STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Description of structure: The main facility is a one story building with a construction type of II (000) Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 1/27/17in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not compliance with the Requirements for Participation Medicare and Medicaid.	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all Federal and State regulations the facility has or will take the following actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the dates indicated.	
K 211 SS=D	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This Standard is not met as evidenced by: Based upon observations there is no all weather walking surface from the exit discharge door to the public way so all occupants can egress safely to the public way and there are doors that require excessive force to unlock the door that could affect the egress from spaces or the facility. Findings include Between 11:00 AM and 11:28 AM on 1/27/17 it is observed that there is no all surface walkway to the public way from the exit discharge door from the pharmacy.	K 211	Exit sign will be removed from door and a sign placed stating "Not an Emergency Exit". Evacuation routes will be reviewed to ensure proper egress paths through the main lobby. Staff working in the area will receive education of the egress change. No other areas affected. Safety committee will monitor.	3/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RES / CEO — (X6) DATE: 2/28/17

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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K 211	Continued From page 1 Around 1:40 PM on 1/27/17 it is observed that the door requires excessive force to initiate time delay magnetic lock countdown to unlock left door near room 140. Around 1:49 PM on 1/27/17 it is observed that the door requires excessive force to initiate time delay magnetic lock countdown to unlock left door near room 148.	K 211	Door contractor in on 2/24/17 and adjusted the affected doors. All doors will be checked for proper operation of magnetic locks. Safety Manager will check doors weekly for proper functioning. safety Committee will monitor quarterly for compliance.	2/24/17
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This Standard is not met as evidenced by: Based upon observations there are areas that do not have the required emergency lighting. Findings include Between 11:00 AM and 11:28 AM on 1/27/17 it is observed that there is an exit sign at the exit discharge door in the pharmacy that there is no emergency lighting outside with at least 2 light bulbs.	K 291	Exit sign will be removed from door and a sign placed stating "Not An Emergency Exit". Evacuation routes will be reviewed and revised as necessary to reflect proper egress paths. Staff working in the area will receive instruction on the change No other areas affected. Safety Committee will monitor as necessary.	3/13/17
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates	K 321		

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K 321	Continued From page 2 that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This Standard is not met as evidenced by: Based upon observations hazardous areas are not maintained to provide required separation and or fire resistant ratings for the hazardous areas. There are doors that are not self closing and latching, are damaged and doors that do not have the required listing for door hardware that could allow smoke and hot gasses to pass through the doors. Findings include Around 2:43 PM on 1/27/17 it is observed that the fire rated door to dirty laundry room is not self closing and latching.	K 321	Laundry door self-closing mechanism was replaced. All self-closing doors will be inspected for proper functioning. Safety Manager will inspect self-closing doors monthly. Safety Committee will monitor for compliance quarterly.	3/13/17
K 324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		

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K 324	Continued From page 3 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This Standard is not met as evidenced by: Based upon observation the kitchen equipment is not located in the correct position to provide proper coverage of the suppression system and to capture grease laden vapors and to maintain the equipment in the correct position under the hood. Findings include Around 12:20 PM on 1/27/17 it is observed that there is a stove that is not in correct location under the hood in kitchen. Around 12:20 PM on 1/27/17 it is observed that there is a stove that is not in correct location under the suppression nozzles in kitchen.	K 324	Stove has been moved to the correct location. Fire Suppressant company will verify placement. Maintenance will install metal guide to prevent the stove from shifting out of the correct location. Safety Manager will inspect stove placement monthly. Safety Committee will monitor for compliance quarterly. Fire Suppressant Company will verify suppression nozzle placement and adjust as necessary. No other area affected Safety Manager will review nozzle placement with contractor quarterly. Safety Committee will monitor for compliance quarterly.	3/13/17 3/13/17

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K 324	Continued From page 4 Around 12:24 PM on 1/27/17 it is observed that there are holes in the kitchen exhaust hood that are not welded shut or sealed with a listed sealing fitting.	K 324	Hole covered with metal plate. No other area affected. Hood will be inspected monthly by safety manager. Safety Committee will monitor quarterly for compliance.	3/13/17
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This Standard is not met as evidenced by: Based upon observations of the fire alarm system that there are areas where the required smoke detectionare not installed according to NFPA 72. Findings include Around 1:20 PM on 1/27/17 it is observed that there is a smoke detector that is not installed in an outlet box that is attached to the grid it is attached to the ceiling tile and the joints in the wires are exposed.	K 341	Smoke detectors will be installed in an outlet box attached to a grid or other support mechanism. All smoke detectors will be inspected for proper installation Safety Manager will inspect semi-annually to ensure proper placement. Safety Committee will monitor annually for compliance.	3/13/17
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing	K 353		

