Printed: 04/05/2018 FORM APPROVED 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 02/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HOLLY MANOR NURSING HOME 2003 COBB STREET FARMVILLE, VA 23901 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 Description of structure: The main facility is a one story building with a construction type of II (000) Sprinkler Status: Fully sprinklered - NFPA 13 K000 The statements made on this plan of An unannounced Standard Recertification Life correction are not an admission to Safety Code Survey was conducted on and do not constitute an agreement 02/26/2018in accordance with 42 Code of Federal Regulation, Part 483: Requirements for with the alleged deficiencies cited Long Term Care Facilities. The facility was herein. To remain in compliance surveyed for compliance using the LSC 2012 with all Federal and State Existing regulations. regulations, that facility has or will The findings that follow demonstrate take the following actions set forth non-compliance with Title 42 Code of in the following plan of correction. Regulations, 483.70(a) et seq (Life Safety from The alleged deficiencies cited have Fire.) been or will be corrected by the K 222 K 222 Egress Doors date(s) indicated. SS=E CFR(s): NFPA 101 Earess Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used. only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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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(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING 0101 **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION 495339 02/26/2018 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 COMPLÉTION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 222 Continued From page 1 K 222 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release K 222 upon loss of power to the device; the building is 1. IT department will investigate protected by a supervised automatic sprinkler and adjust L141 exit door release system and the locked space is protected by a latch to not more than 15 seconds complete smoke detection system (or is constantly monitored at an attended location when a force of not more than 15 4/10/18 within the locked space); and both the sprinkler pounds (67N) is applied for 3 and detection systems are arranged to unlock the seconds. doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 2. All exit panic door devices will **DELAYED-EGRESS LOCKING** be checked for initiation of release ARRANGEMENTS time of not more than 15 seconds Approved, listed delayed-egress locking systems when a force of not more than 15 installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and pound (67N) is applied for 3 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic 3. Will update weekly and monthly fire detection system or an approved, supervised exit door checks to reflect the automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 initiation of an irreversible process ACCESS-CONTROLLED EGRESS LOCKING which will release the latch in not **ARRANGEMENTS** more than 15 seconds when a force Access-Controlled Egress Door assemblies of not more than 15 pounds (67N) is installed in accordance with 7.2.1.6.2 shall be permitted. applied for 3 seconds to the release 18.2.2.2.4, 19.2.2.2.4 device of the exit door. ELEVATOR LOBBY EXIT ACCESS LOCKING continue weekly and monthly **ARRANGEMENTS** inspections based on the update. Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on 4. Exit door inspections will be door assemblies in buildings protected throughout reviewed quarterly by the QA by an approved, supervised automatic fire Committee for recommendations of detection system and an approved, supervised automatic sprinkler system. additional actions, as needed. 18.2.2.2.4, 19.2.2.2.4 5. Completion date of 4/10/18 This REQUIREMENT is not met as evidenced by:

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(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 02/26/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) 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 222 Continued From page 2 K 222 Based upon observation and interview, the facility failed to maintain the delayed-egress locking arrangements. This has the ability to affect all occupants in the effected compartment of the building. Findings include: On 02-26-18 at approximately 1:44 PM, it was observed that the irreversible process to release the delayed egress lock for the exit door of Room 141 was not being maintained. The Facility Safety Manager witnessed this evidence by interview and observation on 02-26-2018 at approximately 4:30 pm during the exit interview. K 293 K 293 Exit Signage K 293 SS=E CFR(s): NFPA 101 1. Replaced AC/DC exit signs to Exit Signage AC only at locations L151, L143, 2012 EXISTING and Unit #21 near L141 to ensure Exit and directional signs are displayed in proper function. accordance with 7.10 with continuous illumination 2. All exit signs will be checked for also served by the emergency lighting system. 19.2.10.1 AC/DC and replaced with AC only (Indicate N/A in one-story existing occupancies signs. Logs will be maintained of with less than 30 occupants where the line of exit concerns identified and corrections travel is obvious.) This REQUIREMENT is not met as evidenced made. by: 3. Will maintain properly Based upon observations and interviews the lights functioning exit and facility failed to maintain that exit and directional document monthly inspections. signs are displayed in accordance with the Life 4. Exit signs inspections will be Safety Code. This has the ability to affect all occupants in the effected compartment of the reviewed quarterly by the QA building. Committee for recommendation of additional actions, as needed. Findings include 5. Completion date of 4/10/18 On 02-26-2018 at approximately 11:00 AM it was observed that the exit lights and not being

