STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on staff interview, facility document review, and clinical record review, the facility staff failed to inform a resident/resident representative of the risks, benefits, and alternatives of medication treatment for one of 13 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to inform the resident/resident representative of the risks, benefits, and alternatives of medication treatment for the use of the anti-anxiety medication lorazepam (used to treat anxiety). A review of R10's clinical record revealed a physician's order dated 2/12/25 for lorazepam 2mg/ml (milligrams/milliliters)- 0.25ml by mouth every four hours as needed for anxiety, sleeplessness, seizure activity or shortness of breath. Further review of R10's clinical record failed to reveal the facility staff informed the resident or the resident's representative of the risks, benefits, and alternative treatments for the use of lorazepam. On 6/5/25 at 9:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that when lorazepam is initiated, the resident and resident representative should be made aware of the targeted behaviors, side effects, black box warnings, and asked if they are aware of any alternative treatments that may work instead of the medication. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Resident Rights documented, 12. The Resident has a right to be fully informed in advance about care and treatment and any changes in that care or treatment that may affect the Resident's well-being. No further information was presented prior to exit.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 2. For Resident #10 (R10), the facility staff failed to notify the resident representative the resident was vomiting and placed on contact precautions on 2/19/25. A review of R10's clinical record revealed a nurse's note dated 2/19/25 that documented the resident was placed on contact isolation precautions due to vomiting during the previous day. Further review of R10's clinical record failed to reveal the resident's representative was notified regarding this change in condition on 2/18/25 or 2/19/25. On 6/4/25 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated a resident's representative should be made aware of the resident's change in condition as soon as possible and this is evidenced by documenting a nurse's note. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Change in a Resident's Condition documented, The facility will promptly notify the resident, his or her physician/practitioner, and representative of changes in the resident's medical/mental condition and/or status. No further information was presented prior to exit. Based on resident interview, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to notify the physician or the responsible party of a change in condition for two of 13 residents in the survey sample, Residents #1 and #10. The findings include: 1. For Resident #1 (R1), the facility staff failed to notify the physician of complaints of burning and pain to the neck and the residents repeated request to call the on-call physician for treatment on 12/2/24. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 4/2/2025, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented no behaviors. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 1:30 p.m., an interview was conducted with R1 who stated that he had an area of skin cancer on his chest that was treated with a chemotherapy cream. R1 stated that a nurse had applied the chemotherapy cream to his neck by mistake and caused a chemical burn because it was only supposed to be applied to the cancer area on the chest. R1 stated that a few weeks after that the area on the neck started burning and hurting and he had asked the evening nurse to call the on-call physician, and she had refused to call. He stated that the nurse told him that it was not an emergency and that he did not have an order for the hydrocortisone cream that he was requesting, and she would put it in the book for the nurse practitioner the next day. R1 stated that he had told her that it was an emergency to him and asked her to call the on-call doctor for an order for hydrocortisone but she stated that there was nothing on his neck and it was not an emergency. He stated that the nurse came in twice more during the night and kept telling him that there was no order for the hydrocortisone and that she was not going to call the on-call physician to get one because his neck was fine every time he asked her to call. The progress notes for R1 documented in part, - 12/02/2024 19:30 (7:30 p.m.) Note Text: Writer approached by resident to apply cream to neck (hydrocortisone cream) stating my neck is burning from my chemical burn I received over 2 weeks ago. Writer then assessed area, no visible marks were apparent to resident's neck area, no redness no swelling nor visible irritation. Writer then assessed resident active orders and notes and notified resident that per active orders and from derm (dermatology) note. Hydrocortisone is not to start until 12/12. Also, that resident and RP (responsible party) was made aware and agreeable to this order. Resident then insisted that I notify the on-provider for non-emergent request. Writer advised resident that this request would be placed in Np (nurse practitioner) communication book. Resident then stated to writer No you need to call the DON (director of nursing) and On-call now cause I have their numbers, and I will contact them, writer then replied that he could contact anyone, but as a licensed nurse and after hours I did not see nor note any emergency to notify on-call for hydrocortisone cream. Resident's vital were obtained WNL (within normal limits), resident not in any distress during any assessment, resident was assessed through entire shift, resident also made aware that if any changes were noted that appeared emergent I would notify On-call. - 12/03/2024 01:39 (1:39 a.m.) Note Text: Resident received scheduled medication as order, Vital obtained, WNL (within normal limits), no redness, irritation, nor swelling noted. Resident noted with skin area to chest as noted only. Neck area dry and intact. Will continue to monitor. - 12/03/2024 03:39 (3:39 a.m.) Note Text: Writer enters room for reassessment to neck area; resident had complaints of burning and pain to area. At this time, no redness, swelling, irritation noted to area. Resident noted in bed with eyes closed during entering of room. Resident appeared to be in no distress. No further complaints made during time since last assessment, no further request made at this time. Resident became upset and irate raising voice, when resident asked writer if I had located and read Derm not [sic] from 10/21 writer advised resident yes at this time, and that there areas that needs clarification and that this matter would be passed on to [Name of former unit manager] in the am for follow as the dermatologist office is closed at this time. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/03/2024 07:05 (7:05 a.m.) Note Text: Writer enters resident room for medication administration, neck assessed, no irritation, no swelling, redness noted to area. Resident updated on status. Continues to state that neck has chemical burn. UM (unit manager) notified of issues and concerns. Medication administered and accepted without difficulty. VS WNL (vital signs within normal limits) at this time. - 12/03/2024 14:05 (2:05 p.m.) Note Text: Hydrocortisone External Gel 1 % Apply to neck topically as needed for as needed for neck burning for 7 Days. On 6/4/25 at 3:33 p.m., an interview was conducted with LPN (licensed practical nurse) #8 who stated that there was an on-call provider available after 7:00 p.m. each day and on weekends. She stated that the staff had a protocol that they followed for calling the on-call provider and had standing orders that they were able to implement for some things. She stated that any non-emergent issues that could wait until the next day were put in the provider book for follow up the next day. LPN #8 provided a printed paper that she stated hung at the nurse's station which contained a stop sign and contained procedures that addressed when to call the on-call provider. When asked if a resident was requesting for the on-call provider to be called due to complaints of skin burning and pain, LPN #8 stated that the nurse should call the on-call provider because it was the residents right. On 6/4/25 at 3:59 p.m., an interview was conducted with ASM (administrative staff member) #3, nurse practitioner. ASM #3 stated that she followed R1 at the facility since November 2024 but was not completely familiar with the cream he was receiving and never saw the chemical burn on his neck. She stated that she did see him on 12/3/24 when he complained of burning but it looked healthy. ASM #3 stated that she was in the facility Monday through Friday and staff could call her until 7:00 p.m. and after that they called the on-call provider. She stated that the criteria for calling the