STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted 7/7/20 through 7/10/20. There were 2 intakes with a total of 7 allegations. Two of the 7 allegations were substantiated. Event ID#FVX811.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and physician interviews the facility failed to complete weekly skin assessments, identify and provide treatment to reddened areas that developed on the buttocks for 1 of 3 residents reviewed for pressure ulcers (Resident #1). Findings included: Resident #1 was admitted to the facility on 05/15/20 with diagnoses which included post-surgical repair of a left hip fracture and a cerebrovascular accident (CVA) with hemiplegia	F 686	Disclaimer Notice: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal Regulations F686 1. Resident #1 has been discharged from the facility. Prior to his departure, a skin check and skin alteration assessment were performed, treatment orders validated and administered and care plan	8/7/20

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

Electronically Signed | 07/24/2020

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F 686	Continued From page 1 (paralysis) affecting the left side. A skin assessment dated 05/15/20 revealed a healing surgical incision site located on the left femur was present upon admission. There were no other areas noted per the nurse's documentation. A care plan, initiated on 05/15/20, identified Resident #1 as having the potential for skin integrity impairment related to a hip fracture, incontinence, and impaired mobility due to a CVA with hemiplegia. The goal was to be free from injury through the review date. Interventions included to monitor and document location, size and treatment of the skin injury and report abnormalities to the Medical Doctor (MD). The admission Minimum Data Set dated 05/21/20 assessed the cognition of Resident #1 as being moderately impaired for making daily decisions. Resident #1 required extensive assistance for bed mobility, transfers, and toilet use. Resident #1 was incontinent of bowel and continent of bladder. No pressure ulcer injuries were present during the lookback period. A surgical wound was identified with no skin or ulcer injury treatments in place. Resident #1's weekly skin assessments, from 05/15/20 to 07/03/20, revealed only two weekly assessments were completed during this time period. The first assessment was completed upon the resident's admission and dated 05/15/20. The second assessment was dated 06/20/20 and identified a right front knee abrasion and a healed scar located at the left femur surgical site. The nurse documented no open skin only redness. There were no skin assessments completed for	F 686	enhanced ensuring a reflection of the resident's current skin condition. 2. All Residents have the potential to be affected. The Director of Nursing (DON) and Unit Managers (UM's) will perform skin checks on all current residents; ensuring all skin alterations are identified and documented. For Residents with identified skin alterations, the DON's and UM's will review the clinical record; confirming a) the presence of treatment orders (inclusive of but not limited to "house orders") for the identified skin alterations, b) the treatment administration records (TAR's) for current residents with identified skin alterations reflects treatment administration in accordance with treatment orders, and c) the presence of weekly skin assessments for all skin alterations since date of identification. Findings will be addressed promptly and reported to the QAA committee for processing. 3. The Facility has reviewed its' skin and wound care program which includes policies and processes related to a) weekly skin checks, b) wound care, c) pressure injury treatment, and d) weekly wound assessment. These policies have been reviewed for clarity and comprehensiveness. No revisions are needed at this time. By 7-31-20 the DON and UM's will in-service all currently employed full time, part time, and/or per diem nurses on the following: a) the completion of weekly skin checks, b) timely response to identified skin	