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 01 - MAIN BUILDING 0101 COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495339 02/26/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 353 Continued From page 4 K 353 observed that the spare sprinklers did not correspond to the types installed in the building, there were no upright sprinklers in the spare cabinet. On 02-26-2018 at approximately 10:30 am, it was observed that the fire department connection is not identified with a sign. (NFPA 13, 8.17.2.4.7.1) The Facility Safety Manager witnessed this evidence by interview and observation on 02-26-2018 at approximately 4:30 pm during the exit interview. a) Date sprinkler system last checked 12-26-2017 b) Who provided system test Fire Sprinkler Service Corp. of Mechanicsville VA c) Water system supply source Municipal K 355 Portable Fire Extinguishers K 355 SS=D CFR(s): NFPA 101 K 355 1. The fire extinguisher in IT Server Portable Fire Extinguishers Room was mounted and the Portable fire extinguishers are selected, installed. inspected, and maintained in accordance with contractor inspected. NFPA 10. Standard for Portable Fire 2. Checked all fire extinguisher Extinguishers. they locations to ensure 18.3.5.12, 19.3.5.12, NFPA 10 mounted and on the inspection list. This REQUIREMENT is not met as evidenced 3. Will update fire extinguisher list Based on observation and interview, the facility and perform monthly in-house and failed to maintain fire extinguishers. This has the annual contractor inspections. ability to affect all occupants of the building. 4. Both the in-house and contractor will be reviewed Findings include inspections quarterly by the QA committee for On 02-26-2018 at approximately 10:45 AM, it was additional recommendation of observed that the fire extinguisher in the IT server actions, as needed. room was not installed and maintained as

required by the Life Safety Code.

5. Completion date of 4/10/18

Printed: 04/05/2018 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 0101 COMPLETED AND PLAN OF CORRECTION 495339 02/26/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME 2003 COBB STREET FARMVILLE, VA 23901 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) 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 355 K 355 | Continued From page 5 The Facility Safety Manager witnessed this evidence by interview and observation on 02-26-2018 at approximately 4:30 pm during the exit interview. K 363 K 363 Corridor - Doors SS=D CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than K 363 required enclosures of vertical openings, exits, or 1. Installed material suggested by hazardous areas resist the passage of smoke Fire Marshall to door at L149 to and are made of 1 3/4 inch solid-bonded core correct the gap which was greater wood or other material capable of resisting fire for than 1/2" on the face and rabbit. at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist 2. Will check all doors in the the passage of smoke. Corridor doors and doors building to ensure gap is not greater to rooms containing flammable or combustible than 1/2" on the face and rabbit. materials have positive latching hardware. Roller 3. Update and continue monthly and latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that annual door inspections to ensure do not contain flammable or combustible that the gap is not greater than 1/2" material. on the face and rabbit. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors Both monthly and annual complying with 7.2.1.9 are permissible if provided inspections will be reviewed by the with a device capable of keeping the door closed Committee OA for when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open recommendations of additional devices that release when the door is pushed or actions, as needed. pulled are permitted. Nonrated protective plates 5. Completion date of 4/10/18 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.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0101		(X3) DATE SURVEY COMPLETED	
495339			B. WING		02/26/2018		
HOLLY MANOR NURSING HOME 2003 C			ORESS, CITY, STATE, ZIP CODE COBB STREET VILLE, VA 23901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 511	Based on observate the facility failed to to ensure that the ecomplies with NFP. This has the ability building:  Findings include: On 02-26-2018 at a observed that the experience of the Life Safety Cool On 02-26-2018 at a observed that the experience is missing location. (NFPA 10 observed that the experience of the Life Safety Cool On 02-26-2018 at a observed that the experience of the Life Safety Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a observed that the Experience of the Cool On 02-26-2018 at a o	ion, inspection and ir maintain the LP Gas electrical wiring and e A 70, National Electric to affect all occupant approximately 8:30 A electrical panel in the was not labeled as rede. (NFPA 70, 408.4) approximately 9:45 at Emergency Gas Shut as it enters the facilit 1, 9.1.1; NFPA 54 - 1 approximately 1:29 Pelectrical panel at roo required by the Life selectrical panel at roo required panel at roo	utility and quipment cal Code. Its of the M it was Human quired by m, it is Off Valve y in one 2; 7.9.2.3 M it was m 143 Safety	K 511	I. Installed Emergency Ga Off Valve signage in identified during the instance signs will include the w Gas or Propane, No Smoki Flammable  2. Will check all propane to signage and correct as needed.  3. Will perform an inspection to ensure signs place.  4. Annual inspections wereviewed by the QA Common completion and recommental as needed.  5. Completion date of 4/10/1	location pection; ords LP ng, and anks for d. annual are in will be ittee for dations,	4/10/18