on-call provider was if a resident needed medications, had acute problems, was having shortness of breath or any new or acute symptoms. She stated that she felt it would be a case-by-case situation and R1 was insistent that he needed the Hydrocortisone for his neck, so she had prescribed it but felt that medically there was no need for it. She stated that as far as whether the nurse called the on-call provider she could not speak to that. On 6/5/25 at 11:06 a.m., an interview was conducted with LPN #5 who stated that R1 had complained of his neck burning and hurting on 12/2/24 when she was caring for him. She stated that R1 had not had any treatment to the neck for about a week and a half, so she had assessed the area and did not see any marks, so she put it in the book for the nurse practitioner to follow up the next day. She stated that R1 wanted her to call the on-call physician, but she felt that she did not need to call, and she told him that she would go in and check him every two hours to make sure the area did not change. She stated that she had called the unit manager and the director of nursing at the time, and they said they would assess his neck the next morning. The facility policy Change in a Resident's Condition documented in part, Policy: The facility will promptly notify the resident, his or her physician/practitioner, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) . On 6/5/25 at 2:47 p.m., ASM #1, the administrator, ASM #6, the regional director of clinical services, ASM #7, the regional director of operations, ASM #8, the risk nurse and ASM #9, the regional human resources were made aware of the above concern. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was obtained prior to exit.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to resolve grievances voiced regarding linen supplies in 10 of 11 months of resident council meetings reviewed. The findings include: The facility staff failed to resolve ongoing grievances regarding shortages of washcloths and towels voiced during resident council meetings in 10 of 11 months reviewed. On 6/3/25 at 1:30 p.m., an interview was conducted with Resident #1 (R1) who stated that there was an ongoing problem with a lack of towels and washcloths at the facility. R1 stated that often the night shift did not have enough linens to get people up and they had to wait for the day shift to get them up when the linens were delivered. R1 stated that often the day shift had to wait for the linens to be delivered before they could get residents up and some were not able to get to the dining room for breakfast because of this. R1 stated that the facility had stopped using disposable wipes for incontinence care and the staff were using wash cloths now which was causing a shortage. On R1's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 4/2/25, the resident was assessed as being cognitively intact for making daily decisions. On 6/3/25 at 2:58 p.m., an interview was conducted with Resident #9 (R9) who stated that the care at the facility depended on who was working and there were days when it took a while for them to get her out of bed. R9 stated that there were problems with a lack of towels and washcloths at the facility and they talked about it in their meetings. On R9's most recent MDS assessment, an annual assessment with an ARD of 5/13/25, the resident was assessed as being cognitively intact for making daily decisions. On 6/4/25 at 1:09 p.m., an interview was conducted with Resident #13 (R13) who stated that staff had advised her that she was allowed one towel and one washcloth per day. R13 stated that she did not understand why the staff were so stingy with them. On R13's most recent MDS assessment, an admission assessment with an ARD of 4/8/25, the resident was assessed as being moderately impaired for making daily decisions. Review of the facility resident council minutes documented in part, - 7/10/24 . would like more towels - 8/14/24 . Need washcloths and sheets . A Grievance/Suggestion Communication form dated 8/14/24 documented in part, 8/15/24 wash cloths have been ordered . - 10/9/24 . We're running out of towels, rags, and washcloths . A Grievance/Suggestion Communication form dated 10/9/24 documented in part, . The closets are filled 2 times daily and linen is being hoarded. DON (director of nursing) addressed issue in a meeting on 10/10 . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 11/13/24 . residents are requesting more washcloths and linens . Most residents would like to be up and in their real [sic] chairs earlier to attend activities . - 12/11/24 . no washcloths, bathing times delayed . A Grievance/Suggestion Communication form dated 12/11/24 documented in part, .There were complaints that there were no washcloths, which caused their bathing times to be delayed. [Name of environmental services (EVS) director] explained that the matter was being handled, and they were in the process of figuring out who is hoarding the clean linen. The matter is being taken care of . Follow up action: Continue to do a closet fill up on each unit 2-3 times a day to accommodate residents and continue to educate nursing staff on hoarding issue . - 1/8/25 . There were complaints that there were no washcloths, which caused their bathing times to be delayed. [Name of EVS director] explained that the matter was being handled, and they were in the process of figuring out who is hoarding the clean linen. He stated laundry was found in certain rooms in the closets and under the beds. The matter is being taken care of. [Name of EVS director] also shared that new washing machine had been ordered . A Grievance/Suggestion Communication form dated 1/8/25 documented in part, .There were complaints that there were no washcloths, [Name of EVS director] explained that the matter was being handled, and they were in the process of figuring out who it is hoarding clean linen was located in bags on [NAME]. It was found in closets and under the beds, the matter is being taken care of . - 2/26/25 . beds are not getting changed in a timely manner. There is bathing schedule delay due to lack of clean towels . A Grievance/Suggestion Communication form dated 2/26/25 documented in part, .Beds are not getting changed in a timely manner. [Name of R1] states you can't get bath because there's no clean towels . It documented the concern referred to nursing, laundry, housekeeping and dietary department. - 3/13/25 . They would like more washcloths . A Grievance/Suggestion Communication form dated 3/19/25 failed to evidence documentation regarding washcloth concerns. - 4/9/25 . They would like more washcloths . A Grievance/Suggestion Communication form dated 4/9/25 failed to evidence concerns regarding washcloths. - 5/28/25 . issues with getting washcloths, pads & towels . There were no grievance/suggestion communication forms regarding the resident council concerns regarding washcloths, pads & towels. On 6/3/25 at 4:03 p.m., an interview was conducted with OSM (other staff member) #12, LTC (long term care) ombudsman. OSM #12 stated that she had been working with the facility for quite a while to try to get the linen shortages fixed for the residents. She stated that she attended the resident council meetings by invitation from the residents and they complained every month about a lack of towels, washcloths and pads. OSM #12 stated that baths, showers and getting residents out of bed were delayed due to a lack of linens. She stated that she had conducted spot checks in the linen closets and would find no linen available. OSM #12 stated that when she asked she was told that the aides were stealing the linens, then she was told that they were hoarding them in the rooms. She stated that she did rounds with the director of environmental services and checked resident rooms where they suspected linens were being hoarded and found nothing. OSM #12 stated that she spoke to residents, and no one knew of any hoarding areas for linen. She stated that the facility had stopped using disposable wipes a while back and staff were using washcloths for incontinence care which had drastically increased the usage and demand. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 between 8:47 a.m. and 9:04 a.m. observations were made of the facility unit linen closets. The findings included the following: - Grace unit (30 beds) linen closet 18 washcloths and 23 towels available. - [NAME] unit (60 beds) linen closet 16 washcloths and 9 towels available. - [NAME] unit (30 beds) linen closet 18 washcloths and 16 towels available. On 6/4/25 at 9:13 a.m. an observation of the laundry clean linen area revealed 25 towels and no washcloths on the shelf. On 6/4/25 at 8:50 a.m., an interview was conducted with CNA (certified nursing assistant) #2 who stated that there were times when they ran out of linens. She stated that when they ran out they went to the laundry and asked for more. CNA #2 stated that they used to have disposable wipes for incontinence care, but they stopped using them and now they used washcloths and towels which caused them to use a lot. She stated that she could not say it made the job harder, but it took more washcloths to clean the resident if they had large bowel movements and she would not want to put the washcloth on her face after that even if it had been washed. She stated that she has had residents that were not able to be gotten out of bed on the night shift due to a lack of linens. On 6/4/25 at 8:56 a.m., an interview was conducted with CNA #6 who stated that the linen was normally stocked in the morning between 8-9 am. She stated that there were times when she ran out of towels and washcloths, but she went to laundry to get more as needed. On 6/4/25 at 12:25 p.m., an interview was conducted with CNA #5 who stated that they used washcloths and towels for incontinence care and bathing of residents. She stated that all linens were sent to the laundry for cleaning, and they disposed of anything that was too soiled to be washed. CNA #5 stated that there were times when they ran out of linens, and they had to call the laundry to bring more up or go down to get more linens. She stated that usually they came within 15 minutes, but residents had to wait until they got the linens to provide the care. CNA #5 stated that this morning the linen closet was stocked when she arrived, but this was unusual because it was not always stocked during the day. She stated that she had some residents who had their bathing or getting out of bed delayed due to a lack of linens. CNA #5 stated that she was not aware of any staff who threw away soiled linens or hoarded them. She stated that she had received report a couple of times from the night shift saying that they could not get a resident up because they did not have any linen and that was within the past four months. On 6/4/25 at 9:05 a.m., an interview was conducted with LPN (licensed practical nurse) #8 who stated that in the past they recalled concerns from residents about not being able to get up due to a lack of towels and washcloths, but they had educated the laundry, and they were doing much better and stocking twice a day before the shift change. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 9:13 a.m., an interview was conducted with OSM #5, the director of environmental services who stated that they had been working at the facility since February of 2024. She stated that the linen situation was in dire straits when she first started, and she had been working to resolve the issues. OSM #5 stated that she kept a supply of new towels and washcloths as a backup for emergencies in the back of the laundry and in her office. She stated that the staff used the washcloths as wipes, and she found that some of the aides were throwing them away in the trash. OSM #5 stated that starting in April 2025 she had hired a night shift laundry person to stock the closets in the mornings to see if that would help the situation. She stated that she had conducted some room audits which found some hoarded linens in resident rooms and she had worked with the unit managers to educate the staff. On 6/4/25 at 4:20 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that since she started working at the facility in February 2025 they had done a lot of education and monitoring of the linen. She stated that they had found that the staff were throwing soiled linens in the trash and they had started ordering more. She stated that they also found that staff were hoarding linens in rooms and other employees were not aware where the linen was. ASM #2 stated that they had taken it upon themselves to try to continuously replenish the laundry on the floors. On 6/5/25 at 9:26 a.m., an interview was conducted with OSM #11, acting activities director. OSM #11 stated that she did not attend the resident council meetings but she understood that the former activities director used to go to the resident council meetings, write down any concerns and the communicate them to the appropriate department by the grievance form. She stated that the residents often complain to her that the laundry runs out of towels and washcloths and the staff do not have any available to get them up and dressed. OSM #11 stated that the residents had complained recently to her about delays in getting up due to linens not being available. On 6/5/25 at 12:53 p.m., an interview was conducted with ASM #1, administrator who stated that since she had been in the position she has made sure that towels and washcloths were ordered at least once a month. She stated that she had created a form that the CNAs could carry that asked them if they had enough linen and she did that for a month or two. She stated that she rounded in the mornings to see if there were washcloths, towels and everything they needed on the units. ASM #1 stated that she had asked EVS to hire the night laundry person. She stated that the housekeeping director thought that the staff were throwing away the washcloths and towels and she continued to authorize the orders for additional linens and was not aware of any current issues. Review of facility invoices for towel and washcloth orders documented orders placed on 7/19/24, 8/8/24, 12/6/24, 12/19/24, 1/16/25, 2/18/25, 3/12/25, 4/15/25, and 5/13/25. The facility policy Resident Rights documented in part, . The resident has the right to and the facility must make prompt efforts to resolve grievances the resident may have . On 6/5/25 at 2:47 p.m., ASM #1, the administrator, ASM #6, the regional director of clinical services, ASM #7, the regional director of operations, ASM #8, the risk nurse and ASM #9, the regional human resources were made aware of the concern. No further information was presented prior to exit.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary psychotropic medication for one of 13 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to ensure the physician documented the duration for the use of prn (as needed) lorazepam and failed to attempt non-pharmacological interventions prior to the administration of prn lorazepam. A review of R10's clinical record revealed a physician's order dated 2/12/25 for lorazepam 2mg/ml (milligrams/milliliters)- 0.25ml by mouth every four hours as needed for anxiety, sleeplessness, seizure activity or shortness of breath. A nurse practitioner note dated 4/1/25 documented, Continue Lorazepam, this is a PRN, she doesn't need it very often but she does need it due to her schizophrenia. Further review of R10's clinical record failed to reveal nurse practitioner or physician documentation regarding the intended duration of use for prn lorazepam. A review of R10's MARs (medication administration records) for February 2025, March 2025, and May 2025 revealed the resident was administered prn lorazepam on 2/14/25, 3/6/25, 3/9/25, and 5/20/25. Further review of R10's clinical record (including the MARs and nurses' notes for those dates) failed to reveal the facility staff attempted non-pharmacological interventions prior to the administration of prn lorazepam on those dates. On 6/5/25 at 9:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated she did not know what the physician should document regarding the use of prn lorazepam. On 6/5/25 at 10:01 a.m., another interview was conducted with RN #1. RN #1 stated non-pharmacological interventions should be individualized and should be attempted prior to the administration of prn lorazepam. RN #1 stated nurses should evidence the attempt of non-pharmacological interventions by documenting a progress note. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Antipsychotic Medication Use documented, 14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. No further information was presented prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview and clinical record review, it was determined that the facility staff failed to review or revise the comprehensive care plan for one of 13 residents, Residents in the survey sample, Resident #11 (R11). The findings include: For R11, the facility staff failed to review or revise comprehensive care plan following a fall on 03/10/2025. R11 was admitted to the facility with diagnosis that included but was not limited to dementia (1). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/14/2024, R11 scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating R11 was severely impaired of cognition for making daily decisions. The facility's nursing note for R11 dated 03/10/2025 documented, Writer was informed by activities worker that resident was on floor. writer went in room with cna (certified nursing assistant). resident was lying on floor, alert and oriented, resident did not hit head, no bruising lacerations or bleeding, neuro checks in place per facility policy, resident was placed back in bed, call bell within. RP (responsible party) was left a voicemail and notified ADON (assistant director of nursing) and provider about fall, vital signs obtained per facility protocol. no new orders were given. The facility's fall investigation for R11 dated 03/10/2025 documented in part, Incident description Writer was informed by activities worker that resident was on floor. writer went in room with cna. resident was lying on floor, alert and oriented, resident did not hit head, no bruising lacerations or bleeding, neuro checks in place per facility policy, resident was placed back in bed, call bell within. RP was left a voicemail and notified ADON (assistant director of nursing) and provider about fall, vital signs obtained per facility protocol. no new orders were given. Was this incident witnessed: N (no). Injury Type: No injuries observed at time of incident. Review of R11's comprehensive care plan with a revision date of 02/05/2025 failed to evidence documentation of R11's fall on 03/23/2024. On 06/05/2025 at approximately 2:45 p.m., an interview was conducted with RN (registered nurse) #4, MDS coordinator. When asked to describe the procedure regarding a resident's care plan following a fall she stated that the care plan is review after each fall and revisions are made if they are needed. After reviewing R11's fall care plan RN #4 stated that a revision was not needed but it was reviewed. When asked for the documentation or evidence that the care plan was reviewed regarding R11's fall on 03/10/2025, she stated that there was no documentation of a review. The facility's policy Care Planning - Comprehensive Person-Centered documented in part, The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: b. When there has been a significant change in the resident's condition; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2025 at approximately 3:05 p.m., ASM (administrative staff member) #1, administrator, and ASM #6, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for four of 13 residents in the survey sample, Residents #1, #5, #7, and #9. The findings include: 1. For Resident #1 (R1), the facility staff failed to administer multiple medications in a timely manner on 12/25/24. A review of R1's clinical record revealed the following physician's orders: 12/27/23-Pseudoephedrine 30mg (milligrams)-one tablet by mouth three times a day for seasonal allergies. 5/15/23-Baclofen 20mg-one tablet by mouth three times a day for spinal stenosis (narrowing of the spine). 1/23/24-Azelastine 137mcg (micrograms)-two sprays in both nostrils two times a day for nasal congestion. 5/13/24-Simvastatin 40mg-one tablet by mouth at bedtime for high cholesterol. 6/16/24-Magnesium Oxide 400mg-one tablet by mouth two times a day for rhabdomyolysis (skeletal muscle breakdown). 9/11/24-Baclofen 5mg-one tablet by mouth three times a day for muscle spasms. A review of a medication administration audit report for 12/25/24 revealed the following: -Pseudoephedrine was scheduled at 7:00 a.m. and was administered at 12:34 p.m. -Pseudoephedrine was scheduled at 8:00 p.m. and was administered at 10:08 p.m. -Baclofen (20mg) was scheduled at 9:00 a.m. and was administered at 12:27 p.m. -Azelastine was scheduled at 7:00 a.m. and was administered at 12:35 p.m. -Azelastine was scheduled at 8:00 p.m. and was administered at 10:07 p.m. -Simvastatin was scheduled at 8:00 p.m. and was administered at 10:08 p.m. -Magnesium Oxide was scheduled at 7:00 a.m. and was administered at 12:33 p.m. -Baclofen (5mg) was scheduled at 9:00 a.m. and was administered at 12:28 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 at 9:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses should administer medications within one hour before or one hour after the medications are scheduled so residents are not overmedicated and are getting their doses correctly. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Medication Administration documented, 14. Medications are administered within 60 minutes of scheduled time . No further information was presented prior to exit. 2. For Resident #5 (R5), the facility staff failed to administer multiple medications in a timely manner on 12/25/24. A review of R5's clinical record revealed the following physician's orders: 1/29/24-hydralazine 50mg (milligrams)-one tablet by mouth three times a day for high blood pressure. 11/19/24-Carvedilol 3.125mg by mouth two times a day for high blood pressure. 12/18/24-Brimonidine Tartrate 0.2%- one drop in the left eye two times a day for increased eye pressure. A review of a medication administration audit report for 12/25/24 revealed the following: -hydralazine was scheduled at 7:00 a.m. and was administered at 10:36 a.m. -hydralazine was scheduled at 11:00 a.m. and was administered at 2:42 p.m. -hydralazine was scheduled at 8:00 p.m. and was administered at 9:43 p.m. -Carvedilol was scheduled at 6:00 p.m. and was administered at 9:43 p.m. -Brimonidine Tartrate was scheduled at 7:00 a.m. and was administered at 10:36 a.m. On 6/5/25 at 9:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses should administer medications within one hour before or one hour after the medications are scheduled so residents are not overmedicated and are getting their doses correctly. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. No further information was presented prior to exit. 3. For Resident #7 (R7), the facility staff failed to administer multiple medications in a timely manner on 12/25/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R7's clinical record revealed the following physician's orders: 5/28/24-levetiracetam 500mg (milligrams) by mouth two times a day for seizure like activity. 10/26/24-Tylenol 500mg-two tablets by mouth two times a day for pain. A review of a medication administration audit report for 12/25/24 revealed the following: -levetiracetam was scheduled at 5:00 p.m. and was administered at 11:07 p.m. -Tylenol was scheduled at 5:00 p.m. and was administered at 11:07 p.m. On 6/5/25 at 9:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses should administer medications within one hour before or one hour after the medications are scheduled so residents are not overmedicated and are getting their doses correctly. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. No further information was presented prior to exit. 4. For Resident #9 (R9), the facility staff failed to administer multiple medications in a timely manner on 12/25/24. A review of R9's clinical record revealed the following physician's orders: 6/15/23-tramadol 50mg (milligrams)-one tablet by mouth three times a day for pain. 2/18/24-Diclofenac 1% gel-apply to shoulder and neck two times a day for arthritic pain. 9/7/24-Miralax 17 grams by mouth two times a day for constipation. A review of a medication administration audit report for 12/25/24 revealed the following: -tramadol was scheduled at 9:00 a.m. and was administered at 10:59 a.m. -Diclofenac was scheduled at 6:00 p.m. and was administered at 10:05 p.m. -Miralax was scheduled at 9:00 a.m. and was scheduled at 11:00 a.m. On 6/5/25 at 9:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses should administer medications within one hour before or one hour after the medications are scheduled so residents are not overmedicated and are getting their doses correctly. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. No further information was presented prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for one of 13 residents in the survey sample, Resident #8. The findings include: For Resident #8 (R8), the facility staff failed to provide personal hygiene on multiple shifts in March 2025 and May 2025. A review of R8's ADL records for March 2025 and May 2025 failed to reveal personal hygiene (combing hair, brushing teeth, washing/drying face and hands) was provided on the following dates/shifts (as evidenced by blank spaces on the records): 3/10/25 during the day shift. 3/17/25 through 3/20/25 during the evening shift. 3/22/25 through 3/23/25 during the evening shift. 5/17/25 during the day shift. On 6/4/25 at 2:23 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated personal hygiene consists of mouth care, nail care, perineal care, and washing under residents' arms/applying deodorant. CNA #2 stated residents' bodies should be washed once per shift, mouth care should be done in the morning and after each meal, and she washes under residents' nails if their nails are dirty. CNA #2 stated CNAs evidence personal hygiene was provided by documenting this every shift in the ADL records. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Activities of Daily Living (ADLs) documented, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. No further information was presented prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, clinical record review, and facility, it was determined that facility staff failed to provide respiratory care and services for one of 13 residents in the survey sample, Resident #5 (R5). For R5, the facility staff failed to obtain a physician's order for the use of oxygen. The findings include: R5 was admitted to the facility with diagnoses that included but were not limited to respiratory failure (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/23/2025, R5 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R5 was cognitively intact for making daily decisions. On 06/03/2025 at approximately 12:25 p.m. an observation revealed R5 receiving oxygen at three liters per minute by nasal cannula (2). The physician's order for R5 dated 06/03/2025 documented in part, Oxygen 3 (three) via (by) NC (nasal cannula) continuous. Order Date: 06/03/2025. Audit Details. Created Date: 06/03/2025. 