care. The residents' plans of care were reviewed and updated to reflect resident-specific bathing/showering needs. 3. The Director of Nursing/designee has in-serviced clinical nursing staff, including RNs, LPNs, CNA's regarding resident preferences and allowing resident choice in determining shower/bathing schedules. The in-service includes the importance of allowing resident self-determination in their plan of care regarding bathing/shower schedule preference. 4. The Director of Nursing/designee will audit shower schedules daily for 4 weeks, then 3 times a week for 4 weeks and weekly for 4 weeks and then monthly for 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 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	

			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: 12/25/2022	

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F 561		F 561		

Continued From page 24

interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, responsible party interview, staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to honor a resident's right to make choices about their bathing preferences for two of 33 residents in the survey sample, Resident #47 and Resident #29.

The findings include:

1. For Resident #47 (R47), the facility staff failed to provide showers as per their preference.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/24/2022, the resident was assessed as being moderately impaired for making daily decisions. Section G documented R47 being totally dependent on one staff member for bathing.

On 11/15/2022 at 11:15 a.m., a telephone interview was conducted with R47's responsible party. R47's responsible party stated that showers were supposed to be given twice a week, however on most weeks R47 was only receiving a shower once a week. R47's responsible party stated that they felt that this was due to staffing and that the aides were doing the best that they could.

On 11/15/2022 at 12:07 p.m., an observation was made of R47 in their room. R47 was observed dressed and sitting in a wheelchair watching

F 561		F 561		
	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.			

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	495339	A. BUILDING _____ B. WING _____	C 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	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 561		F 561		

Continued From page 26

On 11/16/2022 at 10:39 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that showers were offered twice a week to residents. CNA #7 stated that they always asked the resident if they wanted a shower or a bath. CNA #7 stated that depending on the resident, sometimes they would take a shower and sometimes they would refuse. CNA #7 stated that they had a shower book that told them who was scheduled on what day. CNA #7 stated that if the resident refused the shower, they let the nurse know. CNA #7 stated that they documented the showers in the computer in the ADL's.

On 11/16/2022 at 3:07 p.m., an interview was conducted with CNA #8. CNA #8 stated that showers were offered two times a week. CNA #8 stated that showers were always offered to residents prior to a bed bath being given. CNA #8 stated that if a resident refused the shower they notified the nurse and documented it. CNA #8 stated that R47 never refused their shower because they loved them. CNA #8 stated that R47 received their showers on the day shift normally on Tuesdays and Thursdays and they normally gave them when they were working because R47 preferred them.

On 11/16/2022 at 2:55 p.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that they tried to staff two CNA's on R15's unit on day and evening shift. ASM #2 stated that at the minimum there should always be a nurse and a CNA on the unit. ASM #2 stated that the workload for the nurse was not as high for that unit so the expectation was for the nurse to help

F 561		F 561		

Continued From page 27 the CNA. ASM #2 stated that they were out on the unit each day speaking with the staff on the floor and 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 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 they were deemed safe.

The facility policy, "Resident Self Determination and Participation" documented in part, "...1. Each resident is allowed to choose activities, 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"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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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 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..." 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 concern. No further information was presented prior to exit. Complaint deficiency. 2. For Resident #29 (R29), the facility staff failed to honor the resident's preference for showers. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an 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 resident was moderately cognitively impaired for making daily decisions. In Section G - Functional Status, the resident was coded as requiring physical help of the bathing activity with one person assisting. 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. An interview was conducted with CNA (certified nursing assistant) #7 on 11/17/2022 at 8:20 a.m. When asked how she knows what type of bath/shower, R29 wants, CNA #7 stated, [R29]			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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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. 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 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 where the resident should have received a shower. An interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing, on 11/17/2022 at 9:25 a.m. 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 should be asking the resident. Everyone should be asked if they want a shower. The facility policy, "Shower/Tub Bath" documented in part, "POLICY: The purposes of 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 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			

F 561	Continued From page 30 consideration and honored." 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.	F 561		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585	1. It is the policy of Holly Manor to ensure that grievance logs are maintained according to CFR(s): 483.10(j)(1)-(4). All residents have the potential to be affected by this alleged deficient practice 2. A grievance log has been maintained and a staff member has been designated as the grievance officer since 11/16/2022. 3. The Administrator/designee has educated the grievance officer on duties and compliance with maintaining the grievance log according to CFR(s): 483.10(j)(1)-(4). 4. The Administrator/Designee will review the grievance log 5x per week for 4 weeks and then monthly for 2 months to ensure that the log 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 Improvement Committee at least quarterly. 5. Date of Compliance: 12/25/22	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 31 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation 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 misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	495339	B. WING	C 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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F 585		F 585		

Continued From page 32

as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined the facility staff failed to maintain grievance logs from 7/20/2022 through 11/15/2022 potentially affecting most of the 33 residents in the survey sample.

The findings include:

Upon entrance to the facility on 11/14/2022 at approximately 7:00 p.m. a request was made for the grievance logs. A second request was made on 11/15/2022 at approximately 9:00 a.m. On 11/15/2022 the survey team received a document titled, "Concern Log." The document dated

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HOLLY MANOR REHAB AND NURSING	2003 COBB STREET FARMVILLE, VA 23901

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F 585		F 585		

Continued From page 33 concerns from 1/13/2022 through 7/20/2022.

On 11/15/2022 at 1:06 p.m., an interview was conducted by another surveyor with OSM (other staff member) #4, long term care ombudsman. OSM #4 stated that they had received multiple calls from residents and family members regarding the bed rails being removed from 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 restraint free so they had removed all of the bed rails and go through the steps to see if the residents needed the bed rails. OSM #4 stated that they had met with the residents and the administrative staff about this concern but had no resolution at the current time.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/15/2022 at 3:47 p.m. When asked where the grievance logs since July 2022 were, ASM #2 stated, "We haven't kept track of them." When asked why, ASM #2 did not respond. When asked who is responsible for the tracking of grievances, ASM #2 stated, "Social services."

An interview was conducted with OSM (other staff member) #1, the director of admissions, on 11/16/2022 at approximately 12:15 p.m. When asked the process for a resident and/or family member to file a grievance, OSM #1 stated, the process had been if we have any complaints or concerns, we bring them to the administrator in the morning meeting, he would address it with whichever department is involved. He would do the follow up on that. When asked if a log of

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F 585		F 585		

Continued From page 34 grievances is kept, 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. When asked the process for grievances, ASM #4, stated the process was the administrator was 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 facility had no documentation of a log since the end of July. When asked how long the administrator had been gone, ASM #4 stated, within the last 30 days.

The facility policy, "Resident Grievance Procedure" documented in part, "It is the policy of [name of corporation] to recognize that all residents have the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal...Procedure: 2. The facility will designate a staff member as the Grievance Official who is responsible for: a. Overseeing the grievance process. b. Receiving and tracking grievances through to their conclusion. C. Leading any necessary investigation by the facility. d. Maintaining the confidentiality of all information 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

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 585	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.	F 585		
F 602 SS=D	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 602	1. 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. 2. 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. 3. 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. 4. 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	12/25/2022

			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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING	C 11/17/2022

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F 602		F 602		
	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 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section J documented R10 receiving scheduled pain medication and having 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 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 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			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 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 in-service 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			

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	495339	A. BUILDING _____ B. WING _____	C 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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F 602		F 602		
	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, 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 medication. This nurse noted this in the medication progress notes. Patient was made aware of this. Thus nurse will follow up with any further information when it is received." On 11/16/2022 at 8:03 a.m., ASM (administrative staff member) #2, the director of nursing, stated that LPN (licensed practical nurse) #3 and the other agency LPN who also worked on the unit 8/24/2022, no longer worked at the facility. 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 note on 8/29/2022 no longer worked at the facility. On 11/16/2022 at 9:28 a.m., an interview was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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F 602		F 602		
	Continued From page 39 conducted with LPN #4. LPN #4 stated that narcotics were counted at shift change by the off going nurse and the ongoing nurse. LPN #4 stated that the two nurses went through the medication cards and matched them with the count sheets to ensure that everything matched. LPN #4 stated that if anything did not match they were not allowed to leave the building until everything matched. LPN #4 stated that when they were administering any controlled medication they kept a count of the number of pills that were left in a narcotic book which held the narcotic sheets. On 11/16/2022 at 2:55 p.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that they had received a call from the pharmacy stating that a request had been made to refill R10's hydrocodone and that it was too early. ASM #2 stated that the pharmacy had delivered two cards of hydrocodone and two narcotic count sheets at the same time for the resident totaling 60 tablets. ASM #2 stated that after speaking with the pharmacy they advised them that R10 should have 30 more tablets at the facility so they had started an investigation into the missing hydrocodone. ASM #2 stated that the hydrocodone had been discovered to be missing 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			

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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			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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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			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 602	Continued From page 42	F 602		
	provided to facility staff upon hire and annually. In addition to the freedom from abuse, neglect, mistreatment of residents, misappropriation of 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 483.12...Criminal record checks will be obtained in accordance with state law and/or facility policy...Other 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 safety...The facility Quality Assurance/Performance Improvement Committee will review and provide recommendation for unusual occurrences...Virginia 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			

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F 602	Continued From page 43 cannot be treated with other medications or treatments. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a614045.html	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies 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 (2) of the Act. This REQUIREMENT is not met as evidenced	F 607	1. 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. 2. 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. 3. The Administrator/Designee will verify that all potential employees pass a criminal background check prior to beginning employment at Holly Manor. Copies of pre-employment criminal background checks will be kept on file and available in the facility. 4. 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 Administrator/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee quarterly. 5. Date of Compliance: 12/25/22	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 607	Continued From page 44 by: Based on staff interview, facility document review, and clinical record review it was determined that the facility failed to implement the facility abuse policy for screening staff for one of four agency staff reviewed, LPN (licensed practical nurse) #3. The findings include: The facility staff failed to implement their abuse policy for staff screening for LPN #3. During the course of a FRI (facility reported incident) review for Resident #10 (R10) regarding misappropriation of resident property, it was determined that LPN #3 did not have a background check completed prior to working at the facility. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/2/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section J documented R10 receiving scheduled pain medication and having pain almost constantly. Section N documented R10 receiving opioid medications during the assessment period. Review of the FRI's (facility reported incidents) documented a FRI dated 8/29/2022 for 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	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 607		F 607		

Continued From page 45

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 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."