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 02 - MOORE CENTER AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 495339 02/26/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER HOLLY MANOR NURSING HOME 2003 COBB STREET FARMVILLE, VA 23901 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** PRÉFIX DATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 K000 The statements made on this plan of Description of structure: The main facility is a one correction are not an admission to story building with a construction type of V (111) and do not constitute an agreement Sprinkler Status: Fully sprinklered - NFPA 13 with the alleged deficiencies cited herein. To remain in compliance An unannounced Standard Recertification Life with and all Federal Safety Code Survey was conducted on regulations, that facility has or will 02/26/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for take the following actions set forth Long Term Care Facilities. The facility was in the following plan of correction. surveyed for compliance using the LSC 2012 The alleged deficiencies cited have Existing regulations. been or will be corrected by the The findings that follow demonstrate date(s) indicated. non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from K 100 Fire.) 1. All stored items in the basement K 100 K 100 General Requirements - Other are now orderly, stable, SS=D| CFR(s): NFPA 101 protected by the fire sprinkler General Requirements - Other system. No items are stored under List in the REMARKS section any LSC Section ventilation duct work. 18.1 and 19.1 General Requirements that are not 2. All storage areas checked for addressed by the provided K-tags, but are deficient. This information, along with the similar concerns, none found. applicable Life Safety Code or NFPA standard 3. All storage areas will be checked citation, should be included on Form CMS-2567. quarterly for correct placement of This REQUIREMENT is not met as evidenced items being stored and corrected as Based on observation, inspection and interview, needed. Will visibly delineate all the facility failed to maintain special hazard "non storage" areas with visible protection. This has the ability to affect all marking/signage. occupants of the building: 4. The quarterly inspection concerns Findings include: will be reviewed by the OA On 02-26-2018 at approximately 2:20 pm, it is committee to determine further observed by the Safety Manager that the storage actions as needed. in the basement is heavy accumulated and in a 5. Completion date of 4/10/18 disorderly arrangement. Storage is found under LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE (K6) DATE

Any deficiency statement inding 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.

TRECINENT

Printed: 04/05/2018 **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 - MOORE CENTER (X3) DATE SURVEY COMPLETED