1445 (2:45 p.m.). On 06/04/2025 at approximately 3:00 p.m. an interview was conducted with RN 9registered nurse) #1, unit manager. When informed of the observation of R5 receiving oxygen as stated above, RN #1 stated that there was no physician's order for R5's oxygen at the time of the surveyor's observation. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide physician services for three of 13 residents in the survey sample, Residents #1, #5, and #9. The findings include: 1. For Resident #1 (R1), the facility staff failed to provide an individualized response to a nurse's inquiry regarding medication administration when the nurse was responsible for caring for 54 residents. A review of a nursing schedule dated 12/25/24 revealed one nurse worked during the day shift on the [NAME] unit. A resident census form dated 12/25/24 documented 54 residents resided on the [NAME] unit on that date. R1 resided on the [NAME] unit. A review of R1's clinical record revealed the following physician's orders: 12/27/23-Pseudoephedrine 30mg (milligrams)-one tablet by mouth three times a day for seasonal allergies. 5/15/23-Baclofen 20mg-one tablet by mouth three times a day for spinal stenosis (narrowing of the spine). 1/23/24-Azelastine 137mcg (micrograms)-two sprays in both nostrils two times a day for nasal congestion. 6/16/24-Magnesium Oxide 400mg-one tablet by mouth two times a day for rhabdomyolysis (skeletal muscle breakdown). 9/11/24-Baclofen 5mg-one tablet by mouth three times a day for muscle spasms. A review of a medication administration audit report for 12/25/24 revealed the following: -Pseudoephedrine was scheduled at 7:00 a.m. and was administered at 12:34 p.m. -Baclofen (20mg) was scheduled at 9:00 a.m. and was administered at 12:27 p.m. -Azelastine was scheduled at 7:00 a.m. and was administered at 12:35 p.m. -Magnesium Oxide was scheduled at 7:00 a.m. and was administered at 12:33 p.m. -Baclofen (5mg) was scheduled at 9:00 a.m. and was administered at 12:28 p.m. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated two nurses are supposed to work during the day shift on the [NAME] unit, but she was the only nurse who worked on the unit during the day shift on 12/25/24. LPN #2 stated the night shift nurse had already worked 16 hours and stayed until approximately 9:30 a.m. but then left. LPN #2 stated that between 7:00 a.m. and 9:30 a.m., the night shift nurse called staff and tried to obtain coverage for a second nurse but did not provide resident care or administer medications. LPN #2 stated she called ASM (administrative staff member) #3 (the nurse practitioner) and told her she was the only nurse on the [NAME] unit and medications were going to be late. LPN #2 stated ASM #3 said she could not give orders for everybody, and LPN #2 would have to use her nursing judgement and critical thinking. LPN #2 stated she administered medications to every resident on the unit using her best judgment. LPN #2 stated she could not administer medications that were ordered three times a day because the medications were administered late, and the medications would be given too close to the next dose. On 6/4/25 at 4:14 p.m., an interview was conducted with ASM #3. ASM #3 stated that on 12/25/24, LPN #2 called her and told her she was behind on the medication pass. ASM #3 stated she did not remember the details of what she and LPN #2 discussed and did not document any notes. ASM #3 stated she did not remember if she and LPN #2 discussed each resident, but they discussed important medications that could not be missed. ASM #3 stated she would have to refer to LPN #2 on who they discussed. On 6/5/25 at 10:43 a.m., an interview was conducted with OSM (other staff member) #7 (the pharmacist). OSM #7 stated it is not optimal to have missed or late medications. OSM #7 stated some medications work over such a long period of time and some medications are more critical. OSM #7 stated when some critical medications are missed or late, there could be serious adverse effects, and this depends on each person and each medication. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Physician Services documented, 1. The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident. No further information was presented prior to exit. 2. For Resident #5 (R5), the facility staff failed to provide an individualized response to a nurse's inquiry regarding medication administration when the nurse was responsible for caring for 54 residents. A review of a nursing schedule dated 12/25/24 revealed one nurse worked during the day shift on the [NAME] unit. A resident census form dated 12/25/24 documented 54 residents resided on the [NAME] unit on that date. R5 resided on the [NAME] unit. A review of R5's clinical record revealed the following physician's orders: (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/24-hydralazine 50mg (milligrams)-one tablet by mouth three times a day for high blood pressure. 12/18/24-Brimonidine Tartrate 0.2%- one drop in the left eye two times a day for increased eye pressure. A review of a medication administration audit report for 12/25/24 revealed the following: -hydralazine was scheduled at 7:00 a.m. and was administered at 10:36 a.m. -hydralazine was scheduled at 11:00 a.m. and was administered at 2:42 p.m. -Brimonidine Tartrate was scheduled at 7:00 a.m. and was administered at 10:36 a.m. On 6/4/25 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated two nurses are supposed to work during the day shift on the [NAME] unit, but she was the only nurse who worked on the unit during the day shift on 12/25/24. LPN #2 stated the night shift nurse had already worked 16 hours and stayed until approximately 9:30 a.m. but then left. LPN #2 stated that between 7:00 a.m. and 9:30 a.m., the night shift nurse called staff and tried to obtain coverage for a second nurse but did not provide resident care or administer medications. LPN #2 stated she called ASM (administrative staff member) #3 (the nurse practitioner) and told her she was the only nurse on the [NAME] unit and medications were going to be late. LPN #2 stated ASM #3 said she could not give orders for everybody, and LPN #2 would have to use her nursing judgement and critical thinking. LPN #2 stated she administered medications to every resident on the unit using her best judgment. LPN #2 stated she could not administer medications that were ordered three times a day because the medications were administered late, and the medications would be given too close to the next dose. On 6/4/25 at 4:14 p.m., an interview was conducted with ASM #3. ASM #3 stated that on 12/25/24, LPN #2 called her and told her she was behind on the medication pass. ASM #3 stated she did not remember the details of what she and LPN #2 discussed and did not document any notes. ASM #3 stated she did not remember if she and LPN #2 discussed each resident, but they discussed important medications that could not be missed. ASM #3 stated she would have to refer to LPN #2 on who they discussed. On 6/5/25 at 10:43 a.m., an interview was conducted with OSM (other staff member) #7 (the pharmacist). OSM #7 stated it is not optimal to have missed or late medications. OSM #7 stated some medications work over such a long period of time and some medications are more critical. OSM #7 stated when some critical medications are missed or late, there could be serious adverse effects, and this depends on each person and each medication. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. No further information was presented prior to exit. 3. For Resident #9 (R9), the facility staff failed to provide an individualized response to a nurse's inquiry regarding medication administration when the nurse was responsible for caring for 54 residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a nursing schedule dated 12/25/24 revealed one nurse worked during the day shift on the [NAME] unit. A resident census form dated 12/25/24 documented 54 residents resided on the [NAME] unit on that date. R9 resided on the [NAME] unit. A review of R9's clinical record revealed the following physician's orders: 6/15/23-tramadol 50mg (milligrams)-one tablet by mouth three times a day for pain. 9/7/24-Miralax 17 grams by mouth two times a day for constipation. A review of a medication administration audit report for 12/25/24 revealed the following: -tramadol was scheduled at 9:00 a.m. and was administered at 10:59 a.m. -Miralax was scheduled at 9:00 a.m. and was scheduled at 11:00 a.m. On 6/4/25 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated two nurses are supposed to work during the day shift on the [NAME] unit, but she was the only nurse who worked on the unit during the day shift on 12/25/24. LPN #2 stated the night shift nurse had already worked 16 hours and stayed until approximately 9:30 a.m. but then left. LPN #2 stated that between 7:00 a.m. and 9:30 a.m., the night shift nurse called staff and tried to obtain coverage for a second nurse but did not provide resident care or administer medications. LPN #2 stated she called ASM (administrative staff member) #3 (the nurse practitioner) and told her she was the only nurse on the [NAME] unit and medications were going to be late. LPN #2 stated ASM #3 said she could not give orders for everybody, and LPN #2 would have to use her nursing judgement and critical thinking. LPN #2 stated she administered medications to every resident on the unit using her best judgment. LPN #2 stated she could not administer medications that were ordered three times a day because the medications were administered late, and the medications would be given too close to the next dose. On 6/4/25 at 4:14 p.m., an interview was conducted with ASM #3. ASM #3 stated that on 12/25/24, LPN #2 called her and told her she was behind on the medication pass. ASM #3 stated she did not remember the details of what she and LPN #2 discussed and did not document any notes. ASM #3 stated she did not remember if she and LPN #2 discussed each resident, but they discussed important medications that could not be missed. ASM #3 stated she would have to refer to LPN #2 on who they discussed. On 6/5/25 at 10:43 a.m., an interview was conducted with OSM (other staff member) #7 (the pharmacist). OSM #7 stated it is not optimal to have missed or late medications. OSM #7 stated some medications work over such a long period of time and some medications are more critical. OSM #7 stated when some critical medications are missed or late, there could be serious adverse effects, and this depends on each person and each medication. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. No further information was presented prior to exit.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide sufficient nursing staff for three of 13 residents in the survey sample, Residents #1, #5, and #9. The findings include: 1. For Resident #1 (R1), the facility staff failed to provide a sufficient number of nurses during the day shift on 12/25/24. One nurse cared for 54 residents. A review of an as-worked nursing schedule dated 12/25/24 revealed one nurse worked during the day shift on the [NAME] unit. A resident census form dated 12/25/24 documented 54 residents resided on the [NAME] unit on that date. R1 resided on the [NAME] unit. A review of R1's clinical record revealed the following physician's orders: 12/27/23-Pseudoephedrine 30mg (milligrams)-one tablet by mouth three times a day for seasonal allergies. 5/15/23-Baclofen 20mg-one tablet by mouth three times a day for spinal stenosis (narrowing of the spine). 1/23/24-Azelastine 137mcg (micrograms)-two sprays in both nostrils two times a day for nasal congestion. 6/16/24-Magnesium Oxide 400mg-one tablet by mouth two times a day for rhabdomyolysis (skeletal muscle breakdown). 9/11/24-Baclofen 5mg-one tablet by mouth three times a day for muscle spasms. A review of a medication administration audit report for 12/25/24 revealed the following: -Pseudoephedrine was scheduled at 7:00 a.m. and was administered at 12:34 p.m. -Baclofen (20mg) was scheduled at 9:00 a.m. and was administered at 12:27 p.m. -Azelastine was scheduled at 7:00 a.m. and was administered at 12:35 p.m. -Magnesium Oxide was scheduled at 7:00 a.m. and was administered at 12:33 p.m. -Baclofen (5mg) was scheduled at 9:00 a.m. and was administered at 12:28 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated two nurses are supposed to work during the day shift on the [NAME] unit, but she was the only nurse who worked on the unit during the day shift on 12/25/24. LPN #2 stated the night shift nurse had already worked 16 hours and stayed until approximately 9:30 a.m. but then left. LPN #2 stated that between 7:00 a.m. and 9:30 a.m., the night shift nurse called staff and tried to obtain coverage for a second nurse but did not provide resident care or administer medications. On 6/5/25 at 8:52 a.m., an interview was conducted with OSM (other staff member) #6 (the nursing scheduler). OSM #6 stated two nurses should work on the [NAME] unit during the day shift. OSM #6 stated she thought two nurses were scheduled for the [NAME] unit during the day shift on 12/25/24 and something happened but she would check. OSM #6 reviewed her computerized scheduling application and stated it would not allow her to review how many nurses were scheduled for the [NAME] unit during the day shift on 12/25/24. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Staffing documented, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. No further information was presented prior to exit. 2. For Resident #5 (R5), the facility staff failed to provide a sufficient number of nurses during the day shift on 12/25/24. One nurse cared for 54 residents. A review of an as-worked nursing schedule dated 12/25/24 revealed one nurse worked during the day shift on the [NAME] unit. A resident census form dated 12/25/24 documented 54 residents resided on the [NAME] unit on that date. R5 resided on the [NAME] unit. A review of R5's clinical record revealed the following physician's orders: 1/29/24-hydralazine 50mg (milligrams)-one tablet by mouth three times a day for high blood pressure. 12/18/24-Brimonidine Tartrate 0.2%- one drop in the left eye two times a day for increased eye pressure. A review of a medication administration audit report for 12/25/24 revealed the following: -hydralazine was scheduled at 7:00 a.m. and was administered at 10:36 a.m. -hydralazine was scheduled at 11:00 a.m. and was administered at 2:42 p.m. -Brimonidine Tartrate was scheduled at 7:00 a.m. and was administered at 10:36 a.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated two nurses are supposed to work during the day shift on the [NAME] unit, but she was the only nurse who worked on the unit during the day shift on 12/25/24. LPN #2 stated the night shift nurse had already worked 16 hours and stayed until approximately 9:30 a.m. but then left. LPN #2 stated that between 7:00 a.m. and 9:30 a.m., the night shift nurse called staff and tried to obtain coverage for a second nurse but did not provide resident care or administer medications. On 6/5/25 at 8:52 a.m., an interview was conducted with OSM (other staff member) #6 (the nursing scheduler). OSM #6 stated two nurses should work on the [NAME] unit during the day shift. OSM #6 stated she thought two nurses were scheduled for the [NAME] unit during the day shift on 12/25/24 and something happened but she would check. OSM #6 reviewed her computerized scheduling application and stated it would not allow her to review how many nurses were scheduled for the [NAME] unit during the day shift on 12/25/24. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. 3. For Resident #9 (R9), the facility staff failed to provide a sufficient number of nurses during the day shift on 12/25/24. One nurse cared for 54 residents. A review of an as-worked nursing schedule dated 12/25/24 revealed one nurse worked during the day shift on the [NAME] unit. A resident census form dated 12/25/24 documented 54 residents resided on the [NAME] unit on that date. R9 resided on the [NAME] unit. A review of R9's clinical record revealed the following physician's orders: 6/15/23-tramadol 50mg (milligrams)-one tablet by mouth three times a day for pain. 9/7/24-Miralax 17 grams by mouth two times a day for constipation. A review of a medication administration audit report for 12/25/24 revealed the following: -tramadol was scheduled at 9:00 a.m. and was administered at 10:59 a.m. -Miralax was scheduled at 9:00 a.m. and was scheduled at 11:00 a.m. On 6/4/25 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated two nurses are supposed to work during the day shift on the [NAME] unit, but she was the only nurse who worked on the unit during the day shift on 12/25/24. LPN #2 stated the night shift nurse had already worked 16 hours and stayed until approximately 9:30 a.m. but then left. LPN #2 stated that between 7:00 a.m. and 9:30 a.m., the night shift nurse called staff and tried to obtain coverage for a second nurse but did not provide resident care or administer medications. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 8:52 a.m., an interview was conducted with OSM (other staff member) #6 (the nursing scheduler). OSM #6 stated two nurses should work on the [NAME] unit during the day shift. OSM #6 stated she thought two nurses were scheduled for the [NAME] unit during the day shift on 12/25/24 and something happened but she would check. OSM #6 reviewed her computerized scheduling application and stated it would not allow her to review how many nurses were scheduled for the [NAME] unit during the day shift on 12/25/24. On 6/5/25 at 2:59 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, staff interview and facility document review, the facility staff failed to post complete nurse staffing information for three of three reviewed days. The findings include: The facility staff failed document the facility name on the daily nurse staffing sheets. Review of the facility's Nurse Staffing Data dated 06/03/2025, 06/04/2025 and 06/05/2025 sheet failed to evidence the name of the facility. On 06/05/2025 at approximately 2:40 p.m., an interview was conducted with OSM (other staff member) #6, scheduler. OSM #6 stated that she was responsible for post the nurse staffing each day. After reviewing the nurse staffing sheets as dated above she acknowledged that the sheets did not identify the name of the facility. She further stated that she was not aware that the name of the facility was required on the nurse staffing sheets. The facility's policy Posting Nurse Staffing Information it documented in part, The facility will post the following information daily, at the beginning of each shift. The posting shall include: a. The facility name. On 06/05/2025 at approximately 3:05 p.m., ASM (administrative staff member) #1, administrator, and ASM #6, director of clinical services, were made aware of the above findings. No further information was provided prior to exit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure one of 13 residents in the survey sample was free of significant medication errors, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to ensure they were free of significant medication errors A) on 11/8/24 when fluorouracil 5% cream (1) was applied to the neck when it was supposed to be applied to the chest and B) on 9/27/23, 11/19/23, and 5/31/24 when Debrox (2) ear drops were administered into the eye and C) on 12/25/24 when Baclofen 20mg (3) was administered late. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/2/25, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. The assessment documented R1 receiving scheduled pain medication. On 6/3/25 at 1:30 p.m., an interview was conducted with R1 who stated that he went to the dermatologist who had frozen a spot on his chest and when he went back for the follow up visit they had ordered a chemotherapy cream. R1 stated that LPN (licensed practical nurse) #9 had applied the chemotherapy cream to his neck rather than the skin cancer lesion on his chest and caused a reddened area that was treated with hydrocortisone. R1 stated that he had multiple problems with ear wax buildup in the right ear and had Debrox ordered multiple times to soften the ear wax. He stated that there were three times when nurses had administered the ear drops into his eye which caused it to burn like fire and was painful. A) The facility staff failed to administer fluorouracil 5% cream to the correct location on 11/8/24. The physician orders for R1 documented in part, - Fluorouracil External Cream 5 % (Fluorouracil (Topical)) Apply to spot on left chest topically two times a day for actinic keratosis for 3 Weeks apply a thin film only on the spot. Stop for open sores, pain, or bleeding even if they develop before 3 weeks. But redness and scabbing is expected. Leave open to air. Pregnant women should avoid admin. Order Date: 10/30/2024. Start Date: 10/30/2024. The progress notes for R1 documented in part, - 11/08/2024 11:02 (11:02 a.m.) Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Change in skin color or condition . Nursing observations, evaluation, and recommendations are: the fluorouracil 5% cream was applied to spot on the left side of neck when it was supposed to be applied to left chest. Redness noted and resident c/o (complains of) slight burning feeling. Md office called and new order obtained for hydrocortisone 2.5% ointment bid x 1 week . - 11/08/2024 11:19 (11:19 a.m.) Note Text: Residents wife updated on new order for red spot on residents left side of his neck. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 2:17 p.m., an interview was conducted with RN (registered nurse) #1 who stated that prior to medication administration the nurse checked the physician order with the medication itself and followed the five rights of medication administration (right medication, right time, right dose, right person, right route). She stated that they also documented the medication as administered. On 6/5/25 at 9:35 a.m., an interview was conducted with LPN (licensed practical nurse) #9 who stated that the fluorouracil cream had been applied to R1's neck and caused an irritated area which they treated with hydrocortisone cream. LPN #9 stated that the fluorouracil cream was supposed to be applied to the skin cancer area on the chest. On 6/5/25 at 12:37 p.m., an interview was conducted with OSM (other staff member) #7, pharmacist who stated that fluorouracil cream was used for skin lesions and skin cancer. She stated that the usage was to apply sparingly just to the area being treated by the physician, wearing gloves when applying and covering loosely to contain the cream. She stated that since it was used to treat cancer some thought of it as a chemotherapy drug but if it was used appropriately there was no concern. OSM #7 stated that normal gloves were indicated when applying the cream and pregnant women should avoid coming in contact with it. She stated that the cream should only be applied to the skin lesion being treated because it was used to disrupt the cells and used to kill the cancer cells. OSM #7 stated that if the cream was applied to healthy skin it would cause irritation, redness and pain would be subjective to the resident. B) The facility staff failed to administer Debrox ear drops correctly on 9/27/23, 11/19/23, and 5/31/24. The physician orders for R1 documented in part, - Debrox Solution 6.5 % (Carbamide Peroxide) Instill 5 drop in right ear two times a day for excess cerumen for 4 Days. Start Date: 09/26/2023. - Debrox Otic Solution 6.5 % (Carbamide Peroxide (Otic)) Instill 5 drop in right ear two times a day for cerumen impaction for 3 Days x 3 days until irrigation performed per NP (nurse practitioner). Start Date: 11/18/2023. - Debrox Solution 6.5 % (Carbamide Peroxide) Instill 5 drop in both ears two times a day for Cerumen for 4 Days. Start Date: 05/29/2024. Review of the facility medication error report for R1 dated 11/19/23 documented in part, Per [Name of staff member], she took Debrox ear drops out of the Tears eye drop box and did not check the label on the vial and then proceeded put debrox in res L-eye .Nurse immediately flushed res eye with NS (normal saline). Supervisor spoke with resident's wife and then spoke with FNP (family nurse practitioner) and received new orders which were initiated. Res denied any pai [sic] at that time . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A report dated 9/29/23 documented in part, The nurse on shift administered Debrox ear drops in the residents' eyes instead of Natural Tears drops to the residents' eyes on the evening of 9/27/23. The resident reported to this writer (DON) (director of nursing) that when he received his eye drops on the evening of 9/27/23 when the drops were administered the drops burned his eyes. He reported this to the nurse and she flushed his eyes immediately. The resident stated that his eyes were sore and a little blurry .This error was reported to the NP and the resident's eyes was assessed and there was no redness at that time but he resident did state his eyes were a little sore and a little blurry. There were no further adverse reactions noted . A report dated 5/31/24 documented in part, Nurse in patient's room administering morning medications. The patient requested his eye drops, and his ear drops. The patient's eye drops were placed in the ear drops container and the ear drops were placed in the eye drops box. Nurse grabbed both containers while talking with the patient concerning his medications and his care. Nurse accidentally placed ear drops in the patients left eye. Patient complained about his left eye is burning. Nurse flushed the patient's left eye with a large amount of water . Patient's eyes flushed with large amounts of water. Patient stated his eye is fine. Nurse applied artificial tears to the patient's left eye. Patient states his eye feels better, and he is able to see out of his left eye without difficulty . On 6/4/25 at 2:17 p.m., an interview was conducted with RN (registered nurse) #1 who stated that prior to medication administration the nurse checked the physician order with the medication itself and followed the five rights of medication administration (right medication, right time, right dose, right person, right route). She stated that they also documented the medication as administered. On 6/5/25 at 12:37 p.m., an interview was conducted with OSM (other staff member) #7, pharmacist who stated that Debrox was used to loosen up excessive ear wax and the drops were to go in the ear only. She stated that if they were placed in the eye they would be uncomfortable and cause burning, redness, stinging and swelling. She stated that the eye should be immediately flushed out and there would be no permanent effects that she knew of. OSM #7 stated that there was a risk of corneal abrasion because the solution was not filtered for particulates like eye drops were so it should not be placed in anything other than the ear. C) The facility staff failed to administer the medication Baclofen (a muscle relaxant) in a timely manner. A review of R1's clinical record revealed the following physician's orders: 5/15/23-Baclofen 20mg-one tablet by mouth three times a day for spinal stenosis (narrowing of the spine). 9/11/24-Baclofen 5mg-one tablet by mouth three times a day for muscle spasms. A review of a medication administration audit report for 12/25/24 revealed the following: -Baclofen (20mg) was scheduled at 9:00 a.m. and was administered at 12:27 p.m. -Baclofen (5mg) was scheduled at 9:00 a.m. and was administered at 12:28 p.m. (continued on next page)