On 11/16/2022 at 8:03 a.m., ASM (administrative staff member) #2, the director of nursing, stated that LPN (licensed practical nurse) #3 and the other agency LPN who also worked on the unit 8/24/2022, no longer worked at the facility.

On 11/16/2022 at approximately 9:00 a.m., a request was made to ASM #4, the interim administrator, LPN #3's employee record.

On 11/16/2022 at approximately 4:00 p.m., ASM #4 provided copies of documents for LPN #3 including a background search dated 11/16/2022 and license verification report dated 8/8/2022.

On 11/16/2022 at 2:55 p.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that they had received a call from the pharmacy stating that a request had been made to refill R10's hydrocodone and that it was too early. ASM #2 stated that the pharmacy had delivered two cards of hydrocodone and two narcotic count sheets at the same time for the resident totaling 60 tablets. ASM #2 stated that

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F 607	Continued From page 46 after speaking with the pharmacy they advised them that R10 should have 30 more tablets at the facility so they had started an investigation into the missing hydrocodone. ASM #2 stated that the hydrocodone had been discovered to be missing 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 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 10:01 a.m., an interview was	F 607		

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 47 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 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 a background check completed prior to 11/16/2022. 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. On 11/17/2022 at approximately 10:30 a.m., OSM #5 provided page 6 of the employee handbook and stated that they followed the procedure documented as their policy. It documented in part, "...3.7 Background and Criminal History; All newly hired employees will be subject to a background and criminal history check as required by the applicable laws. This will occur on a post-offer, pre-employment basis, as state law requires and upon yearly evaluations. Unsatisfactory reports may result in rescinding an employment offer or termination of employment..." The facility policy "Abuse" revised 10/20/2022 documented in part, "...Criminal record checks will be obtained in accordance with state law	F 607		

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F 607	Continued From page 48 and/or facility policy...Virginia 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.html	F 607		
F 656 SS=E	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	1. 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. 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 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

			3. The Director of Nursing/designee has in-serviced 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	

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 656		F 656		

Continued From page 50

Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for four of 33 residents in the survey sample, Residents #53, #51, #63 and #54.

The findings include:

1. For Resident #53, the facility staff failed to develop a care plan for the use of oxygen.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with the assessment reference date of 10/15/2022, the resident coded as having no short or long term memory issues. In Section O - Special Treatment, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility.

Review of the comprehensive care plan, last updated 11/14/2022, failed to evidence documentation of the use of oxygen for R53.

R53 was observed on 11/15/2022 at approximately 8:45 a.m. with oxygen on via a nasal cannula. The oxygen concentrator was set at 2 LPM (liters per minute). A second observation was made on 11/15/2022 at 11:53 a.m. R53 was in the wheelchair with the oxygen on at 2 LPM via a nasal cannula with a portable tank secured to the wheelchair.

Review of the physician orders failed to evidence a physician order for the use of oxygen.

An interview was conducted with LPN (licensed practical nurse) #4 on 11/16/2022 at 10:20 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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	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 656		F 656		
	Continued From page 51 LPN #4 was asked to review R53's physician orders. When asked if she saw an order for the use of oxygen, LPN #4 stated, no and there 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 #4 stated, yes. 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 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. 2. For Resident #51 (R51), the facility staff failed to develop a comprehensive care plan to address the use of an anticoagulant 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.			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656		F 656		
	Continued From page 52 The physician order dated, 8/27/2022 documented, "Eliquis (used to prevent blood 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, 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/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656		F 656		
	Continued From page 53 injections and seven days of an anti-psychotic, antidepressant and anti-anxiety medications. 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, 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 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 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. 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,			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656		F 656		
	Continued From page 54 their preferences, and what the resident needs. When asked who's responsible for developing the care plans, LPN #4 stated it's normally the unit mangers, assistant director of nursing, director of nursing, therapy, and any department head. An interview was conducted with RN (registered nurse) #3, the MDS nurse, on 11/16/2022 at 3:58 p.m. When asked if a resident is a diabetic and is receiving insulin, should that be addressed on the care plan, RN #3 stated, it normally is. When asked if a resident is on psychotropic medications, should that be addressed on the care plan, RN #3 stated, yes. After reviewing the care plan, RN #3 stated that neither the insulin nor psychotropic medications were documented 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/a603012.html (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682279.html (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a600027.html (4) This information was obtained from the following website:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656		F 656		

Continued From page 55

https://medlineplus.gov/druginfo/meds/a697048.html

(5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605013.html

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

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. No further information was presented prior to exit.	F 656		
F 657 SS=D	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.	12/25/2022

F 657		F 657		

Continued From page 57

(I) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to-(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of 33 residents in the survey sample, Resident #206.

The findings include:

The facility staff failed to review and revise Resident #206's (R206) comprehensive care plan for the use of an incentive spirometer.

On the most recent MDS (minimum data set), an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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F 657		F 657		
	Continued From page 58 admission assessment with an ARD (assessment reference date) of 10/30/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. R206's comprehensive care plan revised on 11/9/22 failed to reveal documented information regarding an incentive spirometer. On 11/15/22 at 9:36 a.m., R206 was observed sitting in a wheelchair in the bedroom. An incentive spirometer was on the resident's over bed table. An interview was conducted with R206. R206 stated they use the incentive spirometer every two hours. On 11/16/22 at 3:26 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the purpose of the care plan is a plan of care for all staff to see what the goals are and interventions in place. LPN #5 stated a resident's care plan should be reviewed and revised to include an incentive spirometer as an intervention. On 11/16/22 at 6:19 p.m., ASM (administrative staff member) #4, the interim administrator and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, "Care Planning - Comprehensive Person-Centered" documented, "11. Each resident's comprehensive care plan will describe the following: a. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."			

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	495339	A. BUILDING _____ B. WING _____	C 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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F 657	Continued From page 59 No further information was presented prior to exit.	F 657		

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

F 658 SS=D	Services Provided Meet Professional Standards 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 by: 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	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. 2. 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. 3. 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. 4. 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. 5. Date of Compliance: 12/25/22	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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F 658		F 658		

Continued From page 60

with weights.

A review of the physician orders dated 8/15/22, revealed, "Daily Weight x3 days, Weekly Weight x4 weeks, then monthly one time a day for Assessment for 3 Days. Per physician orders, weights should have been obtained on 8/15, 8/16, 8/17, 8/22, 8/29, 9/5, 9/12, 10/10 and 11/14/22.

A review of weights showed weights were obtained on 8/25, 9/8, 10/12, 10/23 and 11/14. No weight loss was identified.

An interview was conducted on 11/15/22 at 8:03 AM with LPN (licensed practical nurse) #1. When asked the process for obtaining weekly weights, LPN #1 stated, weekly weights are on the assignment for the CNA to obtain. When asked if the physician ordered weights are not done, are the physician orders followed, LPN #1 stated, no, they are not.

An interview was conducted on 11/15/22 at 4:20 PM, with CNA #6. When asked who obtains weights, CNA #6 stated, the CNAs get the weights, they are on our assignment. When asked when weights are obtained, CNA #6 stated, they are usually obtained on day shift and sometimes on evening shift.

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.

