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 01/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		2/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/13/2023

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

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Maintenance Director and Administrator the facility failed to maintain the emergency preparedness (EP) program by not completing an annual review of the program. This practice had the potential to affect all residents and staff. Findings included: A review of the facilities EP program on 1/20/23 revealed no annual review or revisions had been made to the EP program. There was no documentation indicating when EP program was last reviewed. An interview with the Maintenance Director on 1/20/23 at 2:35 PM revealed he had not reviewed or revised the EP program since he began working at the facility in June 2022. He stated he was unaware when the EP program had been reviewed or revised. The Administrator stated on 1/20/23 at 3:49 PM that she was unaware of when the EP program was last reviewed or revised, and it had not been reviewed since she had started as the Administrator in 2022. The Administrator said the EP program should have been reviewed annually or when updates occurred.	E 004	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. No specific residents were cited in this alleged deficient practice. All residents had the potential to be affected by this alleged deficient practice. However, there were no negative outcomes as the energency preparedness plan had current infoamiton and was up to date. The facility emergency preparedness plan was reviewed on January 23, 2023, by the Administrator, the Mainenance Director, and the Director of Nursing. The Administrator educated the Maintenance Director who is responsible for the emergency plan on January 23, 2023 to enusre the emergency preparedness plan is reviewed annually and as needed.	

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E 004	Continued From page 2	E 004	The Maintenance Director will review the emergency preparedness plan monthly in the safety meeting providing updates each month. The Maintenance Director will provide summary of updates to the QAPI committee for six months and ongoing. The completion date is 2/17/2023.	
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted 01/17/23 through 01/20/23. The following intakes were investigated: NC00196650, NC00196786, NC00196745, NC00195518, NC00195174. There were 11 allegations none of which were substantiated. Event ID #XF4E11.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with staff and Residents, the facility failed to conduct smoking assessment periodically for 2 of 2 residents assessed for smoking (Resident #43 and #28). Findings included:	F 689	Resident #43 and #28 smoking assessments were completed on 1/18/23 by the Unit Coordinator. All residents who smoke have the potential to be affected by this alleged deficient practice.	2/17/23

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F 689	Continued From page 3 1. a. A review of the facility's Smoking Policy revised on 05/27/2017 revealed the staff would review the status of a resident's smoking privileges periodically and consult as needed with the Director of Nursing (DON) and the Attending Physician. Resident #43 admitted to the facility on 01/10/20 with diagnosis included chronic obstructive pulmonary disease (COPD). The annual Minimum Data Set (MDS) assessment dated 12/16/22 coded Resident #43 with intact cognition. He was coded as a tobacco user without dependency on oxygen during the assessment. A review of Resident #43's care plan revealed he required supervision when smoking cigarettes per facility policy. The goal was to remain safe when smoking. Interventions included providing supervision when he smoked within the designated times and ensuring he dressed up appropriately before going out to smoke. A review of the smoking assessments for Resident #43 revealed the last quarterly smoking assessment was completed on 10/06/20. During an interview conducted on 01/17/23 at 5:02 PM, Resident #43 acknowledged that he smoked since he had admitted to the facility. He could not recall any staff had ever conducted smoking assessment for him in the past one year. On 01/18/23 at 9:39 AM, Resident #43 was observed smoking in the courtyard with 6 other smokers under the supervision of 2 activity staffs.	F 689	An audit was completed by the ADON and the Unit Coordinator on 1/18/2023 to ensure all other assessments were completed for residents who smoke. The ADON, Unit Coordinator and MDS were educated by the DON on 1/18/2023 to ensure smoking assessments are completed as per facility policy. ADON and Unit Coordinator will audit all residents who smoke each week for 4 weeks, then each month for six months to ensure smoking assessments are completed timely. The results of the audits will be presented by the ADON to the QAPI Committee monthly for 3 months or until the committee determines complinace. The completion date is 2/17/2023.	

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F 689	Continued From page 4	F 689		

b. Resident #28 admitted to the facility on 03/16/21 with diagnosis included COPD.