495339

02/26/2018

NAME OF PROVIDER OR SUPPLIER

**HOLLY MANOR NURSING HOME** 

STREET ADDRESS, CITY, STATE, ZIP CODE

**2003 COBB STREET** 

OUR MARK OTATION OF DESIGNATION			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)	DD PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 1 ventilation duct work and not protected by the fis sprinkler system. (NFPA 101; 8.7.1.1)  The Facility Safety Manager witnessed this evidence by interview and observation on 02-26-2018 at approximately 4:30 pm during the exit interview.  Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Codelectrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	e K 511	K511 1. Electrical Panel "17" - Breaker 3 & 35, Panel "18" - Breaker 4 Administrative Office Panel "C1" Breaker 34 & 35, and Soiled Utili Room Panel "B5" - Breakers 42 43 are now correctly labeled ar updated on the legend. Tl	
by: Based upon observations and interviews the facility failed to ensure that the electrical wiring and equipment complies with NFPA 70, National Electrical Code. This has the ability to affect all occupants of the building.  Findings include: On 02-26-2018 at approximately 1:50 PM it was observed that the electrical panels "17" Breaker 33 & 35, and Panel "18" Breaker 42 and Administrative Office Panel "C1" Breaker 34 & and Soiled Utility Room Panel "B5" Breakers 45	al I s r 35 2 &	Basement Main Electrical Room.  2. All other panel boxes and doors for labeling of breakers, updated legends and door signage were verified to be in place.  3. Will check all breakers in all panel boxes/doors for correct labeling/signage during monthly inspections.  4. Inspections will be reviewed quarterly by the QA committee to	
	Continued From page 1 ventilation duct work and not protected by the fis sprinkler system. (NFPA 101; 8.7.1.1)  The Facility Safety Manager witnessed this evidence by interview and observation on 02-26-2018 at approximately 4:30 pm during the exit interview.  Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Codelectrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided not hazard to life.  18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to ensure that the electrical wiring and equipment complies with NFPA 70, National Electrical Code. This has the ability to affect all occupants of the building.  Findings include: On 02-26-2018 at approximately 1:50 PM it was observed that the electrical panels "17" Breaker 33 & 35, and Panel "18" Breaker 42 and Administrative Office Panel "C1" Breaker 34 & and Soiled Utility Room Panel "B5" Breakers 4: 43 are not labeled as required by the Life Safet	Continued From page 1 ventilation duct work and not protected by the fire sprinkler system. (NFPA 101; 8.7.1.1)  The Facility Safety Manager witnessed this evidence by interview and observation on 02-26-2018 at approximately 4:30 pm during the exit interview.  Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.  18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to ensure that the electrical wiring and equipment complies with NFPA 70, National Electrical Code. This has the ability to affect all occupants of the building.  Findings include: On 02-26-2018 at approximately 1:50 PM it was observed that the electrical panels "17" Breaker 33 & 35, and Panel "18" Breaker 42 and Administrative Office Panel "C1" Breaker 34 & 35 and Soiled Utility Room Panel "B5" Breakers 42 & 43 are not labeled as required by the Life Safety Code. (NFPA 70, 408.4)	Continued From page 1 ventilation duct work and not protected by the fire sprinkler system. (NFPA 101; 8.7.1.1)  The Facility Safety Manager witnessed this evidence by interview and observation on 02-28-2018 at approximately 4:30 pm during the exit interview.  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.  18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to ensure that the electrical wiring and equipment complies with NFPA 70, National Electrical Code. This has the ability to affect all occupants of the building.  Findings include: On 02-26-2018 at approximately 1:50 PM it was observed that the electrical panels "17" Breaker 33 & 35, and Panel "18" Breaker 42 and Administrative Office Panel "17" - Breaker 33 & 35, and Panel "18" Breaker 42 and Administrative Office Panel "17" - Breaker 34 & 35 and Soiled Utility Room Panel "85" - Breakers 42 & 43 are now correctly labeled and updated on the legend. The Electrical Room door signage were verified to be in place.  3. Will check all breakers in all panel boxes/doors for correct labeling/signage during monthly inspections.  4. Inspections will be reviewed quarterly by the QA committee to determine further actions, as needed.  5. Completion date of 4/10/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MOORE CENTER		(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
495339		B. WING	B. WING		02/26/2018		
NAME OF PROVIDER OR SUPPLIER  HOLLY MANOR NURSING HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  2003 COBB STREET  FARMVILLE, VA 23901							
PREFIX (EACH DEFICIENCY MUS	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	page 2 iew and observation of proximately 4:30 pm o		K 511				