A review of the facility's "Conformity with Laws and Professional Standards" policy with no date, revealed, "Our facility operates and provides services in compliance with current federal, state

F 658	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.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents 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, clinical 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 and #22. 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 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. An occupational therapy note dated 6/15/21 documented, "Pt. (Patient) was self feeding when OTR/L (occupational therapy employee) arrived	F 677	1. The medical records of residents #61 and #22 were reviewed. Resident #61 is no longer a resident at Holly Manor; therefore, no corrective action was necessary. Incontinence ADL care have been provided for resident #22 per facility policy since the completion of the survey. 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. 2. The Director of Nursing/designee has performed an audit of all current resident ADL feeding and incontinence care orders to ensure accuracy and that the care given meets the needs of each resident. Any incorrect ADL orders 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 plan of care. 3. 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 the importance of individualized plans of care, how to properly feed a resident, how to properly perform hygiene/peri-care, and identifying changes in resident ADL care needs. 4. The DON/designee will perform an observation audit of 10 residents, 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks and then monthly for 2 months. The observation audit will include feeding resident and providing daily hygiene ADL care and/or Peri-care. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to re-educate staff until significant compliance is achieved. The Director of Nursing/designee will identify any trends	12/25/2022

			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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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F 677		F 677		
	Continued From page 62 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 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 handed it to patient, she brought it to her mouth. Pt. then demonstrated ability to self feed multiple times with Mod (moderate) I to S/SBA (supervision/stand-by assistance)." An occupational therapy discharge summary dated 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." A nurse's note dated 11/2/22 documented, "Resident brought from dining room with oatmeal on shirt. No injuries noted at this time. Clothes changed and placed in Meaningful Life program." A facility report dated 11/9/22 documented in part, "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] #9), dietary aide. While serving other residents in the dining room, (OSM #9) noticed that (R61) had spilled oatmeal on (the resident's) right arm, leg, lap and wheelchair..." On 11/16/22 at 9:52 a.m., an interview was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 677		F 677		
	Continued From page 63 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 R61's CNA and the CNA immediately removed R61 from the dining room. On 11/16/22 at 10:38 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated R61 requires assistance with eating. CNA #7 stated R61 can feed self sandwiches and finger foods but must be physically assisted with liquids, soups and oatmeal. CNA #7 stated R61's arms are contracted and the resident can't always bring the spoon up right to the resident's mouth. CNA #7 stated R61 spills a lot of food while using utensils. CNA #7 stated she thought there was no nursing staff in the dining room during breakfast on 11/2/22 but she did not know why. CNA #7 stated that on 11/2/22, she was assisting another resident with care when OSM #9 came to her. CNA #7 stated OSM #9 told her R61 spilled oatmeal on the resident's body so she finished care with the other resident and went to the dining room to get R61. CNA #7 stated R61 had oatmeal on clothing covering the resident's right lower arm and right leg so she took R61 to the bed room and changed the resident's clothes. On 11/16/22 at 3:13 p.m., an interview was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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F 677	Continued From page 64 conducted with ASM #2, the director of nursing. ASM #2 stated nursing staff is supposed to be present in the 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. 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: 1. Facility staff will serve resident trays and will help residents who require assistance with eating. 2. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity." No further information was presented prior to exit. 2. For Resident #22, the facility staff failed to provide ADL (activities of daily living) care, specifically incontinence care, for a dependent resident. 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. 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 MDS Section	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 65 G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing and hygiene; total dependence for bathing and supervision for eating. A review of the comprehensive care plan with a revision date of 8/16/22, revealed, "FOCUS: Resident has an ADL self-care performance deficit, requires assist with ADLs. INTERVENTIONS:...Resident requires assistance with bathing, dressing and toileting. Supervision with meals. Physical assist as needed. Encourage resident to use bell to call for assistance. Encourage resident to participate to the fullest extent possible with each interaction." A review of Resident #22's September, October and November 2022 ADL (activities of daily living) record revealed that the resident was incontinent of bladder on each day/evening and night shift. An interview was conducted on 11/15/22 at 8:45 AM with CNA #1. When asked about staffing, CNA #1 stated, it is worse now than when we were in full COVID mode. I have 16 residents to care for today (3 CNAs with 58 residents). I cannot care for them with bathing, incontinence care, feeding, particularly when they were short on night shift (2 CNAs for 58 residents) and they could not keep up with their care either. When asked about the frequency of incontinence care, CNA #1, stated, it is supposed to be every two hours, when we have 3 CNAs, we can get it done 2-3 times a shift. When asked if the documentation under bladder incontinence on the ADL form indicates that incontinence care was provided every two hours during her shift, CNA #1 stated, no, it does not mean we did it every two hours.	F 677	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677		F 677		
	Continued From page 66 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 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 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." 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 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. 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.			

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	495339	A. BUILDING _____ B. WING _____	C 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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F 677	Continued From page 67 A review of the facility's "Activities of Daily Living" policy with no date, revealed, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of living (ADLs). Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene." No further information was provided prior to exit.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide adequate supervision to prevent injury for one of 33 residents in the survey sample, Resident #61, resulting in harm of past non-compliance. The findings include: The facility staff failed to supervise and assist Resident #61 (R61) with breakfast on 11/2/22. The resident spilled oatmeal on themselves and was diagnosed with a second degree burn on the forearm that required treatment with silver	F 689	Past noncompliance: no plan of correction required.	

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689		F 689		
	Continued From page 68 sulfadiazine cream (1). A facility investigation concluded the burn was caused by the spilled oatmeal. 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. 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 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 handed it to patient, she brought it to her mouth. Pt. then demonstrated ability to self feed multiple times with Mod (moderate) I to S/SBA (supervision/stand-by assistance)." An occupational therapy discharge summary dated 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." A dietary service line checklist dated 11/2/22			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689		F 689		
	Continued From page 69 documented the oatmeal temperature was 145 degrees. A nurse's note dated 11/2/22 documented, "Resident brought from dining room with oatmeal on [the resident's] shirt. No injuries noted at this time. Clothes changed and placed in Meaningful Life program." A nurse's note dated 11/3/22 documented, "Area was observed on resident's right forearm. Area was opened, 8cm (centimeters) L (length) x 3cm W (width). Cleaned area with wound cleaner and applied Non adhesive gauze, wrapped with cling. Was informed by day shift staff that resident had spilt hot oatmeal on (the resident's) arm the day before at breakfast, contacted ADON (assistant director of nursing) that will be on unit to assess the area. Added resident to the physician binder for area to be assessed. Removed bandage." A physician's order dated 11/3/22 documented an order for silver sulfadiazine cream 1% to be applied to R61's right forearm every day. A FRI (facility reported incident) submitted to the state agency on 11/3/22 documented, "On 11/03/2022, the facility staff reported that (R61) had a burn noted to her right forearm. The facility Nurse Practicianer (sic) assessed the the (sic) area, a treatment was initiated, and pain medication ordered." A note signed by the wound care nurse practitioner on 11/4/22 documented, "Wound #1 Right Forearm is a Full Thickness Without Exposed Support Structures Burn and has received a status of Not Healed. Initial wound encounter measurements are 9.36 cm			

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	495339	A. BUILDING _____ B. WING _____	C 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	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 689		F 689		
	Continued From page 70 (centimeters) length x 3.56 cm width with no measureable depth..." A nurse's note dated 11/4/22 documented, "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 11/4/22 documented a diagnosis of a second degree (partial thickness) burn. A facility final report dated 11/9/22 documented, "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] #9), dietary aide. While serving other residents 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 pants (right thigh). While wheeling (R61) to room, (LPN [licensed practical nurse] #6), LPN noted oatmeal on (R61's) right side of the long-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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 71 wiped off (R61's) arm to remove the oatmeal that fell off arm. (R61) did not say it was hurting or acted like (the resident) was hurting. (CNA #7) changed (R61's) pants and shirt with another long-sleeved shirt. After changing (R61's) clothing, she placed (R61) at the nurses' station. Per (CNA #7), (R61) spent the rest shift with (activities employee) in activities. (LPN #6), LPN reported that (CNA #7), CNA reported no pain or injury. Numerous other staff were interviewed and none reported any signs or symptoms of pain or injury to (R61). At 730 pm on 11/2/22 (CNA #9), CNA was preparing (R61) for bed, removed the long-sleeved shirt and noted an open area on (the resident's) right arm. No c/o (complaint of) pain voiced. She completed applying (R61's) night gown and notified the assigned nurse, (LPN #4). (LPN #4) said the wound looked like it had been scraped, no blood on arm or clothing. No blisters. Resident unable to answer how it happened. At about 0630 on 11/3/22 (LPN #7), LPN who was providing care to (R61) asked (LPN #4) to look at (R61's) area again. At this point area looked much more like a defined blister. The area was cleansed and a non-adhesive dressing was placed over the open area. The Assistant Director of Nursing (ASM [administrative staff member] #3) also assessed the area of concern and noted for the physician to evaluate (R61's) arm today (11/3/22) on rounds. At about 0815 on 11/3/33 (sic) physician assistant saw resident and silver sulfadiazine cream 1% ordered, lidocaine cream (a numbing agent) ordered. Additional pain medication ordered. Family made aware. SUMMARY OF CRITICAL INFORMATION	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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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 R61's CNA and the CNA immediately removed R61 from the dining room. On 11/16/22 at 10:38 a.m., an interview was conducted with CNA #7. CNA #7 stated R61			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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	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 689		F 689		

Continued From page 73

requires assistance with eating. CNA #7 stated R61 can feed self sandwiches and finger foods but must be physically assisted with liquids, soups and oatmeal. CNA #7 stated R61's arms are contracted and the resident can't always bring the spoon up right to the resident's mouth. CNA #7 stated R61 spills a lot of food while using utensils. CNA #7 stated she thought there was no nursing staff in the dining room during breakfast on 11/2/22 but she did not know why. CNA #7 stated that on 11/2/22, she was assisting another resident with care when OSM #9 came to her. CNA #7 stated OSM #9 told her R61 spilled oatmeal on the resident's body so she finished care with the other resident and went to the dining room to get R61. CNA #7 stated R61 had oatmeal on clothing covering the resident's right lower arm and right leg so she took R61 to the bed room and changed the resident's clothes. CNA #7 stated she did not see any redness or skin abnormalities on R61's right arm at that time.

