Printed: 03/12/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 01 - MAIN BUILDING 0101 (X3) DATE SUR COMPLETE					
	· · · · · · · · · · · · · · · · · · ·	495339	1	B. WING 03/08			/2019	
	HOLLY MANOR NURSING HOME 2003 C			DRESS, CITY, STATE, ZIP CODE COBB STREET VILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETION		
K 000	Sprinkler Status: Find an unannounced Stafety Gode Surve 03-08-2019 in accomplete Federal Regulation Long Term Care Fasurveyed for complexisting regulations. The findings that for non-compliance will Regulations, 483.7	cture: The main facility a construction type of a construction type of a construction type of a culty sprinklered - NFF standard Recertification was conducted on ordance with 42 Code a, Part 483: Requirem a cilities. The facility was constructed in the LSC s.	on Life of of hents for vas	K 000	The statements made on to correction are not an adand do not constitute an with the alleged deficie herein. To remain in comall Federal and State refacility has or will tak actions set forth in the plan of correction. The deficiencies cited have corrected by the dates i	mission agreeme ncies ci pliance gulation e the fo followi alleged been or	to nt ted with s, the llowing ng	
	Fire.) Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to maintain battery operated electric lights. This has the ability to affect all occupants in the effected compartment of the building. Findings include On 03-08-2019 at 1:45 pm, it is observed that hallway egress light #18A did not operate on DC power.			K 281	1. Work order submitted for the repair of light #18A. Batteries were found defective and were replaced. Light has been tested and is working correctly. 2. Safety Manager and Assistant Admin checked all egress lights for proper functioning. 3. All egress lights will be inspected monthly for 30 seconds to ensure lights are properly functioning. 4. Safety Committee will review monthly safety inspections to ensure continued compliance of all egress lights.			
	DA PIDECLUDIO UDIDIO	Mannighti en propre	ELETATIVE O OLO	MATHER	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.

PRESIDENT

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 01 - MAIN BUILDING 0101 COMPLETED. IDENTIFICATION NUMBER: 495339 B. WING 03/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 PROVIDER'S PLAN OF CORRECTION **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY K 281 Continued From page 1 K 281 The Safety Manager witnessed this evidence through inspection and observation on 03-08-2019 at 3:00 PM during the exit interview. K 331 [1.The missing ceiling tile was replaced. 4/21/19 K 331 Interior Wall and Ceiling Finish 2. Safety Manger Inspected all areas in the building SS=E CFR(s): NFPA 101 to ensure there were no other missing tiles. 3. Safety Manager will perform quarterly visual Interior Wall and Ceiling Finish inspections for missing ceiling tile. 2012 EXISTING 4. Safety Committee will review inspections quarterly Interior wall and ceiling finishes, including to ensure continued compliance. exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced Based upon observations of the suspended ceiling system and other ceilings have components that are not maintained according to manufacturer's installation recommendations. This has the ability to affect all occupants in the effected compartment of the building. Findings include On 03-08-2019 at 2:30 pm, it is observed that the Server Room has missing ceiling tile.. The Safety Manager witnessed this evidence through inspection and observation on 03-08-2019 at 3:00 PM during the exit interview.

