Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING 01 - MAIN BUILDING 0101 COMPLETED 495339 B. WING 01/27/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2003 COBB STREET** HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) The statements made on this plan K 000 INITIAL COMMENTS K 000 of correction are not an admission to and do not constitute an Description of structure: The main facility is a one agreement with the alleged deficiencies story building with a construction type of II (000) cited herein. To remain in compliance Sprinkler Status: Fully sprinklered - NFPA 13 with all Federal and State regulations the facility has or will take the An unannounced Standard Recertification Life following actions set forth in the Safety Code Survey was conducted on 1/27/17in accordance with 42 Code of Federal Regulation, following plan of correction. The Part 483: Requirements for Long Term Care alleged deficiencies cited have been Facilities. The facility was surveyed for or will be corrected by the dates compliance using the LSC 2012 Existing indicated. regulations. The facility was not compliance with the Requirements for Participation Medicare and Medicaid. K 211 | Exit sign will be removed from K 211 NFPA 101 Means of Egress - General SS=D door and a sign placed stating Means of Egress - General "Not an Emergency Exit". Aisles, passageways, corridors, exit discharges, Evacuation routes will be reviewed exit locations, and accesses are in accordance to ensure proper egress paths with Chapter 7, and the means of egress is through the main lobby. Staff continuously maintained free of all obstructions to full use in case of emergency, unless modified by working in the area will receive 18/19.2.2 through 18/19.2.11. education of the egress change. 3/13/17 18.2.1, 19.2.1, 7.1.10.1 No other areas affected. This Standard is not met as evidenced by: Safety committee will monitor. 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. LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X2) MULTIPLE CONSTRUCTION

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 projection 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.

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A, BUILDING 01 - MAIN BUILDING 0101 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. 495339 B. WING 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **HOLLY MANOR NURSING HOME** 2003 COBB STREET FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 211 Door contractor in on 2/24/17 K 211 Continued From page 1 and adjusted the affected doors. Around 1:40 PM on 1/27/17 it is observed that the door requires excessive force to initiate time All doors will be checked for delay magnetic lock countdown to unlock left door proper operation of magnetic locks. near room 140. Safety Manager will check doors weekly for proper functioning. 2/24/17 Around 1:49 PM on 1/27/17 it is observed that the safety Committee will monitor door requires excessive force to initiate time delay magnetic lock countdown to unlock left door quarterly for compliance. near room 148. Exit sign will be removed from K 291 K 291 NFPA 101 Emergency Lighting door and a sign placed stating SS=D **Emergency Lighting** "Not An Emergency Exit". Emergency lighting of at least 1-1/2-hour duration Evacuation routes will be reviewed is provided automatically in accordance with 7.9. and revised as necessary to 18.2.9.1, 19.2.9.1 3/13/17 reflect proper egress paths. This Standard is not met as evidenced by: Based upon observations there are areas that do Staff working in the area will not have the required emergency lighting. receive instruction on the change No other areas affected. Findings include Safety Committee will monitor as necessary. 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 321 NFPA 101 Hazardous Areas - Enclosure K 321 SS=D 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

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 0101

(X3) DATE SURVEY COMPLETED

(X4) DATE SURVEY COMPLETED

(X7) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 0101

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME

	FARM	/ILLE, VA 23	901	
(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	K 321		
	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.		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.	3/13/1
	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 324 SS=E	NFPA 101 Cooking Facilities	K 324		

Printed: 03/01/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 0101 IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION 495339 B. WING 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2003 COBB STREET** HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 (X5) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 324 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, * cooking facilities in smoke compartments with Stove has been moved to the 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. correct location. Fire Suppressant Cooking facilities protected according to NFPA 96 company will verify placement. per 9.2.3 are not required to be enclosed as Maintenance will install metal hazardous areas, but shall not be open to the guide to prevent the stove from

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.

18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through

Findings include

corridor.

19.3.2.5.5, 9.2.3, TIA 12-2

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.

If continuation sheet Page 4 of 12

3/13/17

3/13/17

shifting out of the correct location.

Safety Manager will inspect

Fire Suppressant Company will

placement and adjust as necessary.

Safety Manager will review nozzle

placement with contractor quarterly. Safety Committee will monitor for

verify suppression nozzle

No other area affected

compliance quarterly.

stove placement monthly. Safety Committee will monitor for compliance quarterly.