On 11/16/22 at 11:19 a.m., an interview was conducted with LPN #6. LPN #6 stated she observed R61's right forearm on 11/2/22 when CNA #7 changed R61'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 conducted with ASM (administrative staff member)#5, physician assistant. ASM #5 stated she was notified of R61's burn the day after the oatmeal spill (11/3/22). ASM #5 stated R61's right forearm was wrapped with soft gauze and an ace bandage. ASM #5 stated she observed R61's right forearm and there was a "decent size burn." ASM #5 stated the area was a second

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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	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 689		F 689		

Continued From page 74 degree burn and there clearly had been a blister because the skin was folded like when one has a popped blister. ASM #5 stated the skin color was molted pink mixed with white and there was no visualization of muscle or bone. ASM #5 stated she prescribed treatment for the burn and R61 was evaluated by the wound care nurse practitioner the following day.

On 11/16/22 at 1:39 p.m., an interview was conducted with CNA #9. CNA #9 stated that on 11/2/22 around 7:30 p.m., she and a nurse was assisting R61 to bed and noticed a wound on the resident's right forearm. CNA #9 stated it looked like the skin was peeled back and the area was "super red."

On 11/16/22 at 2:22 p.m., an interview was conducted with LPN #4. LPN #4 stated that on 11/2/22, she helped CNA #9 assist R61 into bed and the CNA told her to look at R61's arm. LPN #4 stated the area on R61's right forearm did not look fresh and it was just red with no skin on it so she left it open to air. LPN #4 stated she thought R61 rubbed the area against something. LPN #4 stated the next morning (11/3/22), the area was more red and moist and day shift staff reported R61 spilled oatmeal on self the previous day. LPN #4 stated she called the ADON and the area was assessed by the ADON and the physician assistant.

On 11/16/22 at 3:13 p.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated nursing staff is supposed to be present in the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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	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 689		F 689		

Continued From page 75 many residents are present and how many residents need assistance.

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, "Safety and Supervision of Residents" documented, "POLICY: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.
DEFINITIONS:
"Supervision/Adequate Supervision": refers to an intervention and means of mitigating the risk of an accident.
Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual residents assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident."

The facility policy titled, "Assistance with Meals" documented, "Dining Room Residents:
1. Facility staff will serve resident trays and will help residents who require assistance with eating.
2. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity."

A facility action plan dated 11/4/22 with a completion date of 11/11/22 documented, "ISSUE/CONCERN: 1. Resident received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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	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 689	Continued From page 76 significant injury during breakfast...Root 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 Outcome: 1. Nursing staff will be in the dining room at all meal times on the Lee Unit. 2. Dietary staff will not deliver meals to residents in the Lee dining room until Nursing staff is present. CORRECTION: Resident assessed by PA (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 assistance/supervision. SYSTEM CHANGES: 1. The dietary will check temperature on 10 trays 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)	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 689	Continued From page 77 monthly..." All credible evidence from the above action plan was reviewed on 11/16/22. 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 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690	1. 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. 2. 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. 3. 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. 4. 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	12/25/2022

			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 re-educate 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. 5. Date of Compliance: 12/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING	C 11/17/2022

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F 690		F 690		
	Continued From page 78 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide incontinence care in a timely manner for one of 33 residents in the survey sample, Resident #51 (R51). The findings include: 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 H - Bladder and Bowel, the resident was coded as always being incontinent of both bowel and bladder. On 11/15/2022 at 9:04 a.m. R51 stated, "We don't get changed." R51 stated they were changes at			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 690		F 690		

Continued From page 79

6:30 a.m. and not since then. R51 stated, "It's now 9:00 a.m. and I have moved my bowels." The call bell was initiated by the resident. At 9:06 a.m. a staff member entered the room and then exited without changing the resident. The staff member went into the next room. At 9:26 a.m. the resident stated they still had not been changed. The resident was changed at 10:00 a.m. CNA (certified nursing assistant) #14, the restorative aide.

The comprehensive care plan dated, 5/11/2022 and revised on 11/14/2022, documented in part, "Focus: [R51] has an ADL self care performance deficit AEB (as exhibited by) need for assistance with all ADLs." The "Interventions" documented in part, "Physical assist as needed for all ADLs." There was no documentation related to incontinence or bowel and bladder.

An interview was conducted with CNA #14 on 11/15/2022 at 2:45 p.m. When asked if she assisted R51 that morning, CNA #14 stated she gave the resident a bath and applied lotion on their back, put new sheets on the bed, and stated it was not her usual assignment, but when she sees a call light on, she goes in and see what the resident needs. [R51] told me they wanted a bath and had soiled themselves. CNA #14 stated that since the resident had a BM (bowel movement) and it was all in the front of the resident in the front of the brief, she decided to give her a bath.

On 11/15/2022 at 4:23 p.m. an interview was conducted with CNA #1, the CNA assigned to R51. When asked why R51 had not been changed since 6:30 a.m., CNA #1 stated there was an incident with the resident in the next room, she had to handle that before she did

F 690		F 690		
	Continued From page 80 anything else. CNA #1 stated she was assigned 16 residents that day. When asked if that was normal, CNA #1 stated it's usually two aides and they usually pull from another floor. CNA #1 stated she got four residents up, she got to work at 7:30 a.m.; she hit the floor running and stated the assignment she had is a very heavy assignment. An interview was conducted with LPN (licensed practical nurse) #4, the unit manager, on 11/16/2022 at 10:13 a.m. When asked how often incontinence care is provided to residents, LPN #4 stated it should be every two hours unless the resident asks for it sooner. LPN #4 was informed of R51 waiting to be changed on 11/15/2022. LPN #4 stated she would normally change a resident if they request. [R51] will holler out to her in the hallway to come see her. LPN #4 stated the facility staff do not change residents during meals; she is trying to get a happy medium, if trays are out, we don't do incontinence care, we let them eat and then start changing everyone. The trays come on the floor at 7:30 a.m. and are picked up at 8:30 a.m. Unless someone tells them, they are sitting in stool, we don't know. When asked why it's not good to sit wet or sit in stool, LPN #4 stated, sitting in their own stool can lead to UTIs (urinary track infections). The facility policy, "Incontinence" documented in part, "Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services...4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible."			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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HOLLY MANOR REHAB AND NURSING	2003 COBB STREET FARMVILLE, VA 23901

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

			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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 695		F 695		
	Continued From page 82 term memory issues. In Section O - Special Treatment, Procedures and Programs, the resident was coded as using oxygen while a resident at the facility. R53 was observed on 11/15/2022 at approximately 8:45 a.m. in their bed with oxygen on 2 LPM (liters per minute) via a nasal cannula. A second observation was made on 11/15/2022 at 11:53 a.m. R53 was in the wheelchair with the oxygen on at 2 LPM via a nasal cannula with a portable tank secured to the wheelchair. Review of the physician orders failed to evidence a physician order for the use of oxygen. Review of the comprehensive care plan, last updated 11/14/2022, failed to evidence documentation of the use of oxygen for R53. An interview was conducted with LPN (licensed practical nurse) #4 on 11/16/2022 at 10:20 a.m. LPN #4 was asked to review R53's physician orders. When asked if she saw an order for the use of oxygen, LPN #4 stated, no. When asked if there needed to be a physician order for the use of oxygen, LPN #4 stated, yes and she didn't know why there wasn't an order. The facility policy, "Oxygen Administration," documented in part, "POLICY: The purpose of this procedure is to provide guidelines for safe oxygen administration. SPECIFIC PROCEDURES / GUIDANCE: Preparation -1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." ASM (administrative staff member) #4, the interim			