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K 353	Continued From page 5 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based upon observations of the sprinkler system that the required maintenance of the system is not being maintained. Findings include During review of the inspection reports on 1/27/17 between 10:00AM and 11:30 AM it is observed that there is a note on the sprinkler inspection report dated 9-23-16 and 6-30-16 for glycol system the reports do not have the concentration results for the system. Between 11:00 AM and 11:28 AM on 1/27/17 it is observed that there are openings in ceiling in closet admissions office that could allow hot gases to pass above the ceiling that could affect the operation of the sprinkler system.	K 353	Sprinkler contractor will replace the system so that the actual concentration can be obtained. No other areas affected. Safety Manager will review quarterly reports from contractor to ensure compliance to the reporting requirements. Safety Committee will monitor quarterly for compliance. The closet ceiling openings in the admissions office were sealed. No other areas affected The Safety Manager will review all closets monthly to ensure proper sealing of any openings. Safety Committee will monitor quarterly for compliance. Canopy sprinkler heads were cleaned. All sprinkler heads were inspected for any dirt buildup. Sprinkler heads will be inspected monthly for dirt buildup by he Safety Manager. Safety Committee will monitor quarterly for compliance.	3/13/17 3/13/17 3/13/17

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K 353	Continued From page 6 Around 11:28 AM on 1/27/17 it is observed that there are dirty sprinkler heads in canopy at front entrance. Around 11:30 AM on 1/27/17 it is observed that there is insulation that obstructs sprinkler coverage in attic above the class room. Around 12:00 PM on 1/27/17 it is observed that there is a missing sprinkler escutcheon near exit discharge door in dining room. Around 2:30 PM on 1/27/17 it is observed that the area behind the dryers there is an opening in ceiling.	K 353	Insulation will be removed or properly placed as not to obstruct sprinkler. No other areas affected. Safety Mgr will inspect quarterly for insulation placement. Safety Committee will monitor for compliance semi-annually. Missing escutcheon replaced. All sprinklers will be inspected for escutcheon placement. Safety Mgr will inspect monthly for escutcheon placement. Safety Committee will monitor for compliance quarterly. Maint repairs were in process at the time of inspection. Opening covered upon completion of repairs. No other areas affected. Maint Staff will receive education on proper monitoring of open areas under repair. Safety Mgr will inspect active ceiling work areas for compliance. Safety Committee will monitor for compliance quarterly.	3/13/17 3/13/17 3/13/17
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel	K 363		

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K 363	Continued From page 7 or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This Standard is not met as evidenced by: Based upon observations of all corridor doors there are doors found that did not have positive latching that could allow smoke to pass through the doors. Findings include Around 1:18 PM on 1/27/17 it is observed that there are penetrations in the fire rated smoke barrier wall near nursing office that are not fire stopped with a listed design and product.	K 363	Fire stop has been installed in all penetrations. All fire walls will be checked for proper installation of fire stop in penetrations. Staff will receive education on proper installation of fire stop Safety Manager will inspect all fire walls quarterly. Safety Committee will monitor for compliance quarterly.	3/13/17
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		

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K 372	Continued From page 8 This Standard is not met as evidenced by: Based upon observations the fire rated smoke barrier walls have penetrations, joints and openings that are not fire stopped and could allow smoke to pass from one side of the smoke barrier to the other side. Findings include Around 11:54 AM on 1/27/17 it is observed that there are penetrations that are not fire stopped with a listed design and product in the smoke barrier wall between the assisted living and nursing home. Around 1:45 PM on 1/27/17 it is observed that are penetrations in the fire rated smoke barrier wall near room 130 that are not fire stopped with a listed design and product. Around 1:56 PM on 1/27/17 it is observed that are penetrations in the fire rated smoke barrier wall near room 150 that are not fire stopped with a listed design and product.	K 372	Fire stop has been installed in all penetrations. All fire walls will be checked for proper installation of fire stop in penetrations. Staff will receive education on proper installation of fire stop Safety Manager will inspect all fire walls quarterly. Safety Committee will monitor for compliance quarterly.	3/13/17
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This Standard is not met as evidenced by:	K 374		