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 03 - NEW WING AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 495339 02/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 Description of structure: The main facility is a one K000 story building with a construction type of V (111) The statements made on this plan of Sprinkler Status: Fully sprinklered - NFPA 13 correction are not an admission to and do not constitute an agreement An unannounced Standard Recertification Life with the alleged deficiencies cited Safety Code Survey was conducted on herein. To remain in compliance 02/26/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for all Federal and Long Term Care Facilities. The facility was regulations, that facility has or will surveyed for compliance using the LSC 2012 take the following actions set forth Existing regulations. in the following plan of correction. The findings that follow demonstrate The alleged deficiencies cited have non-compliance with Title 42 Code of been or will be corrected by the Regulations, 483.70(a) et seq (Life Safety from date(s) indicated. Fire.) K 353 Sprinkler System - Maintenance and Testing K 353 K 353 SS=E CFR(s): NFPA 101 1. The sprinkler contractor replaced Sprinkler System - Maintenance and Testing the corroded sprinkler heads inside Automatic sprinkler and standpipe systems are the Pool Pump Room and spares are inspected, tested, and maintained in accordance on hand for future use. with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire 2. All other facility sprinkler heads Protection Systems. Records of system design. checked with no further issues maintenance, inspection and testing are identified. maintained in a secure location and readily 3. Will perform monthly in-house available. a) Date sprinkler system last checked and annual contractor inspections of sprinkler heads. b) Who provided system test 4. Both in-house and contractor inspections will be reviewed during c) Water system supply source the quarterly OA committee to Provide in REMARKS information on coverage determine further actions. for any non-required or partial automatic sprinkler needed. system. 5. Completion date of 4/10/18 9.7.5, 9.7.7, 9.7.8, and NFPA 25 LABORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE (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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NEW WING			(X3) DATE SURVEY COMPLETED	
495339		B. WING	B. WING		02/26/2018			
	ROVIDER OR SUPPLIER MANOR NURSING H	IOME	2003 C	DORESS, CITY, STATE, ZIP CODE COBB STREET IVILLE, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE		
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		K 353					

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 03 - NEW WING COMPLETED 495339 B. WING \_ 02/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HOLLY MANOR NURSING HOME 2003 COBB STREET FARMVILLE, VA 23901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 511 Continued From page 2 This REQUIREMENT is not met as evidenced K511 Based upon observations and interviews the facility failed to ensure that the electrical wiring 1. The Electrical Panel "XLA1" and equipment complies with NFPA 70. National Breaker 9, 11, & 13, Panel "K' Electrical Code. This has the ability to affect all Breaker - 33 & 38 found in the occupants of the building. Jefferson Food Storage area and Findings include: Panel "LA1" - Breakers 30 & 36 in On 02-26-2018 at approximately 3:30 PM it was the Pool Pump Room Electrical observed that the electrical panel "XLA1" Breaker Room are now properly labeled in 9. 11. & 13 and Panel "K' Breaker 33 & 38 found in the Jefferson Food Storage area and Panel the legend. The "Electrical Room" "LA1" Breakers 30 & 36 in the Pool Pump Room door signage was placed on the Electrical Room are not labeled as required by outside of the Pool Pump Room the Life Safety Code. (NFPA 70, 408.4) Electrical Room. The Facility Safety Manager witnessed this 2. No other panel boxes in the new evidence by interview and observation on wing were found to be without 02-26-2018 at approximately 4:30 pm during the proper labeling in the legend or exit interview. missing door signage. 3. Will check all panel boxes for proper labeling during monthly inspections and will verify proper placement of signage on the outside of the Electrical Rooms. 4. Inspections will be reviewed quarterly by the OA committee to actions. determine further needed. 5. Completion date of 4/10/18

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF IDENTIFICATION			A. BUILDING 04 - DAYROOM LTC UNIT		(X3) DATE SURVEY COMPLETED		
	495339	C	B. WING		02/2	26/2018	
HOLLY MANOR NURSING HOME 2003 C			DRESS, CITY, STATE, ZIP CODE COBB STREET VILLE, VA 23901				
PRÉFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENC! T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000 INITIAL COMMEN	TS		K 000				
story building with Sprinkler Status: F An unannounced S Safety Code Surve 02/26/2018 in according Term Care F The facility was su the LSC 2012 Exis in compliance with	cture: The main facilia construction type of cully sprinklered - NFI Standard Recertification was conducted on ordance with 42 Coden, Part 483: Requiremacilities.  Inveyed for compliance ting regulations. The the Requirements for care and Medicaid.	PA 13  on Life  of of hents for  se using facility is					
LABORATORY DIRECTOR'S OF PRO	VIDER/BUPPLIER REPRES	ENTATIVE'S SIG	NATURE	TITLE	.1/,1	(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.