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 0101 COMPLETED 495339 B. WNG 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME 2003 COBB STREET FARMVILLE, VA 23901 (X5) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 324 Hole covered with metal plate. K 324 Continued From page 4 No other area affected. Around 12:24 PM on 1/27/17 it is observed that Hood will be inspected monthly 3/13/17 there are holes in the kitchen exhaust hood that by safety manager. are not welded shut or sealed with a listed sealing Safety Committee will monitor fitting. quarterly for compliance. K 341 K 341 NFPA 101 Fire Alarm System - Installation SS=D 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 Smoke detectors will be installed provide effective warning of fire in any part of the building. In areas not continuously occupied, in an outlet box attached to a detection is installed at each fire alarm control grid or other support mechanism. unit. In new occupancy, detection is also installed All smoke detectors will be at notification appliance circuit power extenders, inspected for proper installation and supervising station transmitting equipment. Safety Manager will inspect 3/13/17 Fire alarm system wiring or other transmission paths are monitored for integrity. semi-annually to ensure proper 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 placement. Safety Committee will monitor annually for compliance. 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 353 NFPA 101 Sprinkler System - Maintenance and K 353 SS=E Testing

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 0101 COMPLETED 495339 B. WING 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **HOLLY MANOR NURSING HOME** 2003 COBB STREET FARMVILLE, VA 23901 (X5) COMPLETION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K353 Sprinkler contractor will replace K 353 Continued From page 5 Sprinkler System - Maintenance and Testing the system so that the actual Automatic sprinkler and standpipe systems are concentration can be obtained. inspected, tested, and maintained in accordance No other areas affected. with NFPA 25, Standard for the Inspection, Safety Manager will review quarterly Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, reports from contractor to ensure maintenance, inspection and testing are compliance to the reporting 3/13/17 maintained in a secure location and readily requirements. available. Safety Committee will monitor a) Date sprinkler system last checked quarterly for compliance. b) Who provided system test The closet ceiling openings in c) Water system supply source the admissions office were sealed. No other areas affected Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler The Safety Manager will review system. all closets monthly to ensure 3/13/17 9.7.5, 9.7.7, 9.7.8, and NFPA 25 proper sealing of any openings. This Standard is not met as evidenced by: Safety Committee will monitor Based upon observations of the sprinkler system quarterly for compliance. that the required maintenance of the system is not being maintained. Canopy sprinkler heads were cleaned. All sprinkler heads were inspected Findings include for any dirt buildup. 3/13/17 During review of the inspection reports on 1/27/17 Sprinkler heads will be inspected between 10:00AM and 11:30 AM it is observed monthly for dirt buildup by he that there is a note on the sprinkler inspection Safety Manager. report dated 9-23-16 and 6-30-16 for glycol Safety Committee will monitor system the reports do not have the concentration quarterly for compliance. 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.

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 0101 COMPLETED 495339 B. WING 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **HOLLY MANOR NURSING HOME** 2003 COBB STREET FARMVILLE, VA 23901 (X5) PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Insulation will be removed or K 353 Continued From page 6 K 353 properly placed as not to obstruct Around 11:28 AM on 1/27/17 it is observed that there are dirty sprinkler heads in canopy at front sprinkler. entrance. No other areas affected. Safety Mgr will inspect quarterly Around 11:30 AM on 1/27/17 it is observed that for insulation placement. 3/13/17 there is insulation that obstructs sprinkler Safety Committee will monitor for coverage in attic above the class room. compliance semi-annually. Around 12:00 PM on 1/27/17 it is observed that there is a missing sprinkler escutcheon near exit Missing escutcheon replaced. discharge door in dining room. All sprinklers will be inspected for escutcheon placement. Around 2:30 PM on 1/27/17 it is observed that the Safety Mgr will inspect monthly 3/13/17 area behind the dryers there is an opening in ceiling. for escutcheon placement. K 363 NFPA 101 Corridor - Doors K 363 Safety Committee will monitor for SS=E compliance quarterly. Corridor - Doors 2012 EXISTING Maint repairs were in process at Doors protecting corridor openings in other than the time of inspection. Opening required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such covered upon completion of repairs. as those constructed of 1-3/4 inch solid-bonded No other areas affected. 3/13/17 core wood, or capable of resisting fire for at least Maint Staff will receive education 20 minutes. Doors in fully sprinklered smoke on proper monitoring of open areas compartments are only required to resist the passage of smoke. Doors shall be provided with a under repair. means suitable for keeping the door closed. Safety Mgr will inspect active There is no impediment to the closing of the ceiling work areas for compliance. doors. Clearance between bottom of door and Safety Committee will monitor for floor covering is not exceeding 1 inch. Roller compliance quarterly. 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

Door frames shall be labeled and made of steel

meeting 19.3.6.3.6 are permitted.

