		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/17/2023 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04 B. WING			(X3) DATE SURVEY COMPLETED C 02/10/2016	
		495339					
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
HOLLY MA	ANOR NURSING HOME		2003 COBB STREET				
				F	FARMVILLE, VA 23901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
		ure: The facility is a two story a construction type of II (B)					
	Sprinkler Status: Full	y Sprinklered NFPA 13					
	survey was conducte 42 Code of Federal R Requirements for Lor facility was surveyed LSC 2000 Existing re compliance with the F	ng Term Care Facilities. The for compliance using the gulations. The facility was in Requirements for					
K 000	Participation in Medic		K	000			
		ure: The facility is a two story a construction type of II (B)					
	Sprinkler Status: Fully	y Sprinklered NFPA 13					
K 000	survey was conducte 42 Code of Federal R Requirements for Lor facility was surveyed	ng Term Care Facilities. The for compliance using the lations. The facility was in Requirements for care and Medicaid.	K	000			
		ure: The facility is a two story		000			
	masonry building with	a construction type of II (B)					
	Sprinkler Status: Full	y Sprinklered NFPA 13					
	An unannounced Rec	certification Life Safety Code					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'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.

		& MEDICAID SERVICES				RM APPROVE 10. 0938-039	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04			(X3) DATE SURVEY COMPLETED	
		495339	B. WING		C 02/10/2016		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL	DE		
HOLLY M	ANOR NURSING HOME	E		2003 COBB STREET FARMVILLE, VA 23901	3901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION		SHOULD BE COMPLETION	
K 000	survey was conduct 42 Code of Federal Requirements for Lo facility was surveyed LSC 2000 NEW reg compliance with the Participation in Med INITIAL COMMENT Description of struct masonry building with Sprinkler Status: Fut An unannounced Re survey was conduct 42 Code of Federal Requirements for Lo facility was surveyed	ted 2/10/2016 accordance with Regulation, Part 483: ong Term Care Facilities. The d for compliance using the yulations. The facility was in e Requirements for licare and Medicaid. TS cture: The facility is a two story ith a construction type of II (B) ully Sprinklered NFPA 13 eccertification Life Safety Code ted 2/10/2016 accordance with Regulation, Part 483: ong Term Care Facilities. The d for compliance using the yulations. The facility was in e Requirements for	К 00	0			

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

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