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Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 at 9:25 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses should administer medications within one hour before or one hour after the medications are scheduled so residents are not overmedicated and are getting their doses correctly. On 6/5/25 at 10:43 a.m., an interview was conducted with OSM (other staff member) #7 (the pharmacist). OSM #7 stated it is important for a resident who is prescribed Baclofen to receive the medication as scheduled because it is for muscle spasms and the resident may present with discomfort if the medication is not administered as scheduled. OSM #7 further stated that if Baclofen is not administered as scheduled and a resident receives doses too close together, the resident may experience an increase in drowsiness, mental confusion and/or a higher risk for falls. The facility policy Medication Administration General Guidelines dated 01/23 documented in part, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only persons legally authorized to do so . Verify medication is correct three (3) times before administering the medication. a. When pulling medication package from med cart. b. When dose is prepared. c. Before dose is administered . Medications are administered within 60 minutes of schedule time, except before or after meal orders, which are administered based on mealtimes . On 6/5/25 at 2:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #6, the regional director of clinical services, ASM #7, the regional director of operations, ASM #8, the risk nurse and ASM #9, the regional human resources were made aware of the concerns. No further information was presented prior to exit. Reference: (1) Fluorouracil cream and topical solution are used to treat actinic or solar keratoses (scaly or crusted lesions [skin areas] caused by years of too much exposure to sunlight). Fluorouracil cream and topical solution are also used to treat a type of skin cancer called superficial basal cell carcinoma if usual types of treatment cannot be used. Fluorouracil is in a class of medications called antimetabolites. It works by killing fast-growing cells such as the abnormal cells in actinic keratoses and basal cell carcinoma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605010.html (2) Debrox (for the ears) is used to soften and loosen ear wax, making it easier to remove . Avoid getting Debrox in your eyes or mouth . This information was obtained from the website: https://www.drugs.com/mtm/debrox-otic.html (3) Baclofen is used to treat pain and certain types of spasticity (muscle stiffness and tightness) from multiple sclerosis, spinal cord injuries, or other spinal cord diseases. Baclofen is in a class of medications called skeletal muscle relaxants. Baclofen acts on the spinal cord nerves and decreases the number and severity of muscle spasms caused by multiple sclerosis or spinal cord conditions. It also relieves pain and improves muscle movement . It usually is taken 3 times a day at evenly spaced intervals. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take baclofen exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682530.html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility staff failed to serve palatable food on one of three units observed, [NAME] unit. The findings include: On 06/04/2025 at t approximately 1:15 p.m. a test tray consisting of pureed fish, pureed broccoli, mashed potatoes, whole broccoli florets, whole fish fillet were placed on a cart and sent to the [NAME] Unit. The cart was followed by this and another surveyor and OSM (other staff member) #2, dietary manager. At approximately 1:26 p.m., the last lunch tray was served to a resident on the [NAME] Unit and OSM #2 was asked to remove the test tray from the cart and proceeded to take the temperatures of the food. The pureed fish was 140° (degrees) F (Fahrenheit), pureed broccoli at 144° F, mashed potatoes 140° F, whole fish fillet at 135° F, and the whole broccoli florets at 135° F. After tasting the food listed above OSM #2 stated that the pureed food did not have any flavor and agreed it was not palatable. When asked about seasoning for the food she stated that they do not add any seasoning to the food. She further stated that the kitchen supplies packets of salt and pepper on the units for residents who want and are allowed salt and/or pepper. When ask if she suppled any type of salt-substitute for resident who cannot have salt she stated no and that if a resident wanted it, it would be supplied by the resident's family. The facility's policy Food and Nutrition Services Staff documented in part, 4. Food will be palatable, attractive, and served in a timely manner at proper temperatures. On 06/05/2025 at approximately 3:05 p.m., ASM (administrative staff member) #1, administrator, and ASM #6, director of clinical services, were made aware of the above findings. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, it is determined that the facility staff failed to prepare and serve food in a sanitary manner in one of two facility kitchens. The findings include: On 04/14/2025 an observation of the facility's kitchen revealed the following: On 06/04/2025 at 11:00 a.m. to 1:15 p.m., an observation in the facility's (Name of Facility Kitchen) revealed OSM (other staff member) #3, cook, plating lunch trays for the [NAME], [NAME], and Grace units and the [NAME] dining room. Observations of OSM #3 revealed he had a beard and mustache and had a covering over the beard, but it did not extend over the mustache. Further observation revealed that OSM #3 did not have his mustache covered while plating the lunch trays. On 06/04/2025 at approximately 1:40 p.m. an interview was conducted with OSM #3. When asked to describe the procedure for facial hair when working in the kitchen, he stated that beards and mustaches were to be covered to prevent hair from falling into the food. When informed of the observation described above OSM #3 stated that he was unaware that his mustache was not covered. On 06/04/2025 at approximately 1:05 p.m. an observation in the facility's (Name of Facility Kitchen) kitchen revealed OSM #4 cooking fish filets, raising and lowering the deep fry baskets while wearing gloves. Further observation revealed OSM #4 dumping the cooked fish filets into a four-inch-deep pan and arranging the filets while wearing the same gloves she used to raise and lower the deep fry baskets. On 06/04/2025 at approximately 1:41 p.m. an interview was conducted with OSM #4. When informed of the observation of handling the fish filets for the resident's meal, she stated that she should have not touched the resident's food with her hands. On 06/04/2025 at approximately 11:30 a.m. an observation of the (Name of Facility Kitchen) accessory table next to the steam table revealed a container of chicken salad. OSM # 3, cook, was asked to obtain the temperature of the chicken salad. Using a digital thermometer, he read a temperature of 53 degrees. Further observation revealed immediately after the temperature was obtain, a sandwich was made, placed on a plate, put on a resident's lunch tray and sent out of the kitchen for a resident's lunch. On 06/05/2025 at approximately 4:05 p.m., an interview was conducted with OSM #2, dietary manager. When informed of the observation of OSM #3 not having his mustache covered while plating resident's lunch, she stated that all facial hair, beards and mustaches, should be covered to prevent hair from falling into the resident's food. When informed of the observation of OSM #4 as stated above she stated that OSM #$ should have changed her gloves before handling the resident's food to prevent contamination. When informed of the observation of the chicken salad temperature and being sent to a resident, she stated that the holding temperature should have been 41 degrees or lower and should not have been served. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/05/2025 at approximately 3:05 p.m., ASM (administrative staff member) #1, administrator, and ASM #6, director of clinical services, were made aware of the above findings. No further information was provided prior to exit.