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HOLLY MANOR REHAB AND NURSING	2003 COBB STREET FARMVILLE, VA 23901

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F 695		F 695		
	Continued From page 83 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 provided prior to exit. 2. For Resident #98 (R98), the facility staff failed to obtain a physician's order for the use of an incentive spirometer and failed to store the incentive spirometer in a sanitary manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/20/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of Review of R98's November 2022 physician's orders failed to reveal a physician's order for an incentive spirometer. R98's comprehensive care plan dated 10/16/22 documented, "The resident has altered respiratory status/difficulty breathing r/t (related to) respiratory failure, COPD (chronic obstructive pulmonary disease), recent aspiration. Administer medication/puffers as ordered." On 11/15/22 at 9:12 a.m., R98 was observed sitting in a wheelchair in the bedroom. An incentive spirometer was on the resident's over bed table. The incentive spirometer mouth piece was uncovered and exposed to air. On 11/16/22 at 10:11 a.m., the incentive spirometer remained uncovered on R98's over bed table. At this time, an interview was conducted with R98. R98 stated they try to use the incentive spirometer ten times every hour and staff had not offered a covering for the device.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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F 695		F 695		
	Continued From page 84 On 11/16/22 at 3:26 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated residents should have a physician's order for the use of an incentive spirometer so the nurses can encourage use, make sure residents are using the device properly and make sure the device is within residents' reach. LPN #5 stated an incentive spirometer should be stored in a Ziploc bag for sanitation and cleanliness. On 11/16/22 at 6:19 p.m., ASM (administrative staff member) #4, the interim administrator and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, "Incentive Spirometry" documented, "To have patient perform sustained maximal inspiration without added resistance or positive pressure while presenting visual feedback of effort. Incentive Spirometry can be instructed/administered by an Respiratory Care Practitioner upon written physician's order." The policy failed to document information regarding incentive spirometer storage. No further information was presented prior to exit. 3. For Resident #206's (R206), the facility staff failed to obtain a physician's order the use of an incentive spirometer and failed to store the incentive spirometer in a sanitary manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/30/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 85 cognitively impaired for making daily decisions. A review of R206's November 2022 physician's orders failed to reveal a physician's order for an incentive spirometer. R206's comprehensive care plan revised on 11/9/22 failed to document information regarding an incentive spirometer. On 11/15/22 at 9:36 a.m., R206 was observed sitting in a wheelchair in the bed room. An incentive spirometer was on the resident's over bed table. The incentive spirometer mouth piece was uncovered, touching the over bed table and exposed to air. At that time, an interview was conducted with R206. R206 stated they use the incentive spirometer every two hours and staff had not provided a covering for the device. On 11/16/22 at 10:03 a.m., R206's incentive spirometer remained on the over bed table, with the mouth piece uncovered and touching the over bed table. On 11/16/22 at 3:26 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated residents should have a physician's order for the use of an incentive spirometer so the nurses can encourage use, make sure residents are using the device properly and make sure the device is within residents' reach. LPN #5 stated an incentive spirometer should be stored in a Ziploc back for sanitation and cleanliness. On 11/16/22 at 6:19 p.m., ASM (administrative staff member) #4, the interim administrator and ASM #2, the director of nursing were made aware of the above concern.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 695	Continued From page 86 No further information was presented prior to exit.	F 695		

F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) 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	1. 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. 2. 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. 3. 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	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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	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 698		F 698		
	Continued From page 87 11/15/2022 at approximately 8:45 a.m. When asked if they took any papers or a notebook to give to the dialysis staff when they go to dialysis, R63 stated, no. R63 stated they go to dialysis on Monday, Wednesday, and Friday. Review of the clinical record revealed one form titled, "Dialysis Assessment" dated 11/4/2022. The form was filled in by both the facility and the dialysis center. A request was made on 11/15/2022 for additional "Dialysis Assessment" forms. The comprehensive care plan dated, 9/29/2022, documented in part, "Focus: The resident has ESRD (end stage renal disease) and received hemodialysis at [name of dialysis center] in [name of town] M, W, F (Monday, Wednesday, Friday). The "Interventions" documented, "If bleeding from the vascular access is not controlled, apply direct pressure, call the dialysis team/nephrologist to determine the need for the resident to be transported emergently to the ED (emergency department). Pre-Post dialysis weights. Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis M, W, F. Auscultation/palpation of the AV (arterial Venous) fistula (pulse, bruit and thrill) to assure adequate blood flow per protocols. Do not draw blood or take B/P (blood pressure) in arm with graft." An interview was conducted with LPN (licensed practical nurse) #6 on 11/16/2022 at 7:39 a.m. When asked where the dialysis communication book for R63 was, LPN #6 stated she did not believe they had one. When asked what paperwork goes with the resident to dialysis, LPN #6 stated, the face sheet, medication list, and the			

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F 698		F 698		
	Continued From page 88 dialysis assessment form. When asked where these forms are stored when the resident gets back from dialysis, LPN #6 stated she puts them in the chart, but she comes back after she is off. An interview was conducted with LPN #4, the unit manager, on 11/16/2022 at 9:21 a.m. When asked what documents are sent with the residents who go to dialysis, LPN #4 stated, the dialysis assessment form, current list of medications and lunch. When asked where the dialysis assessment sheet is filed upon the resident's return from dialysis, LPN #4 stated, it's given to medical record to scan in. LPN #4 stated most of the time they (dialysis center) don't send it back. We send them but they won't send it back. LPN #4 stated she does not call the dialysis center for the forms, [the resident] gets back around 4:30 p.m. to 5:00 p.m. LPN #4 stated maybe if we sent a binder, that might work better. When asked what the purpose of the assessment form was, LPN #4 stated it's to put the vitals, medication changes or observations on. We are trying to communicate with them what's going on with her and it's them telling us what they did; was her BP normal during the process. LPN #4 was asked, if you don't get the form back is that communicating with them, LPN #4 stated, no. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/16/2022 at 2:57 p.m. who stated there is a communication form we send with the resident. When asked what the purpose of the form was, ASM #2 stated it's so we can monitor their care. They [dialysis center] usually don't fill out their form and send it back here, and the staff should be calling. There has to be continuity of care between the dialysis center and us.			

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F 698	Continued From page 89 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 how the resident's care will be managed including but not limited to:...b. communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination and collaboration." ASM #4, 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.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700	1. Informed consent for siderail rail usage has been obtained and siderail rail assessments have been completed for residents #68. Informed consent for siderails not obtained #20, siderails removed. The residents' care plans have been updated to reflect a current individualized plan of care related to siderail usage. Holly Manor Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2. Director of Nursing/designee has performed an audit of all current residents using side rails to ensure that informed consent is obtained, and the siderail assessment has been completed. Any variances that were found have been corrected. 3. Director of Nursing/designee has in-serviced licensed clinical staff, including RNs, LPNs and Nursing/Clinical leadership staff regarding the importance of discussing risks versus benefits of siderails 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 assessment, and obtaining informed consent for siderail usage. 4. Director of Nursing/designee will audit all 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 siderail assessments have been completed,	12/25/2022

			informed consent has been obtained for siderail usage, and that the resident medical record reflects the individual choices of each resident. Any issues identified will be addressed immediately by the 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 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	

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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 failed 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.			

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F 700		F 700		
	Continued From page 91 On 11/16/22 at 3:26 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (the nurse who completed the side rail assessment). LPN #5 stated she did not review the risks and benefits of bed rails and obtain informed consent from R68 or the resident's representative. LPN #5 stated the unit manager may have done this. On 11/17/22 at 9:19 a.m., an interview was conducted with RN (registered nurse) #4, R68's unit manager and ASM (administrative staff member) #3, the assistant director of nursing. RN #4 and ASM #3 stated they had not reviewed the risks and benefits of bed rails and obtain informed consent from R68 or the resident's representative. ASM #3 stated ASM #2, the director of nursing may have done this. On 11/17/22 at 10:24 a.m., an interview was conducted with ASM #2. ASM #2 stated she had not reviewed the risks and benefits of bed rails and obtain informed consent from R68 or the resident's representative. 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, "Bed Rail Risk and Safety" documented, "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			

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F 700	Continued From page 92 documented in the medical record." No further information was presented prior to exit. 2. For Resident #20 (R20), the facility failed to evidence a consent and a bed rail assessment indicating the need for bed rails while they were in use. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/25/2022, the resident was assessed as being moderately impaired for making daily decisions. On 11/15/2022 at 9:20 a.m., an observation of R20 was made in their room. R20 was observed lying in bed asleep with bilateral upper half bed rails in place. Additional observations of R20 on 11/15/2022 at 11:23 a.m., 11/15/2022 at 4:04 p.m. and 11/16/2022 at 8:45 a.m., revealed R20 in bed with bilateral upper half bed rails in place. The comprehensive care plan for R20 failed to evidence documentation of the use of bed rails. The physician orders for R20 failed to evidence documentation for the use of bed rails. The side rail and entrapment risk assessment dated 11/1/2022 for R20 documented in part, "...Is the resident dependent in bed mobility? Yes...Will the use of side rails optimize resident independence in bed mobility and transfer? No...Can the resident demonstrate use of the side rails, independently or with little prompting, for bed mobility? No...Has the resident or resident representative requested use of side rails?	F 700		

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F 700		F 700		
	Continued From page 93 No...Will the use of side rails during care provided by staff optimize resident safety and security? No...The following side rail use is recommended. No side rails indicated at this time...Other recommendations: Resident is unable to raise and lower side rails independently..." On 11/16/2022 at 9:28 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated they were not sure why R20 had bed rails. LPN #4 stated that R20 could not pull themselves up and could not hold onto them during care. LPN #4 reviewed the bed rail assessment for R20 and stated that it appeared that R20 was not supposed to have the bed rails on the bed. On 11/16/2022 at 1:36 p.m., an interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing. ASM #3 stated that they completed a bed rail safety assessment to ensure that they were safe for the resident to use them. ASM #3 stated that they assessed whether the resident was able to release the bed rail. ASM #3 stated that they had recently made changes to their process for bed rails. ASM #3 stated that when they evaluated a resident for bed rails they would see 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. The facility policy "Bed Rail Risk and Safety" documented in part, "...This organization will take measures to develop and implement a strategy to minimize the possibility of resident entrapment and or injury while using bed rails. This will			

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F 700	Continued From page 94 include an evaluation of residents who have a need for or desire to use bed rails and that may have characteristics that place them at special risk for entrapment...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..." 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 concern. No further information was presented prior to exit.	F 700		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725	1. Residents #22 was assessed and interviewed by nursing staff and interviewed by social services. The resident's concerns about staffing were addressed. The president's plan of care was reviewed and updated to reflect their resident-specific needs. It is the policy of Holly Manor to ensure that the facility has sufficient nursing staff to meet the needs of the residents. All residents have the potential to be affected by this alleged deficient practice. 2. Resident concerns related sufficient nursing staff have been addressed in a December 2022 resident council meeting. The steps of this plan of correction, as well as the 2567, were shared with resident council and their input was encouraged and received. The 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 Nursing/designee. 3. The Director of Nursing/designee has in-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 is insufficient staff, and how to schedule sufficient nursing staff.	12/25/2022