The quarterly MDS assessment dated 12/01/22 coded Resident #28 with intact cognition with bilateral impairments of her lower extremities. She used wheelchair as her primary mode of mobility devices. She was coded as a tobacco user and dependent on oxygen during the assessment.

A review of Resident #28's care plan revealed she required supervision when smoking cigarettes per facility policy. The goal was to remain safe when smoking. Interventions included providing supervision when she smoked within the designated times and ensuring she dressed up appropriately before going out to smoke.

A review of the smoking assessments for Resident #28 revealed the last smoking assessment was completed during her admission on 04/13/21.

During an interview conducted on 01/17/23 at 5:02 PM, Resident #28 who was also the roommate of Resident #43 acknowledged that she smoked since she had admitted to the facility. She could not recall any staff had ever conducted smoking assessment for her in the past one year.

On 01/18/23 at 9:39 AM, Resident #28 was observed smoking in the courtyard along with 6 other smokers under the supervision of 2 activity staffs. The oxygen tank was not attached to her wheelchair during the observation.

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F 689	Continued From page 5	F 689		

During an interview conducted on 01/18/23 at 3:50 PM, the Medical Director stated it was her expectation for all the smokers to be assessed at least once quarterly.

An interview was conducted with the Activity Director on 01/19/23 at 10:48 AM. She stated when a smoker admitted to the facility, she would refer the smoker to nursing department for initial smoking assessment. Nursing staff would assess the smoker in-person to determine if the smoker was a safe or unsafe smoker. She would not allow any resident to smoke in the designated smoking area without the initial smoking assessment in place. If she noticed any smoker with changes in smoking pattern or habits, she would notify the nursing department for a re-assessment. She stated each smoker should be assessed at least once quarterly or as needed to ensure the assessment was up-to-date and for the safety of smokers and residents in the facility.

During an interview with Nurse #1, she denied she had ever completed a smoking assessment for Resident #42 and Resident #28 in the past one year. She stated all smokers should be assessed at least once yearly to reflect changes in functions, capabilities, and smoking habits.

An interview conducted with the DON on 01/20/23 at 11:11 AM revealed it was her expectation for all the smokers to be assessed at least once yearly or as needed, especially when the smoker had changes in condition.

During an interview conducted on 01/20/23 at 11:12 AM, the Administrator expected the facility to follow facility's smoking policy to assess all smokers routinely as outlined in the smoking

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F 689	Continued From page 6 policy.	F 689		
F 812 SS=E	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 and staff interviews the facility failed to maintain a clean walk-in refrigerator from an accumulation of a grayish matter and a sticky floor with black stained areas for 1 of 1 walk-in refrigerators. Additionally, the facility failed to date opened food in 1 of 1 walk-in refrigerators. This practice had the potential to affect food served to residents. The Findings included 1. On 1/17/23 at 9:26 AM an observation of the walk-in refrigerator with the Dietary Manager	F 812	No residents were cited in this alleged deficient practive. All residents have the potential to be affected by this alleged deficient practive. The walk-in refrigerator, ceiling, walls, and food storage racks were cleaned on 1/17/23 by the Dietary Manager. The undated food located in the walk-in refrigerator was immedidately discarded on 1/17/2023 by the Dietary Manager.	2/17/23