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K 374	Continued From page 9 Based upon observations the smoke barrier fire rated doors have gaps between the door and the astragal that could allow smoke to pass through the doors observed at one out of three smoke barrier doors. Findings include Around 1:52 PM on 1/27/17 it is observed that there is a gap that is greater than 1/8" between the astragal and the face of the opposite fire rated door in the 1-hour smoke barrier near room 143.	K 374	Gap has been repaired and door now meets code. All fire doors will be checked for proper gapping. Safety Manager will receive education on how to inspect for proper gapping. Safety Manager will inspect for proper gapping monthly. Safety Committee will monitor for compliance quarterly.	3/13/17
K 911 SS=D	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This Standard is not met as evidenced by: Based upon observations the electrical systems and equipment is not being maintained. Findings include Between 11:00 AM and 11:28 AM on 1/27/17 it is observed that there is low voltage cable laying on the ceiling and sprinkler pipes in the pharmacy. Between 11:00 AM and 11:28 AM on 1/27/17 it is observed that the clear working space in front of electrical panel 15 in closet admissions office is maintained clear of storage. Around 11:30 AM on 1/27/17 it is observed that there is low voltage cable laying on ceiling and is not Supported class room.	K 911	Low voltage cables have been tied up so that they do not lay on the ceiling. All ceiling areas will be checked for proper low voltage cable placement. IT department will receive education on the proper placement of low voltage cables. Safety Manager will inspect ceiling areas quarterly. Safety Committee will monitor for compliance quarterly. Admissions closet was cleared of storage items in from of panel. All panels will be inspected for proper clearance. Staff will be educated on proper clearance in front of panels. Safety Mgr will inspect monthly. Safety Committee will monitor for compliance quarterly.	3/13/17 3/13/17

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K 911	Continued From page 10 Around 12:05 PM on 1/27/17 it is observed that there are electrical panels that are not labeled as to what panel it is and there is a panel that does not have a directory noting what circuit the break serves in the main electrical room. Around 12:29 PM on 1/27/17 it is observed that the breakers are not labeled as to what circuits that they supply in panel 7 in the kitchen. Around 12:35 PM on 1/27/17 it is observed that There is a disconnect that is not labeled in janitors closet in kitchen as to what it feeds. Around 1:56 PM on 1/27/17 it is observed that there are low voltage electrical cables that are laying on the ceiling and not supported above the ceiling near room 150. Around 2:30 PM on 1/27/17 it is observed that the area behind the dryers there is open in wiring and the.	K 911	Electric panels and disconnect boxes have been properly labeled. All panels and disconnect boxes will be inspected for proper labeling. Safety Mgr will inspect panels and disconnect box labeling quarterly. Safety Committee will monitor for compliance quarterly. 3/13/17 Wiring behind dryers was corrected. No other areas affected. Safety Manager will inspect behind the dryers monthly for open wiring Safety Committee will monitor for compliance quarterly. 3/13/17	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL	K 920		