			4. The Director of Nursing/designee will meet with staffing coordinator 5x weekly for four weeks and then monthly for 2 months to review staffing patterns and ensure sufficient nursing staff are always in the facility. The Director of Nursing/designee will meet with the administrator and HR director weekly for 4 weeks and then monthly for 2 months to review hiring and recruitment goals to monitor the success of, and strengthen, recruitment efforts. 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	

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F 725	Continued From page 95 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident observation, facility document review and clinical record review, it was determined that the facility staff failed to provide sufficient staffing to meet resident needs for one of 33 residents, Resident #22. The findings include: The facility staff failed to provide sufficient staffing to meet resident needs. A request was made during the entrance conference on 11/14/22 at approximately 6:45 PM to ASM (administrative staff member) #2, the director of nursing to provide "as worked" staffing schedules from 10/14/22-11/14/22. When asked during the entrance conference if there were any staffing waivers, ASM #2 stated, "No, there are no waivers." As a part of the sufficient staffing facility task and a complaint investigation the as worked staffing sheets for 10/14/22-11/14/22 sheets for Lee Unit were reviewed. Lee Unit has 60 available beds with 58 beds occupied during survey.	F 725		

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F 725		F 725		
	Continued From page 96 A review of the Lee Unit as worked nursing schedule for 10/14/22-11/14/22 revealed, 2 CNAs (certified nursing assistants) scheduled on day shift: 10/21, evening shift: 10/11, 10/13, 10/16, 10/17, 10/29, 10/30, 11/2, 11/6, 11/13 and night shift: 10/10, 10/11, 10/14, 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. A review of the Lee Unit has worked nursing schedule for 10/14/22-11/14/22 revealed, 3 CNA (certified nursing assistant) scheduled on day shift: 10/10, 10/11, 10/17, 10/22, 10/24, 10/29, 10/30, 11/3, 11/4, 11/7, 11/11, 11/12, 11/13 and 11/14, evening shift: 10/10, 10/12, 10/15, 10/19, 10/20, 10/21, 10/22, 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, 11/4, 11/7, 11/8, 11/9, 11/10, and 11/11/22. Ratios on these dates were approximately 16 residents to one CNA. An interview was conducted at 8:45 AM with CNA #1. When asked about staffing, CNA #1 stated, it is worse now then when we were in full COVID mode. "I have 16 residents to care for today (3 CNAs with 58 residents). I cannot care for them with bathing, incontinence care, feeding, particularly when they were short on night shift (2 CNAs for 58 residents) and they could not keep up with their care either." When asked what the usual staffing numbers are, CNA #1 stated, a lot of times we have 3 CNAs, when we should have 4 at least. Overtime is not approved until that day, but they will use agency staff. Some of us have children and have to plan ahead for childcare to work the overtime.			

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F 725		F 725		
	Continued From page 97 On 11/15/22 at 9:00 AM, an 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 blanket and Resident #22 was naked except for heavy, full 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 daughter asked the CNA, when did you last change my mother. CNA #1 stated, "She has not 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." An interview was conducted on 11/15/22 at 2:43 PM, with OSM, #3, the scheduling coordinator. When asked what the staffing pattern is for each unit, OSM #3 stated, Brantley has 2 RN (registered nurses) and 1 CNA (certified nursing assistant) on days/evenings and 1 RN and 2 CNAs on nights. Grace has 1 RN and 2 CNAs on days/evenings and 1 RN and 1 CNA on nights. Lee has 2 RNs and 4 CNAs on days/evenings and 1 RN and 3 CNAs on nights. When asked how staffing vacancies are filled, OSM #3 stated, "We send out the daily open shifts. I send out a week or two ahead. Overtime is approved. We have agency fill in and we pull staff between Grace and Lee units. We have hired some CNAs and they are starting this coming week." When asked if she was aware that the facility triggered for staffing issues in the third quarter of 2022, OSM #3 stated, "No, I was not aware of that." An interview was conducted on 11/15/22 at 10:15 AM with ASM #2, the director of nursing. When			

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F 725	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.	F 725		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §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 based on the outcome of these	F 730	1. The facility has completed annual 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 in-serviced 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 conduct an audit of annual CNA	12/25/2022

			performance reviews weekly for 4 weeks and then monthly for 2 months to ensure that the reviews are completed. The Director of Nursing/designee will identify any trends and/or patterns and additional education 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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HOLLY MANOR REHAB AND NURSING	2003 COBB STREET FARMVILLE, VA 23901

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F 730	Continued From page 99 reviews. In-service 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 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. 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 CNA's with a request for evidence of performance review. 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	F 730		

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F 730	Continued From page 100 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 been working on getting the files correct." 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. A review of the facility's policy "Performance Evaluations" policy with no date, revealed, "The job performance of each employee shall be reviewed and evaluated at least annually." No further information was provided prior to exit.	F 730		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757	1. Resident #16's drug regime was reviewed by Nurse Practitioner. A new order was received by Nurse Practitioner for the Hydrochlorothiazide. 2. The Director of Nursing/designee will 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 will in-serviced nurses on the importance of administering medications in a safe and effective manner. The education included, but was not limited to, obtaining and recording vital signs or other monitoring parameters ordered prior to medication administration. 4. The Director of Nursing/Designee will perform an audit of residents with an order for Hydrochlorothiazide 5 times a week for 4 weeks, then 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 ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of compliance: 12/25/22	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 757		F 757		

Continued From page 101 consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review it was determined that the facility staff failed to ensure one of 33 residents in the survey sample was free of unnecessary medications, 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 than 140 ten times during October 2022 and five times during November 2022.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/26/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was cognitively intact for making daily decisions. R16 was coded as receiving a diuretic during the look back period and having high blood pressure.

The physician orders for R16 documented in part, "Hydrochlorothiazide 12.5 MG (milligram) * Give 1 tablet orally every day shift related to Essential (Primary) Hypertension. HOLD IF SBP (systolic blood pressure) < (less than) 140. Order Date: 06/13/2022. Start Date: 06/14/2022."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 757		F 757		

Continued From page 102

A review of R16's MAR (medication administration record) for October 2022 revealed the following blood pressures: 10/12/2022 Morning 137/82; 10/19/2022 Morning 134/70; 10/21/2022 Morning 132/71; 10/22/2022 Morning 121/68; 10/23/2022 Morning 121/68; 10/24/2022 Morning 122/66; 10/25/2022 Morning 128/72; 10/26/2022 Morning 119/73; 10/27/2022 Morning 122/75; and 10/28/2022 Morning 126/73. Further review of the October 2022 MAR revealed that Hydrochlorothiazide 12.5 mg was administered to R16 on each of the dates listed above when the systolic blood pressure was less than 140.

A review of R16's MAR (medication administration record) for November 2022 revealed the following blood pressures: 11/1/2022 Morning 126/71; 11/6/2022 Morning 137/72; 11/8/2022 Morning 138/74; 11/10/2022 Morning 125/59; and 11/12/2022 Morning 135/64. Further review of the November 2022 MAR revealed that Hydrochlorothiazide 12.5 mg was administered to 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

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 757		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.html			

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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-pressure#:~:text=Systolic%20pressure%20is%20the%20pressure,day%20based%20on%20your%20activities.	F 757		
F 760 SS=E	Residents are Free of Significant Med Errors 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 760	1. Resident #16's drug regime was reviewed 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 in-serviced 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	12/25/2022

			ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of compliance: 12/25/22	

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 760		F 760		
	Continued From page 105 than 140 ten times during October 2022 and five times during November 2022. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/26/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident was cognitively intact for making daily decisions. R16 was coded as receiving a diuretic during the look back period and having high blood pressure. The physician orders for R16 documented in part, "Hydrochlorothiazide 12.5 MG (milligram) * Give 1 tablet orally every day shift related to Essential (Primary) Hypertension. HOLD IF SBP (systolic blood pressure) < (less than) 140. Order Date: 06/13/2022. Start Date: 06/14/2022." A review of R16's MAR (medication administration record) for October 2022 revealed the following blood pressures: 10/12/2022 Morning 137/82; 10/19/2022 Morning 134/70; 10/21/2022 Morning 132/71; 10/22/2022 Morning 121/68; 10/23/2022 Morning 121/68; 10/24/2022 Morning 122/66; 10/25/2022 Morning 128/72; 10/26/2022 Morning 119/73; 10/27/2022 Morning 122/75; and 10/28/2022 Morning 126/73. Further review of the October 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. A review of R16's MAR (medication administration record) for November 2022 revealed the following blood pressures: 11/1/2022 Morning 126/71; 11/6/2022 Morning 137/72; 11/8/2022 Morning 138/74; 11/10/2022 Morning			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 107 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.html (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-pressure#:~:text=Systolic%20pressure%20is%20the%20pressure,day%20based%20on%20your%20activities.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 801	Continued From page 108	F 801		