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 0101

(X3) DATE SURVEY COMPLETED

(M3) DATE SURVEY COMPLETED

(M3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME

		FARIVIVILLE, VA 2	D90 I	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)	SULATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 7 or other materials in compliance with 8.3, unlithe smoke compartment is sprinklered. Fixed window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 4 and 485 Show in REMARKS details of doors such as 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 positilatching 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.	or 183, fire 5, styve 19th	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
	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrie Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium v Smoke dampers are not required in duct penetrations in fully ducted HVAC systems w 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 systin REMARKS.	-hour vall. vhere		

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

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

495339 B. WING _______ 01/27/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME

	FARM	VILLE, VA 23	901	
(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 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.	3/13/1
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrier 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		

Printed: 03/01/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

495339

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 0101

(X3) DATE SURVEY
COMPLETED

01/27/2017

NAME OF PROVIDER OR SUPPLIER
HOLLY MANOR NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

	ANON NORSING FIGURE	FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
K 374	Continued From page 9	K 374	Gap has been repaired and door now	
	Based upon observations the smoke barrier	fire	meets code.	
	rated doors have gaps between the door and		All fire doors will be checked for	
	astragal that could allow smoke to pass throu	ugh	proper gapping.	
	the doors observed at one out of three smoke	е	Safety Manager will receive 3/13/1	
	barrier doors.		education on how to inspect for	
	Findings include		proper gapping.	
	T manage morade		Safety Manager will inspect for	
	Around 1:52 PM on 1/27/17 it is observed that	at	proper gapping monthly.	
	there is a gap that is greater than 1/8" between	en	Safety Committee will monitor for	
	the astragal and the face of the opposite fire	rated	_	
	door in the 1-hour smoke barrier near room 1	143.	compliance quarterly.	
K 911	NFPA 101 Electrical Systems - Other	K 911	Low voltage cables have been tied	
SS=D				
	Electrical Systems - Other		up so that they do not lay on the	
	List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements the		ceiling.	
	are not addressed by the provided K-Tags, b		All ceiling areas will be checked	
	are deficient. This information, along with the		for proper low voltage cable 3/13/1	
	applicable Life Safety Code or NFPA standar		placement.	
	citation, should be included on Form CMS-25		IT department will receive education	
	Chapter 6 (NFPA 99)		on the proper placement of low voltage	
	This Standard is not met as evidenced by:		cables.	
	Based upon observations the electrical syste	ems	Safety Manager will inspect ceiling	
	and equipment is not being maintained.		areas quarterly.	
	Findings include		Safety Committee will monitor for	
	Between 11:00 AM and 11:28 AM on 1/27/17	'it is	compliance quarterly.	
	observed that there is low voltage cable layir		compitance quarterly.	
	the ceiling and sprinkler pipes in the pharmac		Admissions closet was cleared of	
			storage items in from of panel.	
	Between 11:00 AM and 11:28 AM on 1/27/17		All panels will be inspected for	
	observed that the clear working space in from		proper clearance. 3/13/1	
	electrical panel 15 in closet admissions office	e is	Staff will be educated on proper	
	maintained clear of storage,		clearance in front of panels.	
	Around 11:30 AM on 1/27/17 it is observed the	nat		
	there is low voltage cable laying on ceiling ar		Safety Mgr will inspect monthly.	
	not Supported class room.		Safety Committee will monitor for	
1			compliance quarterly.	