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HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 11 standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This Standard is not met as evidenced by: Based upon observations the electrical systems and equipment is not being inspected and tested. Findings include Around 1:40 PM on 1/27/17 it is observed that there is a non-approved power strip in room 141. Between 1:56 PM and 2:43 PM on 1/27/17 it is observed that there are non-approved power strips at patient bed locations in rooms150, 156, and 161. Around 2:50 PM on 1/27/17 it is observed that there is an extension cord that is plugged into power strip in IT Office.	K 920	All power cords have been removed from the facility and replaced with approved surge protectors. Staff will receive education on proper uses of power cords including approved types for nursing facilities. Safety Manager will inspect all areas in the facility for proper usage of power cords quarterly. Safety Committee will monitor for compliance quarterly.	3/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **02 - GRACE WING** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Description of structure: The Grace Wing is a one story building with a partial basement with a construction type of V (111) Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 1/27/17in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not compliance with the Requirements for Participation Medicare and Medicaid.	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all Federal and State regulations, the facility has or will take the following actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the dates indicated.	
K 161 SS=D	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Pres / CEO — (X6) DATE: 2/28/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **02 - GRACE WING** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 1 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This Standard is not met as evidenced by: Based upon observations there is paper backed insulation exposed to the interior of the building and is not enclosed with limited or non combustible construction. Findings include Around 2:10 PM on 1/27/17 it is observed that there is paper backed Insulation where the paper is exposed above the ceiling in the connector wall.	K 161	Insulation exposed will be removed and/or covered with sheetrock. No other areas affected. Safety Mgr will inspect areas above the ceiling semi-annually to ensure no insulation with paper backing is exposed. Safety Committee to monitor for compliance annually.	3/13/17
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **02 - GRACE WING** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This Standard is not met as evidenced by: Based upon observations hazardous areas are not maintained to provide required separation and or fire resistant ratings for the hazardous areas. There are doors that are not self closing and latching, are damaged and doors that do not have the required listing for door hardware that could allow smoke and hot gasses to pass through the doors. Findings include Between 2:10 PM and 2:49 PM on 1/27/17 it is observed that the serving area has been changed to a housekeeping storage room. The room is less than 50 square feet and the doors are not self closing and latching.	K 321	Housekeeping items have been removed from the room. The room will no longer be used as a storage room. All storage rooms will be checked for compliance. Staff will receive education on the proper storage of supplies and chemicals. Safety Manager will inspect all storage areas monthly to ensure compliance to regulatory guidelines Safety Committee will monitor for compliance quarterly.	3/13/17
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **02 - GRACE WING** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

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K 345	Continued From page 3 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based in observations the fire alarm system is not beining maintained. Finding include Around 2:49 PM on 1/27/17 it is observed that there is a ground fault trouble on the fire alarm panel.	K 345	Fire Alarm Contractor contacted about the ground fault trouble and repaired the problem. No other areas were affected. Staff will be educated on proper procedures to notify Safety Mgr of trouble alarms. Safety Manager will check panels at least weekly. Safety Committee will monitor for compliance quarterly.	at 3/13/17
K 918 SS=D	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **02 - GRACE WING** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

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K 918	Continued From page 4 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by: Based upon review of documentation that there is not complete documentation of the testing and inspection of the emergency generator according NFPA 110. Findings include During review of the inspection reports on 1/27/17 between 10:00AM and 11:30 AM it is observed that there is no documentation noting that the generators have been run under load for 4 hours every 3 years.	K 918	Generator will receive the required load test and documentation of test will be maintained by the Safety Manager. Required testing will be scheduled per regulatory requirements. 3/13/17 Safety Committee will monitor for compliance quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **03 - BRANTLEY WING** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

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K 000	INITIAL COMMENTS Description of structure: The Brantley Wing is a one story building with a construction type of V (111) Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 1/27/17 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not compliance with the Requirements for Participation Medicare and Medicaid.	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all Federal and State regulations, the facility has or will take the following actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the dates indicated.	
K 100 SS=D	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Based upon observations the electrical equipment rooms are not maintained clear of combustible material. Findings include Between 2:49 PM and 3:18 PM on 1/27/17 it is observed that there is combustible storage in the main mechanical room.Referenced by Virginia Statewide Fire Prevention Code 313.1	K 100	Combustible items were removed from the mechanical room. No other areas were affected. Staff will receive education about the proper storage of combustible item. All storage areas will be inspected monthly to verify that combustible items are properly stored. The Safety Committee will monitor for compliance quarterly.	3/13/17
K 324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities	K 324		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: HRS / CEO — (X6) DATE: 2/28/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **03 - BRANTLEY WING** B. WING _____	**01/27/2017**

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HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

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K 324	Continued From page 1 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This Standard is not met as evidenced by: Based upon observation the kitchen equipment is not located in the correct position to provide proper coverage of the suppression system and to capture grease laden vapors and to maintain the equipment in the correct position under the hood. Findings include Around 3:49 PM on 1/27/17 it is observed that the electric gas valve to shut off the fuel to the kitchen equipment when the hood suppression is activated is installed in the vertical position and not in a horizontal position.	K 324	Contractor has been contacted to reposition the valve in the approved position. Appropriate repairs will be made. No other areas were affected. The safety Committee will monitor for compliance quarterly. 3/13/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **03 - BRANTLEY WING** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