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F 686	Continued From page 2 the following weeks: 5/22/20, 5/29/20, 6/5/20, 6/12/20, 6/26/20, and 7/3/20. A review of the Treatment Administration Record (TAR) for Resident #1 revealed for the months of May and June 2020 no treatments were in place for the red areas located on the buttocks. A review of the current physician orders for Resident #1 revealed no standing order for a barrier cream or treatment of red areas on the buttocks. An interview with the Registered Nurse (RN) Unit Manager on 07/07/20 at 10:32 AM revealed the nurses were responsible for completing the weekly resident skin checks. The RN Unit Manager indicated Resident #1's skin was in good condition. An observation of Resident #1's skin was made on 07/07/20 at 10:47 AM with the RN Unit Manager present and revealed 2 areas on the left buttocks and 3 areas on the right buttocks which were red in color. All areas were approximately 2 to 3 centimeters in size with no drainage and blanchable skin. One area on the left buttocks appeared to have a scab with peeling skin. During an interview on 07/07/20 at 10:58 AM the RN Unit Manager indicated the areas on Resident #1's buttocks were red but not open and the skin was blanchable. She said the protocol for redden areas was to use the physician's standing order for a barrier cream. The RN Unit Manager reviewed the physician orders for Resident #1 and confirmed there was no standing order for barrier cream on the list of medications or treatments and stated, "It must have fallen	F 686	alterations, c) completion of an initial skin alteration assessment, d) setting up weekly skin checks and/or assessments in Point Click Care (PCC-the facilities electronic medical record) which in turn will trigger to assigned nursing staff for completion, e) accessing and activating the Facility's standing order template located in PCC, and f) entering received physician orders into PCC for identified skin alterations. By 7-31-20 the DON and UM's will inservices all currently employed full time, part time, and/or per diem nursing assistants on the identifying changes in the resident's skin and promptly notifying the assigned nurse. No nursing assistants or licensed nurses will be scheduled after August 7, 2020 until the above education is completed. By 7-31-20 the DON will meet with the UM's ensuring their responsibility for checking the completion of weekly skin sheets, weekly skin alteration assessments, PCC assessment scheduling, review of orders for skin alterations, and review of the TAR's confirming administration compliance with related orders. Weekly the DON & UM's during Resident at Risk (RAR) meetings will review compliance with weekly skin checks, physicians treatment orders for identified skin alterations, TAR administration of prescribed skin alteration treatments, and completion of weekly wound assessments. 4. The Licensed Nursing Home Administrator ("LNHA") is responsible for the Plan of Correction ("POC")	

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F 686	Continued From page 3 through the cracks." She also confirmed there was no documentation of staff providing any treatment to the red areas that were observed on Resident #1's buttocks. During an interview on 07/07/20 at 3:01 PM Nurse Aide #1 (NA) explained during care if skin issues were noted such as bruises, a skin tear, or an area of redness she would notify the nurse. The system in place was to use the skin inspection form, "New Skin Conditions/Wounds/Pressure Ulcers" to document the location of the affected area on the resident's body. She gives the form to the nurse who then checks the resident's skin. NA #1 was aware of the use of a barrier cream to prevent and/or heal red areas on the skin and implied she applied after each incontinence episode. During an interview on 07/08/20 at 3:09 PM Nurse #1 indicated she was scheduled to work Monday through Thursday from 7:00 PM to 7:00 AM and was assigned to Resident #1 during the month of June. Nurse #1 explained if a weekly skin assessment for a resident was due to be performed it would "flag red" on the resident's Treatment Administration Record (TAR) and the nurse would complete the assessment. Nurse #1 did not recall completing any skin assessments for Resident #1. To complete a skin assessment Nurse #1 indicated she would check for areas of redness and if any were present she would initiate physician standing orders as needed for the use of a barrier cream. Nurse #1 stated she was not aware Resident #1 had reddened areas on his buttocks and these areas were currently not being treated. Nurse #1 was unsure who was responsible for adding the weekly skin assessments to the TAR so they were done in a	F 686	implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: A) Weekly x 2 then monthly x 2 then quarterly x 1 the DON & UM's will conduct skin checks on up to 30% of current residents; ensuring that identified skin alterations are identified, treatment orders received, treatment administered and weekly skin checks and skin alteration assessments have been performed. B) Weekly x 2 then monthly x 2 the DON will review the weekly skin checks, skin alteration assessments, physician treatment orders, and TAR's of up to 30% of all current residents with skin alterations ensuring compliance with policies. C) The DON and UM's will perform the Pressure Injury Audit monthly until 95% compliance is achieved; confirming compliance with pressure injury standards. Findings will be promptly addressed. . After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 8-7-20.	

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F 686	Continued From page 4	F 686		

timely manner.