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 02 - MOORE CENTER COMPLETED IDENTIFICATION NUMBER: 495339 B. WING 03/08/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2003 COBB STREET HOLLY MANOR NURSING HOME FARMVILLE, VA 23901 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY INITIAL COMMENTS** K 000 K 000 The statements made on this plan correction are not an admission to Description of structure: The main facility is a one and do not constitute an agreement story building with a construction type of V (111) with the alleged deficiencies cited herein. To remain in compliance with Sprinkler Status: Fully sprinklered - NFPA 13 all Federal and State regulations, the facility has or will take the following An unannounced Standard Recertification Life Safety Code Survey was conducted on actions set forth in the following 03-08-2019 in accordance with 42 Code of plan of correction. The alleged Federal Regulation, Part 483: Requirements for deficiencies cited have been or will be Long Term Care Facilities. The facility was corrected by the dates indicated. 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.) 4/21/19 1. Inspection will be scheduled with the fire alarm K 345 Fire Alarm System - Testing and Maintenance K 345 contractor. CFR(s): NFPA 101 SS=F 2. The sensitivity of all smoke detectors in the building will be checks per regulatory requirements. Fire Alarm System - Testing and Maintenance 3. Annual inspections will be scheduled with the fire A fire alarm system is tested and maintained in alarm contractor. Inspection reports will be reviewed accordance with an approved program complying by the Safety Manager at the time of the inspection with the requirements of NFPA 70, National to ensure proper documentation. Electric Code, and NFPA 72, National Fire Alarm 4. Safety Committee will review inspection reports and Signaling Code. Records of system annually to ensure continued compliance. acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced Based upon interviews and observations of the fire alarm system reports that there are components that are not maintained according to NFPA 72. This has the ability to affect all occupants in the effected compartment of the building. Findings include (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.

If continuation sheet Page 1 of 3

PECSIDENT

TITLE

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MOORE CENTER (X3) DATE 6 COMPL			
		495339		B. WING_		03/08/2019		
HOLLY MANOR NURSING HOME 2003			2003 CC	RESS, CITY, S DBB STRE LLE, VA				
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	COMPLETION DATE	
K 345	Continued From pa	age 1		K 345				
	observed on Mitche completed annual to 01-29-2019 has no detector sensitivity. The Safety Manage	er witnessed this evic n on 03-08-2019 at 3	on ne smoke lence		<u>ge</u> 0			
	Subdivision of Build CFR(s): NFPA 101 Subdivision of Build Construction 2012 EXISTING Smoke barriers shall be permitted to Smoke dampers at penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechan REMARKS. This REQUIREME by: Based on observatifalled to maintain the required by the Life.	ding Spaces - Smoke ding Spaces - Smoke all be constructed to ag per 8.5. Smoke ba to terminate at an atr re not required in duc y ducted HVAC syste ther system is installe nts adjacent to the si	a 1/2-hour rriers ium wall. et ms where d for moke	K 372	1. Penetration will be properly sealed. 2. Education will be provided to maintenathe proper technique to seal penetration contractors are on site, Safety Manager areas where work was performed to enspenetration has been properly sealed. 3. Safety Manager will perform quarterly of the basement and mechanical rooms penetration sealing. 4. Safety Committee will review inspection ensure continued compliance.	s. When will review ure any Inspections to proper	4/21/19	
-	observed by inspectors basement mechan	approximately 11:45 ction that the ceiling a ical room has unprot enetrations or with ar	area in the ected		•			