Printed: 03/01/2017 FORM APPROVED DMB NO. 0938-0391

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 0101 COMPLETED AND PLAN OF CORRECTION 495339 B. WING 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME 2003 COBB STREET FARMVILLE, VA 23901 (X5) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Electric panels and disconnect K 911 K 911 Continued From page 10 boxes have been properly labeled. Around 12:05 PM on 1/27/17 it is observed that there are electrical panels that are not labeled as All panels and disconnect boxes to what panel it is and there is a panel that does will be inspected for proper labeling. not have a directory noting what circuit the break Safety Mgr will inspect panels 3/13/17 serves in the main electrical room. and disconnect box labeling quarterly. Safety Committee will monitor for Around 12:29 PM on 1/27/17 it is observed that the breakers are not labeled as to what circuits compliance quarterly. that they supply in panel 7 in the kitchen. Wiring behind dryers was corrected. Around 12:35 PM on 1/27/17 it is observed that No other areas affected. There is a disconnect that is not labeled in Safety Manager will inspect behind the janitors closet in kitchen as to what it feeds. dryers monthly for open wiring Safety Committee will monitor for Around 1:56 PM on 1/27/17 it is observed that there are low voltage electrical cables that are compliance quarterly. 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 K 920 NFPA 101 Electrical Equipment - Power Cords K 920 SS=D 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/01/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY STATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING 0101 AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED 495339 B. WING 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME 2003 COBB STREET FARMVILLE, VA 23901 (X5) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 920 | Continued From page 11 K 920 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 All power cords have been removed Around 1:40 PM on 1/27/17 it is observed that from the facility and replaced there is a non-approved power strip in room 141. with approved surge protectors. Staff will receive education on Between 1:56 PM and 2:43 PM on 1/27/17 it is proper uses of power cords observed that there are non-approved power including approved types for strips at patient bed locations in rooms150, 156, and 161. nursing facilities. 3/13/17 Safety Manager will inspect all Around 2:50 PM on 1/27/17 it is observed that areas in the facility for proper there is an extension cord that is plugged into usage of power cords quarterly. power strip in IT Office. Safety Committee will monitor for compliance quarterly.

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - GRACE WING		(X3) DATE SURVEY COMPLETED		
495339			B. WING			/2017	
	OVIDER OR SUPPLIER ANOR NURSING HON	IE		SS, CITY, STA BB STREE LE, VA 23	т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 161 SS=D	Description of structures tory building with a property of North Sprinkler Status: Full An unannounced State Safety Code Survey accordance with 42 CP Part 483: Requireme Facilities. The facility compliance using the regulations. The facilithe Requirements for Medicaid. NFPA 101 Building CBuilding Construction 2012 EXISTING Building construction	re: The Grace Wing is partial basement with a / (111) y sprinklered - NFPA 13 ndard Recertification L was conducted on 1/27 Code of Federal Regulants for Long Term Care was surveyed for LSC 2012 Existing ity was not compliance Participation Medicare onstruction Type and Hamilton Type and Height type and stories meets to otherwise permitted bit.6.7	ife /17in with and deight	K 000	The statements made on to of correction are not an to and do not constitute agreement with the alleg deficiencies cited here; remain in compliance with Federal and State regulate facility has or will tak actions set forth in the of correction. The alleg cited have been or will dates indicated.	admissic an ed n. To h all tions, to e the for following	ne Llowing ng plan Lencies
LABORATOR	Y DIRECTOR'S OR PROVIDE	BASUPPLIER REPRESENTATIV	/E'S SIGNATURE		D TITLE	2/05	(X6) DATE

(X2) MULTIPLE CONSTRUCTION

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.

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - GRACE WING COMPLETED 495339 B. WING _ 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **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.	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		K 321		

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A BUILDING 02 - GRACE WING		VEY ED
		495339		B, WING		01/27	7/2017
	OVIDER OR SUPPLIER ANOR NURSING HOM	IE .		ess, city, sta BB STREE LLE, VA 23	т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 321	doors in accordance of self-closing or automa have nonrated or field that do not exceed 48 the door. Describe the floor and hazardous areas that 19.3.2.1 Area Separation N/A a. Boiler and Fuel-Finds. Laundries (larger that c. Repair, Maintenand d. Soiled Linen Roome. Trash Collection Reference (exceeding 64 gallons f. Combustible Storage (over 50 square feet) g. Laboratories (if class Hazard - see K322) This Standard is not Based upon observat not maintained to proor fire resistant rating There are doors that a latching, are damaged the required listing for allow smoke and hot doors. Findings include Between 2:10 PM and observed that the sert to a housekeeping steless than 50 square feetless than 50 square feetless garden and latching and latching and latching and latching and latching and latching self closing and latching and latching and latching and latching and latching self closing and latching and latch	with 8.4. Doors shall be atic-closing and permitt d-applied protective plated and permitted and permitted and protective plated and are deficient in REMAI Automatic Sprink and Automatic Sprink and Heater Rooms and 100 square feet) be, and Paint Shops as (exceeding 64 gallon booms and are as evidenced by: ions hazardous areas a vide required separations for the hazardous areas are not self closing and d and doors that do not a door hardware that congasses to pass through a congasses to pass through a congasses to pass through a congasses are not self closing and and doors that do not a door hardware that congasses to pass through a congasses to pass through a congasses to pass through a congasses and the doors are refing.	ed to tes m of RKS. cler s) are m and eas. It have build the this anged is	K 321	Housekeeping items have removed from the room. T will no longer be used a storage room. All storag will be checked for comp Staff will receive educathe proper storage of su and chemicals. Safety Manager will insp storage areas monthly to compliance to regulatory Safety Committee will mo for compliance quarterly	The room as a se rooms cliance. ation on applies sect all sect ensure reguideli onitor	
	NFPA 101 Fire Alarm	System - Testing and		K 345			