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K 324	Continued From page 2 Around 3:37 PM on 1/27/17 it is observed that the strain relief is not connected to stove that is on wheels to prevent damage to the flexible gas supply is not connected to the stove. Around 3:37 PM on 1/27/17 it is observed that the facility replaced a 2 burner stove with 4 burner stove is not located where the edge of the cooking is located at least 6 inches away from the inside edge of the hood. Around 3:37 PM on 1/27/17 it is observed that there is no device installed to maintain the stove in the correct location under the suppression nozzles.	K 324	The strain relief was connected to the stove. No other areas were affected. Safety Manager will inspect for proper connection monthly. Safety Committee will monitor for compliance. A non-combustible wall will be added to the right of the stove. Staff will be educated on the proper placement of items under the hood. Safety Manager will inspect for proper placement monthly. Safety Committee will monitor for compliance.	2/1/17 3/13/17
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363	Stabilizers will be secured to floor that will maintain stove in proper position. Staff will be educated on proper placement of the stove under the hood. Safety Manager will monitor for proper placement monthly Safety Committee will monitor for Compliance.	3/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **03 - BRANTLEY WING** B. WING _____	**01/27/2017**

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HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

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K 363	Continued From page 3 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This Standard is not met as evidenced by: Based upon observations of all corridor doors there are doors found that did not have positive latching that could allow smoke to pass through the doors. Findings include Around 3:18 PM on 1/27/17 it is observed that the right dining room door is not latching. Around 3:37 PM on 1/27/17 it is observed that the corridor door to room 122 is not latching 122.	K 363	The latch on the right dining room door was repaired. No other doors were affected. Safety Manager will check doors for proper closure monthly. Safety Committee will monitor for compliance. The door to room 122 was repaired all resident room doors were checked for proper closure. Safety Manager will check doors monthly for proper closure and repair as necessary. Safety Committee will monitor for compliance.	3/13/17 3/13/17
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **03 - BRANTLEY WING** B. WING _____	**01/27/2017**

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K 918	Continued From page 4 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by: Based upon review of documentation that there is not complete documentation of the testing and inspection of the emergency generator according NFPA 110. Findings include During review of the inspection reports on 1/27/17 between 10:00AM and 11:30 AM it is observed that there is no documentation noting that the generators have been run under load for 4 hours every 3 years.	K 918	Generator will receive the required load test and documentation of test will be maintained by the Safety Manager. Required testing will be scheduled per regulatory requirements. Safety Committee will monitor for compliance.	3/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **04 - DAYROOM LTC UNIT** B. WING _____	**01/27/2017**

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HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

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K 000	INITIAL COMMENTS Description of structure: The DAYROOM LTC UNIT Day Room and LTC wing is part of a one story building with a construction type of V (111) Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 1/27/17in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not compliance with the Requirements for Participation Medicare and Medicaid.	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all Federal and State regulations, the facility has or will take the following actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the dates indicated.	
K 343 SS=E	NFPA 101 Fire Alarm System - Notification Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This Standard is not met as evidenced by: Based upon observations of the fire alarm system that there are areas where the required visual notification devices are not installed according to NFPA 72. Findings include Around 2:05 PM on 1/27/17 it is observed that in	K 343	Fire Alarm contractor will be contacted to install the required visual notification device. No other areas affected. Fire Alarm contractor will inspect per regulatory guidelines. Safety Committee will monitor for compliance quarterly.	3/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RES / CEO — (X6) DATE: 2/28/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **04 - DAYROOM LTC UNIT** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 343	Continued From page 1 the new day room there is no fire alarm visual devices in corridor, TV room and sun room.	K 343		
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by: Based upon review of documentation that there is	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **04 - DAYROOM LTC UNIT** B. WING _____	**01/27/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	**2003 COBB STREET FARMVILLE, VA 23901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 2 not complete documentation of the testing and inspection of the emergency generator according NFPA 110. Findings include During review of the inspection reports on 1/27/17 between 10:00AM and 11:30 AM it is observed that there is no documentation noting that the generators have been run under load for 4 hours every 3 years.	K 918	Generator will receive the required load test and documentation of test will be maintained by the Safety Mgr. Required testing will be scheduled per regulatory requirements. Safety committee will monitor for compliance quarterly.	3/13/17