F 801 SS=F	Qualified Dietary Staff 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	1. 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. 2. 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 full-time basis since June 15, 2022. 3. The Administrator/designee has in-serviced Human Resources staff on the qualifications of a Registered Dietician for a skilled nursing facility. The in-service 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. 4. 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. 5. Date of Compliance: 12/25/22	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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F 801		F 801		
	Continued From page 109 requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired 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 law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or(C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and			

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	495339	A. BUILDING _____ B. WING _____	C 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	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 801		F 801		
	Continued From page 110 (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to continuously employ a registered dietitian (RD) or qualified nutritional professional. The findings include: The facility staff failed to employ a registered dietitian or qualified nutritional professional from 4/30/22 until 6/15/22. A complaint submitted to the state agency on 6/29/22 alleged there was no registered dietitian employed by the facility since 5/1/22. A review of facility documents/timesheets revealed a RD began employment on 6/15/22. On 11/16/22 at 5:52 p.m., an interview was conducted with ASM (administrative staff member) #4, the interim administrator. ASM #4 stated the former RD left the facility right before the facility was sold to another company. ASM #4 stated another RD was not employed until 6/15/22. On 11/17/22 at 12:35 p.m., ASM #4 stated the former RD's last day of employment was 4/30/22 (no RD or qualified nutritional profession was employed at the facility from 4/30/22 until 6/15/22). On 11/17/22 at 12:55 p.m., ASM #4 and ASM #2,			

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F 801	Continued From page 111 the director of nursing, were made aware of the above 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 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. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed..." No further information was presented prior to exit. Complaint deficiency.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812	1. Certified Dietary Manager/Cook has performed a walk-through inspection and discarded expired items, has ensured all products were properly stored and dishwasher is in good repair. It is the policy of Holly Manor Rehab and Nursing to ensure food is procured, stored, and prepared in a sanitary manner and dishwasher is in good repair. Auto-Chlor performed inspection of dishwasher. Residents receiving meals from the kitchen have the potential to be affected by this alleged deficient practice. 2. The Certified Dietary Manager/designee 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 items found out of compliance have been corrected. 3. The Certified Dietary Manager/designee 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	12/25/2022

			per week for 4 weeks and then weekly for 2 months to ensure expired items have been discarded, products properly stored, and dishwasher is in good repair. Any variances identified will be immediately corrected and further education will be provided to staff regarding prevention of these variances. Certified Dietary Manager will present audit findings and any trends/patterns to the QAPI committee on a quarterly basis. 5. Date of Compliance: 12/25/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812		F 812		

Continued From page 112

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to properly store food products in the walk in refrigerator, discard expired food, and maintain the dishwasher in good repair in one of two kitchens in the facility.

The findings include:

On 11/14/2022 at 6:37 p.m., an observation of the kitchen on the Grace unit was conducted with OSM (other staff member) #8, dietary cook. Observation of the walk in refrigerator revealed a 12 pound container of homestyle potato salad with a use by date of 10/25/2022 on the lid. The container was observed to be unopened. OSM #8 observed the container and stated that the potato salad was old and needed to be thrown away. OSM #8 stated that the container was available for use. Observation of the walk in freezer revealed a 10 pound box of diced grilled chicken breast sitting on the freezer floor, a 16.72 pound box of oven ready four cheese pizzas sitting on the freezer floor and a 10 pound box of hotdogs sitting on the freezer floor. OSM #8 stated that they did not have a lot of room in the freezer, however the boxes should not be stored

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 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. 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 stated that the gauge did not appear to be getting to the temperature and they would report this to the supervisor. OSM #8 stated that the dishwasher had recently been repaired and they frequently had 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 the dishwasher was leased from the vendor and they had multiple problems with getting service from them. OSM #7 proceeded to run the dishwasher and observed the temperature gauge staying below 120 during the cycle. OSM #2 stated that the dietary staff had a thermometer 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 thermometer and 115 on the dishwasher temperature gauge. OSM #2 stated that it

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F 812		F 812		
	Continued From page 114 appeared that the temperature gauge was not accurate on machine and they needed to call the vendor to come in. A request was made to OSM #2 and OSM #7 for the manufacturers instructions for use and the past three months of temperature logs for the dishwasher. Review of the temperature logs dated 9/1/2022-11/15/2022 provided by OSM #2 documented the dishwasher temperature at 120 degrees or above daily for breakfast, lunch and dinner. On 11/15/2022 at approximately 1:30 p.m., OSM #2 provided instructions for use for the dishwasher which documented in part, "...Water supply temp 140 [degrees] F (Fahrenheit) Recommended (120 [degrees] F Minimum Water Temperature)..." The facility policy "Dishwashing Machine Use" documented in part, "Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation...7. The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately..." On 11/16/2022 at 6:17 p.m., ASM (administrative staff member) #4, the interim administrator and ASM #2, the director of nursing were made aware of the findings.			

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F 812	Continued From page 115 No further information was provided prior to exit.	F 812		

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

F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, 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	F 839	1. 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. 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 in-serviced 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	

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F 839		F 839		
	Continued From page 116 verification was not obtained from the DHP until 9/8/22. 2. CNA #2 with a date of hire of 11/17/20, the previous certification expired 3/31/22, however verification was not obtained from the DHP until 4/18/22. 3. CNA #3 with a date of hire of 3/16/92, the previous certification expired 8/31/22, however verification was not obtained from DHP until 9/8/22. 4. CNA #4 with a date of hire of 5/27/13, the previous certification expired 8/31/22, however verification was not obtained from DHP until 10/6/22. 5. CNA #5 with a date of hire of 8/18/97, the previous certification expired 12/31/21, however verification was not obtained from DHP until 4/18/22. 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 been working on getting the files correct. I know the certification has to be pulled from the Virginia Department of Health Professions site prior to the end of the month of expiration. 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. A review of the facility's policy "Licensure, Certification and Registration of Personnel" policy with no date, revealed, "A copy of the current license, certification or registration must be filed in the employee's personnel record. A copy of the recertification must be filed prior to the			

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F 839	Continued From page 117 expiration of current licensure, certification or registration." No further information was provided prior to exit.	F 839		
F 865 SS=F	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 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	F 865	1. 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)(I). All residents have the potential to be affected by this alleged deficient practice 2. A QAPI program has been maintained since August 2022. 3. 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). 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. 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	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 865	Continued From page 118 evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.	F 865		

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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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; §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 §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 compliance of such committee with the requirements of this section. §483.75(i) Sanctions. 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 residents in the survey sample. The findings include:			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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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..." No further information was presented prior to exit.	F 865		
F 867 SS=F	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	1. 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 2. A QAPI program has been maintained since August 2022. 3. 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). 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	12/25/2022

			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. 5. Date of Compliance: 12/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 121 policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action.	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 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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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 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. §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 outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct	F 867		

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F 867		F 867		
	Continued From page 123 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to implement policies and procedures for QAPI (Quality Assurance and Performance Improvement) program feedback, data systems and monitoring potentially affecting all residents in the survey sample. The findings include:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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HOLLY MANOR REHAB AND NURSING	2003 COBB STREET FARMVILLE, VA 23901

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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 impacting larger systems, corrective action and monitoring of the effectiveness of performance improvement activities 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. 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 follows up and verifies the results.

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 - Governance and Leadership" documented, "4. The responsibilities of the QAPI committee are to: a. Collect and analyze performance indicator data

F 867		F 867		
	Continued From page 125 and other information. b. Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services; c. Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process; d. Utilize root cause analysis to help identify where identified problems point to underlying systemic problems; e. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care; f. Establish benchmarks and goals by which to measure performance improvement; g. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals..." No further information was presented prior to exit.			
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 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 performance improvement projects required under the QAPI program, are necessary. §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 QAPI (Quality Assurance and Performance Improvement) meetings potentially affecting all residents in the survey sample. The findings include The facility staff failed to evidence quarterly QAPI meetings were conducted 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 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 manager, activities director, laundry manager, a			

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 868	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 role...6. 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.	F 868		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	1.) The facility has written evidence of current infection control policy and procedure, including guidance related to the COVID 19 from CMS and the U.S Centers for Disease Control and Prevention (CDC) a. Training: Holly Manor Healthcare Center has an infection prevention program to include surveillance, tracking, and trending of infection. Licensed nursing staff (RN and LPNs) including the nursing 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	12/15/2020

resident (s) neighborhoods/ nursing unit identified.

b. The Infection Preventionist and Director of Nursing, in conjunction with the medical Director and senior leadership /Governing body concurrence, shall:

i. Developed and implemented procedures to strictly limit all visitors to the facility.

ii. Developed and implemented procedures to utilize an at the door symptom check for all visitors, vendors, and others before entering the facility.

iii. Developed and implemented procedures to screening all staff at the beginning of their shift for fever and respiratory symptoms. Procedure actively measures and records staff temperatures, assessment of shortness of breath, sore throat, fever, body aches, nausea, vomiting, new loss of taste, new loss new or changed cough and sore throat.

3.) Systemic changes:

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

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

			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 with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA was incorporated into the intervention plan 7) Date of compliance: 12/15/22	

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HOLLY MANOR REHAB AND NURSING	2003 COBB STREET FARMVILLE, VA 23901

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F 880	Continued From page 128 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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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.

§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 by:
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.