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - GRACE WING

(X3) DATE SURVEY COMPLETED

(X4) DATE SURVEY
COMPLETED

(X7) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - GRACE WING

(X3) DATE SURVEY
COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME

	FARM	VILLE, VA 23	3901	
(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 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	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	l .
	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.		least weekly. Safety Committee will monitor for compliance quarterly.	3/13/1
	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		

Printed: 02/20/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING 02 - GRACE WING COMPLETED AND PLAN OF CORRECTION 495339 B. WING 01/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **HOLLY MANOR NURSING HOME** 2003 COBB STREET FARMVILLE, VA 23901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 918 Continued From page 4 K 918 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 Generator will receive the required NFPA 110. load test and documentation of Findings include test will be maintained by the Safety Manager. During review of the inspection reports on 1/27/17 Required testing will be scheduled between 10:00AM and 11:30 AM it is observed that there is no documentation noting that the per regulatory requirements. 3/13/17

Safety Committee will monitor for

compliance quarterly.

every 3 years.

generators have been run under load for 4 hours

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BRANTLEY WING (X3) DATE SURVE' COMPLETED					
	495339		B. WING		01/27	//2017	
	OVIDER OR SUPPLIER ANOR NURSING HOM	E		SS, CITY, STA BB STREE LE, VA 23	т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING 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	one story building with (111) Sprinkler Status: Fully An unannounced Stat Safety Code Survey vaccordance with 42 C Part 483: Requirement Facilities. The facility compliance using the regulations. The facility	re: The Brantley Wing in a construction type of a construction type of a sprinklered - NFPA 13 and ard Recertification Linux as conducted on 1/27 and of Federal Regulants for Long Term Care was surveyed for	f V 3 fe /17 in tion, with	K 000	The statements made on to correction are not an adding and do not constitute any with the alleged deficient herein. To remain in compall Federal and State refacility has or will take actions set forth in the plan of correction. The deficiencies cited have corrected by the dates in	mission agreeme ncies ci pliance gulation e the fo followi alleged been or	to nt ted with s, the llowing ng
SS=D	18.1 and 19.1 General addressed by the prodeficient. This informal applicable Life Safety citation, should be incompleted in the Standard is not Based upon observate equipment rooms are combustible material. Findings include Between 2:49 PM and observed that there is main mechanical rooms Statewide Fire Prevention	ts - Other s section any LSC Section al Requirements that are vided K-tags, but are ation, along with the c Code or NFPA standa cluded on Form CMS-2 met as evidenced by: ions the electrical not maintained clear or d 3:18 PM on 1/27/17 it is combustible storage in m. Referenced by Virgin ntion Code 313.1	re not rd 567. If is n the		Combustible items were removed from the mechanical room. No other areas were affected. Staff will receive education about the proper storage of conitem. All storage areas will be inspected monthly to verify that combustible items are properly stored. The Safety Committee will monitor for compliance quarterly.	nbustible	3/13/17
K 324 SS=E	NFPA 101 Cooking Facilities	acilities		K 324	noi compliance quarterly.		
LABORATOR	ANDEC TOP'S OF PROVINCE	RISTIPPINE REPRESENTATIV	E'S SIGNATURE		TITLE		(X6) DATE

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.

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 03 - BRANTLEY WING

(X3) DATE SURVEY COMPLETED

(X4) PROVIDER/SUPPLIER/CLIA A. BUILDING 03 - BRANTLEY WING

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 03 - BRANTLEY WING

(X3) DATE SURVEY COMPLETED

(X4) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME

	FARMV	ILLE, VA 23	901	
(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 324	Continued From page 1	K 324		
	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.		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 monitofor compliance quarterly.	