During an interview on 07/08/20 at 11:32 AM the Director of Nursing (DON) explained upon admission a nurse does a head to toe skin assessment to ensure a resident does not have an issue. After the initial assessment, the skin is monitored as needed and weekly by the nurses using an assessment tool. A weekly skin assessment was scheduled for each resident as a reminder for the nurse to complete. The weekly assessment will appear with a "red flag" on the resident's computer generated TAR when it was due. The DON recognized weekly skin assessments were not completed as scheduled for Resident #1. During a second interview on 07/09/20 at 1:35 PM the DON explained if weekly skin assessments for Resident #1 were completed as scheduled the red areas on the buttocks might have been identified and a physician's standing order for barrier cream added to the resident's list of medications for treatment.

During an interview on 07/10/20 at 10:01 AM the Medical Doctor (MD) considered a skin assessment an important tool used to protect residents from developing skin issues and pressure ulcers and should be done in a timely manner. The facility's protocol was for the nurse to initiate standing orders for reddened skin areas and begin treatment using a barrier cream. The MD expected when reddened areas on the skin were discovered the nurse notified the Wound Practitioner and the DON. The nurse would document the size and location of the areas to ensure the treatment was effective and the area was healing. The MD was familiar with Resident #1 and considered him to be at high risk for the

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F 686	Continued From page 5 development of a pressure ulcer.	F 686		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the facility's policy on, "Foods Brought by Family/Visitors", the facility failed to label food items with a use by date, dispose of spoiled food, and store food at the appropriate temperature for 1 of 1 resident in room refrigerator reviewed for safe food storage (Resident #1). Findings included: A review of the facility's policy titled, "Foods Brought by Family/Visitors", revised on 2017 stated containers will be labeled with the	F 812	F 812 1. Resident #1 has been discharged from the facility. Prior to discharge, on 7/8/202 and with the permission of Resident #1, his refrigerator was cleaned by the Unit Manager using an EPA approved solution. All undated items as well as those requiring a freezer were discarded with Resident #1's permission. 2. All Residents have the potential to be affected. The facility conducted refrigerator rounds of all refrigerators in	8/7/20

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F 812	Continued From page 6	F 812		

resident's name, the item, and with a use by date. The nursing staff is responsible for discarding perishable foods on or before the use by date. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger for example: mold growth or a foul odor.

Resident #1 was admitted to the facility on 05/15/20 with diagnoses which included post-surgical repair of a left hip fracture and a cerebrovascular accident (CVA) with hemiplegia (paralysis) affecting the left side.

During an interview on 07/07/20 at 3:21 PM Nurse Aide (NA) #1 explained last Sunday she noticed a foul odor coming from the resident's refrigerator and found and threw away spoiled food items. The NA noted there continued to be a foul odor coming from the refrigerator when it was open but was unsure where it was coming from. When asked about safe storage of food in a resident's refrigerator, NA #1 was unsure about the facility's policy regarding who was responsible to label food items being stored in a resident's personal in room refrigerator but did confirm she was to throw away any spoiled or expired food. NA #1 indicated she was responsible for providing Resident #1 food from his refrigerator upon request and explained he required extensive assistance with activities of daily living but was able to feed himself with setup.

An observation on 07/07/20 at 3:23 PM revealed Resident #1 had a small personal refrigerator in his room. The refrigerator was opened, with the resident's permission, which revealed a foul odor that resembled spoiled food. Multiple food items stored in the refrigerator were not labeled with a

which a resident's personal food items are stored; confirming a) the refrigerator is clean, b) food products are properly stored (e.g. if foods requiring a freezer, those foods are appropriately placed in the freezer), c) foods are dated, d) refrigerators are checked at least weekly. Findings were promptly addressed and forwarded to the QAA committee for processing.