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MOORE CENTER		(X3) DATE SURVEY COMPLETED	
		495339		B. WING		03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, S	TATE, ZIP CODE		ヿ
	MANOR NURSING	IOME		OBB STRE			- 1
		*	1	ILLE, VA			- 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETIC	ж
17.0		,			DEFICIENCY)		- 1
K 372	Continued From pa	20e 2		K 372			⊣
	listed product (LSC						
		0.0.0,					ı
	interview and obse	er witnessed this evid rvation on 03-08-201 pm during the exit in	9 at				
				ŀ			
		1.2					
	1						
					V.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				PLE CONSTRUCTION B 03 - NEW WING	(X3) DATE SU COMPLET			
_		495339		B. WING			03/08/2019	
	HOLLY MANOR NURSING HOME 2003 C			BESS, CITY, 8 BB STRI				
(X4) ID PREFIX TAG	FIX KEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE COMPLETIO		
K 000	story building with a Sprinkler Status: F An unannounced S Safety Code Surve 03-08-2019 in accordance Federal Regulation Long Term Care Faurveyed for comp Existing regulation. The findings that for non-compliance with sprinkless status and several status are surveyed for comp Existing regulations.	cture: The main facilita construction type of a construction type of all the construction type of a construction was conducted on ordance with 42 Code of Part 483: Requirem acilities. The facility will ance using the LSC s.	f V (111) PA 13 on Life of the	K 000	The statements made on correction are not an a and do not constitute a with the alleged defici herein. To remain in co all Federal and State r facility has or will ta actions set forth in th plan of correction. The deficiencies cited have corrected by the dates	dmission n agreem encies c mpliance egulatio ke the f e follow alleged been or	to ent ited with ns, the ollowing ing will be	
K 223 SS=F	Doors with Self-Ck Doors in an exit pa or horizontal exit, s area enclosure are closed position, un device complying v closes all such doc compartment or er * Required manual * Local smoke dete smoke passing thr smoke detection s * Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2. This REQUIREME by: Based upon obser	osing Devices assageway, stairway of moke barrier, or haz a self-closing and kep aless held open by a r with 7.2.1.8.2 that aut ors throughout the sm attire facility upon activation activ	ardous of in the release comatically noke vation of: nd etect a required d; and 2.2.8 idenced the facility	K 223	Doors Identified will be repaired to pro Safety Manager will inspect all doors i facility for proper self-closing and latching Safety Manager will perform monthly i on all doors assemblies. Safety Committee will review inspection for continued compliance.	n the g. nspections	4/21/19	
LADODATO	(4.671)	VIDER/SUPPLIER REPRES		MATURE	TITLE		(X6) DATE	

Any deficiency statement excing 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/SUPPLIED IDENTIFICATION NUMBER			G 03 - NEW WING			
		495339		B. WING		03/08	/2019	
HOLLY MANOR NURSING HOME 2003 (FARM				RESS, CITY, S DBB STRI ILLE, VA				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE		
	This has the ability effected compartment of the co	to affect all occupant ent of the building. 1:30 pm, it is observe not self-close and law or at Brantley cross is door in the Pool Mesor. er witnessed this evid and observation on PM during the exit in the pool in the pool in the exit in the pool in the po	od that the tch: corridor schanical dence sterview.	K 223	1. Service contractor will be scheduled to fire damper inspections. 2. Safety Manager will identify all fire dan building and label each. 3. Safety Manager will verify that all ident are inspected by the contractor. 4. Safety Committee will review annual in for continued compilance.	npers in the	4/21/19	
	by: Based on observat failed to maintain th with the Life Safety 90B, and 80. This	NT is not met as evident and interview, the ne fire dampers in accode (9.2.1) and NF has the ability to affer fected compartment	e facility cordance =PA 90A, act all					
	Findings include							
		approximately 1:00 Pire damper access pa						

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION 3 03 - NEW WING	(X3) DATE SURVEY COMPLETED	
	495339			B. WING		03/08	/2019
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, S	TATE, ZIP CODE		
HOLLY	HOLLY MANOR NURSING HOME 2003 C						
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 521	not contain the projin 1" letters. On 03-08-2019 at a observed that docu available of the late completed or schedriser /attic access in The Safety Manage interview and observed.	per signage of "Fire Inperoximately 1:15 Pinentation is not readest fire damper inspeduled as found in spr	M, it is dily ctions inkler dence by 9 at	K 521			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			PLE CONSTRUCTION 3 04 - DAYROOM LTC UNIT	(X3) DATE SURVEY COMPLETED		
	495339			B. WING		03/08	/2019	
HOLLY MANOR NURSING HOME 2003 C			2003 CO	ESS, CITY, S BB STRE LLE, VA				
(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 CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS			K 000				
	story building with a	cture: The main facili a construction type o	fV (111)	;				
	•	ully sprinklered - NFF						
	An unannounced Standard Recertification Life Safety Code Survey was conducted on 03-08-2019 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities.						:	
	The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility is in compliance with the Requirements for Participation Medicare and Medicaid.							
					<u>ئ</u>			
	_	-						
LABORATO	ABORATORY DIRECTIONS OR PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE PRESIDENT CE U							

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.