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F 812	Continued From page 7 (DM) revealed the ceiling, walls, and food storage racks contained grayish matter that was crumbly to touch. The floor of the walk- in refrigerator was sticky when walked on and black stained areas were visible under the food storage racks. The same observation with the DM revealed 1 open to air bag of chopped lettuce that did not contain an open date and 1 opened ham roll product in a sealable plastic bag did not contain an open date. Additionally, one 7.5-quart size container covered with a lid was expired. The container was labeled "fortified pudding" and dated 1/7 with a use by date of 1/13. The DM immediately removed the items from the walk-in refrigerator. The DM stated in an interview on 1/17/23 at 9:38 AM the walk-in refrigerator was cleaned on a weekly basis on Wednesdays and was not cleaned the previous Wednesday due to recent staff shortage. The DM said the grayish matter looked like dust. The DM stated the lettuce and ham was opened and used on 1/16 and should have been dated by the cook who opened them. The DM said the facility uses the fortified pudding frequently and the fortified pudding was made on 1/16 and the old label should have been removed and replaced with the correct date. The DM said the cook was responsible for checking the dates in the cooler and she was working as the cook today. She was responsible for checking the dates in the walk-in refrigerator at the beginning of their shift and had overlooked checking the dates. The Administrator stated on 1/20/23 at 3:49 PM that food in the walk-in refrigerator should be	F 812	An audit of the refrigerators in the kitchen was conducted by the Dietary Manager on 1/17/2023 to ensure cleanliness of the refrigerators, food storage racks, floors, ceiling and walls and unlabeled or outdated food products in the refrigerator have been discarded. The Regional Dietary Manager educated the dietary staff on 1/23/2023 to ensure the walk-in refrigerator, floors, ceilings, walls are kept clean and that left over food is dated and labeled properly. The Dietary Manager/Manager in Training will monitor/audit the walk-in refrigerator 3x/week and ongoing to ensure the floor is clean, ceiling, walls, food storage racks are clean, and the food is dated/labeled properly. The results of the audits will be presented by the Dietary Manager to the QAPI committee each month for 12 months until the QAPI committee will determin compliance. The compeltion date is 2/17/2023.	

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F 812	Continued From page 8 dated when it was opened. The walk-in refrigerator including the food storage racks should be cleaned regularly.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility's Quality Assurance Activity (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the facility's 04/29/21 recertification and complaint survey. The failure related to a deficiency that was originally cited during the 7/10/20 complaint survey then cited on the 04/29/21 recertification and complaint survey and was cited on the current recertification and complaint survey of 01/20/23. The recited deficiency was in the area of food safety requirements and store, prepare, distribute and serve food in accordance with professional standards for food service safety. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance program. The Findings included: This tag is cross referenced to:	F 867	No residents were cited in the alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. The walk-in refrigerator, ceiling, walls, and food storage racks were cleaned on 1/17/2023 by the Dietary Manager. The undated food located in the walk-in refrigerator was immediately discarded on 1/17/2023 by the Dietary Manager. An audit of the refrigerators in the kitchen were conducted by the Dietary Manager on 1/17/2023 to ensure cleanliness of the refrigerators, and food storage racks; as well as ensure the food is dated/labeled properly. The Regional Dietary Manager educated the dietary staff on 1/23/2023 to ensure the walk-in refrigerator, floors, ceilings, walls are kept clean and that left over food	2/17/23

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F 867	Continued From page 9 F-812 Based on observations and staff interviews the facility failed to maintain a clean walk-in refrigerator from an accumulation of a grayish matter and a sticky floor with black stained areas for 1 of 1 walk-in refrigerators. Additionally, the facility failed to date opened food in 1 of 1 walk-in refrigerators. This practice had the potential to affect food served to residents. During the recertification and complaint survey of 04/29/21 the facility was cited for F-812 failure to discard expired perishable foods and follow safe food storage guidelines by properly labeling and dating opened/prepared foods. During the complaint survey of 7/10/20 the facility was cited F812 for failure 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). On 01/20/23 at 5:00 PM the Administrator was interviewed and explained the quality assurance committee met monthly and the goal was to be and remain in compliance with CMS regulations.	F 867	is dated and labeled properly. The Dietary Manager/Manager in Training will monitor/audit the walk-in refrigerator 3x/week and ongoing to ensure the floor is clean, ceiling, walls, food sotrage racks are clean, and the food is dated/labeled properly. The Management staff received education on QAPI to include process and plan to review data collected from the audits to ensure systems are maintained to achieve compliance by the Administrator to be completed by 2/17/2023. The Administrator will review the food procurement, store/prepare/serve-sanitary audit data weekly for three months and then monthly for nine months with the dietary manager to ensure compliance with cleanliness of the refrigerator, floors, ceilings, and that left over food is dated and labeled properly. The results of the audits will be presented by the Dietary Manager to the QAPI committee each month for 12 months until the QAPI committee will determine compliance. The completion date is 2/17/2023.	