3. The facility has reviewed its' policy on "Foods Brought by Family/Visitors" for clarity and comprehensiveness. No revisions are needed at this time. The process for assessing, managing, and cleaning refrigerators in which resident foods are stored has been assigned to housekeeping. By 7-31-20 all full time, part time and/or per diem housekeepers will be reeducated by the Director of Housekeeping to the process of assessing refrigerators at least weekly, assessing the contents within -discarding foods that are spoiled or undated with the consent of the Resident, and cleaning the refrigerator weekly. Housekeeping staff shall alert his/her supervisors of any concerns. By 7-31-20 the DON will educate all current full time, part time, and/or per diem nursing assistants and nurses of his/her responsibility to label and date resident foods; placing them in the correct cold storage (e.g. refrigerator or freezer) and to report concerns to his/her supervisor with the contents in a resident's personal refrigerator promptly. No housekeeping staff, nursing assistants or licensed nurses will be scheduled after

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F 812	Continued From page 7 use by date. During an observation on 07/07/20 at 4:02 PM when the Registered Nurse (RN) Unit Supervisor opened the personal refrigerator of Resident #1 a strong foul odor resembling spoiled food was noted. When the lid was removed from a container of fresh fruit a foul odor was noted and there were multiple pieces of cantaloupe with brown colored edges. The RN supervisor removed 2 turkey sandwiches, 6 granola muffins, 5 herbed biscuits from the refrigerator. All items had no use by date. An opened package of 2-3 microwavable fish sticks contained 1 with visible white, furry spots resembling mold. There were 5 other unopened microwaveable meals in the refrigerator containing fish sticks, beef and chicken patties. All the meals were labeled keep frozen on the product package. None of the meals were being stored in the freezer per the instructions on the package nor did they have a used by date to show when they had been unfrozen. The RN supervisor explained Resident #1 needed extensive with activities of daily living and his mobility had recently declined. Staff assisted with getting his food from the refrigerator in the room. During an interview on 07/07/20 at 4:02 PM the RN supervisor acknowledge the label on the unopened microwavable meals read keep frozen and was unable to provide a date of when they were thawed or brought into the facility. The RN supervisor observed the white spots on the fish stick and noted the strong odor coming from the refrigerator which smelled of spoiled food. The RN supervisor explained when food was brought from outside by family or a visitor it should be labeled with the resident's name and a use by	F 812	August 7, 2020 until the above education is completed. A resident council meeting will be held by 7-31-20 wherein the NHA will review the “Foods brought by Family/Visitors” with the residents. Copies of this policy will be provided to the Residents as well. By 7-31-20 the Department Managers will be assigned resident room rounds to further monitor the cold storage of a Resident’s personal foods in accordance with policy. Findings will be promptly addressed and forwarded to the QAA committee for processing. 4. The Licensed Nursing Home Administrator (“LNHA”) is responsible for the Plan of Correction (“POC”) implementation. The Quality Assessment and Assurance (“QAA”) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process through A) Monday through Friday Department Manager resident room rounds shall occur monthly x 2 then quarterly x 2; confirming compliance with the policy and established practice as noted above. These room rounds will be documented on a provided form and maintained by the LNHA. B) The Weekend Manager on Duty resident room rounds shall occur Saturday and Sunday, monthly x 2 then quarterly x 2; confirming compliance with the policy and established practice as noted above. These room rounds will be documented on a provided form and maintained by the LNHA. C) Monthly x 2 then quarterly thereafter, the Environmental Rounds & Emergency Safety Review will be	

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F 812	Continued From page 8 date and if a foul odor was present or signs of spoilage the food should be discarded. During an interview on 07/08/20 at 11:44 AM the Director of Nursing (DON) stated food stored in a resident's personal refrigerator should be labeled with a use by date and if not discarded. Foods should be thrown away if there were visible signs or odors to indicate it was spoiled. The DON revealed it was the responsibility of nursing staff to correctly label and dispose of expired and spoiled food from a resident's personal refrigerator. The DON thought nursing staff were relying on family members or the resident to dispose of the expired or spoiled food.	F 812	conducted by the Maintenance Director and Housekeeping Director; confirming compliance with established standards found in this audit. Findings will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 8-7-20	