STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Description of structure: The main facility is a one story building with a construction type of II (000) Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 02/26/2018in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	K000 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies cited herein. To remain in compliance with all Federal and State regulations, that facility has or will take the following actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the date(s) indicated.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress 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	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT / CEO — (X6) DATE: 04/06/18

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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**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 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 222	Continued From page 2 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 222		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to maintain that exit and directional signs are displayed in accordance with the Life Safety Code. This has the ability to affect all occupants in the effected compartment of the building. Findings include On 02-26-2018 at approximately 11:00 AM it was observed that the exit lights and not being	K 293	K 293 1. Replaced AC/DC exit signs to AC only at locations L151, L143, and Unit #21 near L141 to ensure proper function. 2. All exit signs will be checked for AC/DC and replaced with AC only signs. Logs will be maintained of concerns identified and corrections made. 3. Will maintain properly functioning exit lights and document monthly inspections. 4. Exit signs inspections will be reviewed quarterly by the QA Committee for recommendation of additional actions, as needed. 5. Completion date of 4/10/18	4/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**02/26/2018**

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

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K 293	Continued From page 3 maintained and do not have continuous illumination in rooms 151, 143, Unit #21, and near room 141. 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 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to test and maintain the building fire sprinkler system. This has the ability to affect all occupants of the building. Findings include: On 02-26-2018 at approximately 10:30 AM it was	K 353	K 353 1. The facility has spare sprinkler heads in stock and installed 6" FDC lettering signage for HM sprinkler riser system 2. Safety manager to check all storage areas to ensure all types of sprinkler heads used have available spares and 6" FDC lettering signage is in place. 3. Will perform quarterly checks of types and quantity of sprinkler heads available in stock, and that proper 6" FDC signage remains in place for the sprinkler riser system. 4. The quarterly checks will be reviewed by the QA Committee for recommendation of additional actions, as needed. 5. Completion date of 4/10/18	4/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**02/26/2018**

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

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K 353	Continued From page 4 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 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire extinguishers. This has the ability to affect all occupants of the building. Findings include On 02-26-2018 at approximately 10:45 AM, it was observed that the fire extinguisher in the IT server room was not installed and maintained as required by the Life Safety Code.	K 355	K 355 1. The fire extinguisher in IT Server Room was mounted and the contractor inspected. 2. Checked all fire extinguisher locations to ensure they are mounted and on the inspection list. 3. Will update fire extinguisher list and perform monthly in-house and annual contractor inspections. 4. Both the in-house and contractor inspections will be reviewed quarterly by the QA committee for recommendation of additional actions, as needed. 5. Completion date of 4/10/18	4/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING 01 - MAIN BUILDING 0101 B. WING _____	02/26/2018

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

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K 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 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel 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.	K 363	K 363 1. Installed material suggested by Fire Marshall to door at L149 to correct the gap which was greater than ½" on the face and rabbit. 2. Will check all doors in the building to ensure gap is not greater than ½" on the face and rabbit. 3. Update and continue monthly and annual door inspections to ensure that the gap is not greater than ½" on the face and rabbit. 4. Both monthly and annual inspections will be reviewed by the QA Committee for recommendations of additional actions, as needed. 5. Completion date of 4/10/18	4/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**02/26/2018**

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

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K 363	Continued From page 6 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the doors protecting corridor openings as required by the Life Safety Code. This has the ability to affect all occupants in the effected smoke compartment of the building. Findings include: On 02-26-2018 at approximately 1:34 PM it was observed that the door to patient room 149 would not resist the passage of smoke. 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 511 SS=E	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:	K 511		

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	495339	A. BUILDING **01 - MAIN BUILDING 0101** 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**

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K 511	Continued From page 7 Based on observation, inspection and interview, the facility failed to maintain the LP Gas utility and 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 8:30 AM it was observed that the electrical panel in the Human Resources Office was not labeled as required by the Life Safety Code. (NFPA 70, 408.4) On 02-26-2018 at approximately 9:45 am, it is observed that the Emergency Gas Shut Off Valve signage is missing as it enters the facility in one location. (NFPA 101, 9.1.1; NFPA 54 - 12; 7.9.2.3) On 02-26-2018 at approximately 1:29 PM it was observed that the electrical panel at room 143 was not labeled as required by the Life Safety Code. (NFPA 70, 408.4) 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 511	K 511 1. Installed Emergency Gas Shut Off Valve signage in location identified during the inspection; new signs will include the words LP Gas or Propane, No Smoking, and Flammable 2. Will check all propane tanks for signage and correct as needed. 3. Will perform an annual inspection to ensure signs are in place. 4. Annual inspections will be reviewed by the QA Committee for completion and recommendations, as needed. 5. Completion date of 4/10/18	4/10/18

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT / CEO — (X6) DATE: 4/6/18

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	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **02 - MOORE CENTER** 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 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 100	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.	K 100		
K 511 SS=E	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) The Facility Safety Manager witnessed this	K 511	K511 1. Electrical Panel "17" - Breaker 33 & 35, Panel "18" - Breaker 42, Administrative Office Panel "C1" - Breaker 34 & 35, and Soiled Utility Room Panel "B5" - Breakers 42 & 43 are now correctly labeled and updated on the legend. The Electrical Room door signage was placed on the outside of the 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 determine further actions, as needed. 5. Completion date of 4/10/18	4/10/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **02 - MOORE CENTER** B. WING _____	**02/26/2018**

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K 511	Continued From page 2 evidence by interview and observation on 02-26-2018 at approximately 4:30 pm during the exit interview.	K 511		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT / CEO — (X6) DATE: 4/6/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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K 353	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to test and maintain the building fire sprinkler system. This has the ability to affect all occupants of the building. Findings include: On 02-26-2018 at approximately 3:30 pm, it is observed that the sprinkler heads found in the Pool Pump Room are found to be corroded and that the spare sprinklers did not correspond to the types installed in the building, there were no upright sprinklers in the spare cabinet 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 353		
K 511 SS=E	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	K 511		

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

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

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K 511	Continued From page 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 3:30 PM it was observed that the electrical panel "XLA1" Breaker 9, 11, & 13 and Panel "K' Breaker 33 & 38 found in the Jefferson Food Storage area and Panel "LA1" Breakers 30 & 36 in the Pool Pump Room Electrical Room are not labeled as required by the Life Safety Code. (NFPA 70, 408.4) 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 511	K511 1. The Electrical Panel "XLA1" - Breaker 9, 11, & 13, Panel "K' Breaker - 33 & 38 found in the Jefferson Food Storage area and Panel "LA1" – Breakers 30 & 36 in the Pool Pump Room Electrical Room are now properly labeled in the legend. The "Electrical Room" door signage was placed on the outside of the Pool Pump Room Electrical Room. 2. No other panel boxes in the new wing were found to be without proper labeling in the legend or 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 QA committee to determine further actions, as needed. 5. Completion date of 4/10/18	4/10/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING **04 - DAYROOM LTC UNIT** B. WING _____	**02/26/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT / CEO — (X6) DATE: 4/6/18

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