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING 03 - BRANTLEY WING

495339

(X3) DATE SURVEY COMPLETED

01/27/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

HOLLY MANOR NURSING HOME

	FAF	RMVILLE, VA 23	3901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR' OR LSC IDENTIFYING INFORMATION)	ID Y PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	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.	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	2/1/17
	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. NFPA 101 Corridor - Doors	K 363	proper placement monthly. Safety Committee will monitor for compliance.	3/13/17
SS=E	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		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

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING 03 - BRANTLEY WING

(X3) DATE SURVEY
COMPLETED

01/27/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME 2003 COBB STREET

		FARMVILLE, VA 23	3901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE- OR LSC IDENTIFYING INFORMATION)	GULATORY ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 3 of unlimited height are permitted. Dutch door meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of st or other materials in compliance with 8.3, un the smoke compartment is sprinklered. Fixed window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 4 and 485 Show in REMARKS details of doors such as protection ratings, automatics closing device etc. This Standard is not met as evidenced by: Based upon observations of all corridor door there are doors found that did not have posit latching that could allow smoke to pass throu the doors. Findings include Around 3:18 PM on 1/27/17 it is observed th right dining room door is not latching. Around 3:37 PM on 1/27/17 it is observed th corridor door to room 122 is not latching 122	eel less d fire or 483, fire s, s ive ugh	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 repaire all resident room doors were che for proper closure. Safety Manager will check doors monthly for proper closure and repair as necessary. Safety Committee will monitor for compliance.	1
	NFPA 101 Electrical Systems - Essential Electrical Systems - Essential Electric Essential Electric Systems - Essential Electric Electric Systems - Essential Electric Electric Systems - Essential Electric Elec	m ce plying n this thes.		

Printed: 02/20/2017 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 03 - BRANTLEY WING AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 495339 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 REGULATO OR LSC IDENTIFYING INFORMATION)	DRY 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 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.		Generator will receive the required test and documentation of test will be maintained by the Safety Manager. Required testing will be schedule per regulatory requirements. Safety Committee will monitor for compliance.			

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDING		A. BUILDING	04 - DAYROOM LTC UNIT	COMPLETED	
495339			B. WING		01/27/2017		
NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET FARMVILLE, VA 23901					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)) BÉ	(X5) COMPLETION DATE
K 000	UNIT Day Room and story building with a construction Sprinkler Status: Fully An unannounced State Safety Code Survey vaccordance with 42 CO Part 483: Requirement Facilities. The facility compliance using the regulations. The facility	re: The DAYROOM LTC LTC wing is part of a or construction type of V (12) y sprinklered - NFPA 13 andard Recertification Lives conducted on 1/27/ code of Federal Regulants for Long Term Care was surveyed for	ne 1111) fe /17in tion, with	K 000	The statements made on the correction are not an addrand do not constitute an with the alleged deficientherein. To remain in compall Federal and State regacility has or will take actions set forth in the plan of correction. The adeficiencies cited have a corrected by the dates in	agreementies cipliance gulation to following alleged peen or	to nt ted with s, the llowing ng
K 343 SS=E	9.6.3.4 are permitted throughout by a sprinl notification is provided accordance with 9.6.3 signals. In critical care areas, The fire alarm system automatically to notify event of a fire. 19.3.4.3, 19.3.4.3.1, 1 This Standard is not Based upon observat that there are areas with the standard in the standard is not the standard in the	on one in accordance with in buildings protected kler system. Occupant d automatically in 8 by audible and visual visual alarms are sufficit transmits the alarm emergency forces in to 19.3.4.3.2, 9.6.4, 9.7.1.	cient. he 1(1) vstem al	K 343	Fire Alarm contractor will contacted to install the visual notification device No other areas affected. Fire Alarm contractor will inspect per regulatory guidelines. Safety Committee will more for compliance quarterly.	required ce. l	3/13/17
LABORATOR		/27/17 it is observed th			TITLE	-	(XR) DATE
LABORATOR\	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE	1	(X6) DATE

(X2) MULTIPLE CONSTRUCTION

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.

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495339

(X2) MULTIPLE CONSTRUCTION
A, BUILDING 04 - DAYROOM LTC UNIT

(X3) DATE SURVEY COMPLETED

01/27/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME

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	K 343				
	the new day room there is no fire alarm visual devices in corridor, TV room and sun room.					
	NFPA 101 Electrical Systems - Essential Electric Syste	K 918				
	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					

Printed: 02/20/2017 FORM APPROVED OMB NO. 0938-0391

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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLLY MANOR NURSING HOME

2003 CORR STREET

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 RE- OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
TAG	Continued From page 2 not complete documentation of the testing are inspection of the emergency generator according include During review of the inspection reports on 1/between 10:00AM and 11:30 AM it is observe that there is no documentation noting that the generators have been run under load for 4 hevery 3 years.	nd rding 727/17 red e		CROSS-REFERENCED TO THE APPROPRIATE	3/13/17	