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.

ASM (administrative staff member) #2, the director of nursing, stated on 11/16/2022 at 5:25 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 130 had a line listing of the infections in the facility with type of infections, source, culture results and/or x-ray results, ASM #2 stated, no. When asked the process for tracking and trending infections in the facility, ASM #2 stated they know what antibiotic, what organism is being treated, watch if there is a pattern on a particular room, assignment, or shift. When asked where all of this is located, ASM #2 stated she hadn't seen any tracking and trending of infections since she arrived the end of July. When asked if she had seen any tracking and trending logs, ASM #3 stated, in the 45 days she was the acting director of nursing, she did not see any logs. The facility policy, "Surveillance for \Infections" documented in part, "Policy: The infection preventionist [designee] will conduct ongoing surveillance for healthcare-associated infections [HAIs] and other epidemiologically significant infections that have substantial impact on potential resident outs comes and that may require transmission -based precautions and other preventative interventions...Gathering Surveillance Data: 1. The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data...Data Collection and Recording: 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate. 2. Identifying information (i.e., resident's name, age, room number, unit and attending physician); a. Diagnosis. b. Admission date, date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test). c. Infection site (be as specific as possible, e.g., cutaneous infections should be listed as "pressure ulcer, left foot, " pneumonia as right	F 880		

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F 880	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 infection...Monthly - 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.	F 880		
F 881 SS=C	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 881	1. It is the policy of Holly Manor Rehab and Nursing to implement an antibiotics stewardship program. Holly Manor Rehab and Nursing has determined that all residents have the potential to be affected by this alleged deficient practice. 2. Holly Manor Rehab and Nursing has implemented an antibiotics stewardship program under the supervision of the Director of Nursing/Infection Preventionist. 3. The Director of Nursing/Infection Preventionist has educated all licensed clinical staff, including RNs and LPNs on the antibiotic stewardship program. The education included, but was not limited to, the importance of antibiotic stewardship in infection control, and the individual responsibilities of nurses in supporting and adhering to the antibiotic stewardship program. 4. The Director of Nursing /Designee will perform an audit of all antibiotics used in the facility 5 times weekly for 4 weeks and then weekly for 6 weeks to ensure that antibiotics are administered, and antibiotic orders written, in accordance	12/25/2022

			with the antibiotic stewardship program. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 881		F 881		
	Continued From page 132 system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to conduct an ongoing antibiotic stewardship program. The findings include: There was no documentation of any antibiotic stewardship program. Upon entrance on 11/14/2022 a request was made for evidence of an antibiotic stewardship program. On 11/16/2022 at 5:25 p.m. ASM (administrative staff member) #2, the director of nursing, stated the facility had no documentation of an antibiotic stewardship program. ASM #2 stated there was no QA (quality assurance) documentation prior to September 2022. ASM #2 stated she had called the pharmacist who stated they (pharmacist) was not allowed to be involved in the antibiotic stewardship program before. An interview was conducted on 11/17/2022 at 10:08 a.m. with ASM #2 and ASM #3, the assistant director of nursing. When asked the process for the antibiotic stewardship program, ASM #2 stated we see if the infections meet the McGreer's definition of an infection. We look at the antibiotic, bacteria involved, ensure a start, and stop date for the antibiotics, and make sure it's the right antibiotic for the infection. When asked who reviews the use of antibiotics in the facility, ASM #2 stated they review them in their morning meetings. When asked if the medical			

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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			

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	495339	A. BUILDING _____ B. WING _____	C 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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F 881	Continued From page 134 establish and maintain and interdisciplinary Antibiotic Stewardship Program that will at a minimum include participation by the medical director, prescribing physicians/non-physician practitioners, consulting pharmacist, 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, 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. 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 further information was provided prior to exit.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training,	F 882	1. It is the policy of Holly Manor Rehab and Nursing to ensure that the facility has a qualified Infection Preventionist. 2. A qualified Infection Preventionist who fulfills the requirements has been employed at Holly Manor Rehab and Nursing on a full-time basis since 7/25/22. 3. A new qualified Infection Preventionist has been designated and the Director of Nursing has trained the individual in responsibilities. 4. 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 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. 5. Date of Compliance: 12/25/22	12/25/2022

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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 by:
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 failed 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"

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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 882		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:	F 888	1. A staff matrix was created to track and document the COVID-19 vaccination status of contract staff. 2. The Infection Preventionist/designee has reviewed COVID-19 vaccination status for all contract staff of Holly Manor Rehab and Nursing. All current contract staff are either vaccinated or have a valid exemption from vaccination and the information has been documented on the matrix. 3. The Administrator/Designee has in-serviced Infection Preventionist on COVID-19 vaccination for staff. The education includes but is not limited to the importance of tracking and documenting the COVID-19 vaccination status of contract staff. 4. The Infection Preventionist /Designee will perform an audit of vaccination status of contract staff weekly for 4 weeks and then monthly x2 months to ensure employees are fully vaccinated or have a valid exemption documented on the staff matrix. The Infection Preventionist /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	12/25/2022

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F 888	Continued From page 137 (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses	F 888		

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F 888	Continued From page 138 as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received	F 888		

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	495339	A. BUILDING _____ B. WING _____	C 11/17/2022

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F 888	Continued From page 139 monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed implement their COVID-19 policy to track and document the COVID-19 vaccination status for contract employees. The findings include: Upon entrance on 11/14/2022, a request was made of the list of contracted staff or vendors that come into the facility to provide services and care to the residents. A second request was made on 11/15/2022. The staff matrix, COVID - 19 Staff Vaccination Status for Providers was presented. An interview was conducted with ASM (administrative staff member) #4, the interim administrator, on 11/16/2022 at 5:25 p.m. When asked if there was any documentation of vendors or contract employee vaccination status, ASM #4	F 888		

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F 888	Continued From page 140 stated they have folders on the agency staff (nurses and CNAs [certified nursing assistants]) but no other providers. When asked if they had documentation of the hospice staff coming in the building of their vaccination status, ASM #4 stated, no. ASM #4 stated they do not have a list of any non-nursing vendors entering the building. An interview was conducted with ASM #2, the director of nursing, on 11/17/2022 at 10:08 a.m. When asked why the tracking of contract employees or anyone who routinely enters the facility to provide services, ASM #2 stated the facility did not have a list of contracted employees. The agency nurses and CNAs have a file, and their vaccination status is in the file. What is the process for a vendor entering the building, ASM #2 stated the facility should be asking their vaccination status prior to them entering the building. If the vendor is not vaccinated, there are to wear an N-95 mask, which the facility would provide. When asked if the facility tests for COVID of the vendors, ASM #2 stated, no. The facility policy, "COVID-19 Vaccination for Staff" documented in part, "Policy: The facility is committed to maintaining infection control protocols to minimize transmission of COVID -19 to residents and staff. In order to protect residents and staff from COVID-19, the facility will develop and implement policies and procedures that meet each resident's, resident representatives, and staff member's information needs and will offer vaccines to all residents and staff..."Staff - means those individuals who work in the facility on a regular (that is, at least once a week) basis, including individuals who may not be physically in LTC (long term care) facility for a	F 888		

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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.	F 888		
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to maintain an effective training program for two of 5 employee reviews. The findings include: The facility staff failed to train LPN (licensed practical nurse) #8 and CNA (certified nursing assistant) #11 regarding the new electronic	F 940	1. Employee #8 has been trained on the electronic medical record system and employee #11 is no longer employed by the facility. 2. The Administrator/designee has performed an audit on the education records of CNA and licensed nurses to ensure training on the electronic medical record has been completed. All current CNA and licensed nurses have been trained on the electronic medical record. 3. The Administrator/Designee has in-serviced Human Resource Director and nurse management team on the importance of training CNA and licensed nurses on the electronic medical record and the record keeping of the employee training. 4. The Administrator/Designee will conduct an audit of the education records of 10% of the CNA and licensed nurses weekly x4 weeks and monthly x2 months to ensure that upon hire all new CNA and licensed nurses have received education on the 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. 5. Date of Compliance: 12/25/22	12/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	495339	B. WING	C 11/17/2022

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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.	F 940		
F 943 SS=E	Abuse, Neglect, and Exploitation Training	F 943	1. Employees #5, #3, #12, #13 and #9 have now received abuse and dementia management training. 2. 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	12/25/2022

			employees have the abuse and dementia management training. 3. The Administrator/Designee has in-serviced 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. 4. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 943		F 943		
	Continued From page 143 CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to provide abuse and dementia management training for five of six agency employee reviews. The findings include: The facility staff failed to provide abuse and dementia management training to RN (registered nurse) #5, LPN (licensed practical nurse) #3, CNA (certified nursing assistant) #12, CNA #13 and LPN #9. A complaint submitted to the state agency on 6/29/22 alleged a concern regarding agency staff training. RN #5 was hired on 9/2/22.			

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F 943	Continued From page 145 The facility policy titled, "Abuse" documented in part, "...At a minimum, education on abuse, neglect, and exploitation will be provided to facility staff upon hire and annually. In addition to the freedom from abuse, neglect, mistreatment of residents, misappropriation of property and exploitation requirements in 483.12, the organization will also provide training to their staff 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 above concern. No further information was presented prior to exit. Complaint deficiency.	F 943		