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 08/17/2020

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 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 08/03/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# UXQX11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/03/20 with additional interviews and record review conducted after the exit date of 8/3/2020. Therefore, the survey exit date was changed to 08/17/20. There were (4) four complaint allegations and none were substantiated. Event ID # UXQX11	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		9/21/20

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

Electronically Signed | 09/10/2020

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 08/17/2020

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
F 880	Continued From page 1	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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 08/17/2020

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
F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, review of signage posted outside of the quarantine unit, and review of the facility protocol documents, the facility failed to ensure staff performed hand hygiene after contact with a resident or objects in the residents room for 4 of 4 residents (Resident #1, #2, #3 and #4), failed to ensure staff donned and doffed Personal Protective Equipment (PPE) per Centers for Diseases and Prevention (CDC) guidelines when entering and exiting resident rooms on a quarantine unit for 4 of 4 residents (Resident #1, #2 #3,and #4), failed to ensure proper use of face coverings were worn while in the facility, failed to display isolation signage per CDC guidelines to indicate Enhanced Droplet Contact Precautions on the designated quarantine unit for 4 of 4 residents (Resident #1, #2, #3, and #4), the facility failed to develop and implement policies on all staff wearing face coverings, the facility failed to implement policies for screening visitors upon entry to the facility (1 of 1 visitors), failed to develop and implement a policy on sanitation of multi-use equipment used in rooms on the quarantine unit (blood pressure cuff, pulse oximeter, thermometer, clipboard, and pen), failed to implement policies on wearing PPE and performing hand hygiene when entering and exiting resident care rooms for residents on the quarantine unit and failed to develop and	F 880	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 F880 Vero Health & Rehab of Sylva acknowledges the DPOC and asserts compliance with the same effective 9-10-20 1. The facility has ensured Enhanced Droplet Contact Precautions signs are present on the doors/door frames of each resident□s rooms on the Quarantine unit. The facility has verified the following policies are current, present in the facility□s Risk & Response Manual and present in . COVID 19 Staff Education Books: Pandemic Surveillance, placed in manual 4/10/2020 COVID 19 Screening placed in manual 4/12/2020, Cleaning and Disinfection of Environmental Surfaces and Equipment, placed in the manual on 3 -21-20, Isolation Categories and Transmission Based Precautions, placed in manual 3/25/2020,PPE-Wearing Face Masks, placed in manual 3/6/2020 Hand	

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 08/17/2020

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
F 880	Continued From page 3 implement policies on transmission-base precautions that included Enhanced Droplet Contact Precautions. These failures in infection control practices per the CDC recommended guidelines occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through the transmission of COVID-19. Findings included: 1. According to the facility protocol document titled "Handwashing/Hand Hygiene" revised 06/2020, all staff should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene was to be performed before and after direct contact with residents, after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, and before and after staff entered isolation precaution settings. It further indicated the use of gloves did not replace handwashing/ hand hygiene. Integration of glove use, along with routine hand hygiene, was recognized as the best practices for preventing healthcare-associated infections. According to the facility protocol document titled "Personal Protective Equipment- Gloves" revised 2009, gloves should be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed. According to the facility protocol titled "Isolation-Notices of Transmission-Based Precautions" revised 2010, appropriate isolation notices were to be used to alert staff of the	F 880	Hygiene, placed in manual 3/21/2020, Vero□s Resource tools and signage and PPE COVID 19, placed in manual 5/18/2020. NA #1 re-educated on 8/3/2020 to the facility□s policies and processes for hand hygiene, changing PPE between residents and the disinfection of multi-use equipment between residents. The Activities Director was re-educated on 8/4/2020 to the facility□s policy and expectation of properly wearing a face mask at all times while in the facility. The Receptionist, Nurse #1, NA # 2 and PTA#1 were re-educated on 9/10/20 on COVID 19 PPE, mask usage. The Receptionist was re-educated on 8/4/2020 to the facility□s policy and process for screening all visitors to the facility for COVID 19. 2. All Residents have the potential to be affected. On 8/31/2020 the facility conducted a facility wide Infection Control Observation audit; ensuring a) proper signage is in place on outside of all residents rooms in the Quarantine unit; b) PPE is being properly worn by staff while in the facility; c) hand hygiene is performed between resident care, d) equipment is cleaned and disinfected between use and e) COVID-19 Screening is performed with all visitors at point of entry to the facility. Findings were addressed promptly, corrective action implemented as needed and reported to the QAA team for processing. 3. The facility has conducted a Root Cause Analysis (RCA) of the above cited variances along with compliance strategies for the same. The facility has	

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 08/17/2020

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
F 880	Continued From page 4 implementation of Transmission-based precautions, while it protected the privacy of the resident. It further indicated when transmission-based precautions were implemented, an appropriate sign would be placed on the doorway of the resident's room. According to the facility protocol titled "Precautions- Categories of Transmission- Based Precautions" revised 2-2020, standard precautions would be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-based precautions would be used when caring for resident who were documented or suspected to have communicable diseases or infections that can be transmitted to others. The protocol addressed transmission-based precautions such as airborne, contact, and droplet precautions but did not address the Enhanced Droplet Contact Precaution transmission-based precaution designated for COVID-19 care units per CDC guidelines. A continuous observation on 08/03/20 that began at 11:50 AM and ended at 12:00 PM revealed Nurse Aide (NA) #1 entered and exited rooms on the quarantine unit to obtain resident vital signs. Residents #1, #2, #3, and #4 each resided on the facilities quarantine unit, but no visible signage that indicated Enhanced Droplet Contact Precautions was observed on the doors of Resident #1-4's rooms. NA #1 entered the room of Resident #1. NA #1 wore a gown, gloves, mask, and a face shield as he entered Resident #1's room and carried a wrist blood pressure cuff, thermometer, pulse oximeter, a clipboard, and pen. NA #1 placed the clipboard and pen on Resident #1's bedside table and obtained vital	F 880	conducted a review of the COVID 19 Risk and Response Plan which includes policies on COVID 19 PPE, Cleaning and Disinfection of Environmental Surfaces and Equipment, Handwashing/Hand Hygiene, Visitor COVID 19 Screening and Vero□s Resource tools and signage. No revisions are needed at this time. The facility has reviewed and verified that on 3/21/2020, the Cleaning and Disinfection of Environmental Surfaces and Equipment policy was placed into the COVID 19 Risk and Response manual. The facility has verified that Vero□s Resource tools and signage is now in the COVID 19 Risk and Response manual 9/10/2020. The facility has verified that the policy COVID 19 PPE, PPE face mask is present in the COVID 19 Risk and Response manual as of 5/18/2020, with an update of 7/31/2020. By 9/21/2020- all currently employed full time, part time and/or per diem facility staff will be re-educated to the facility□s policies and processes for Cleaning and Disinfection of Environmental Surfaces and Equipment, Handwashing/Hand Hygiene , COVID 19 PPE, Visitor COVID 19 Screening and Vero Resource Tools and Signage by 9/21/20 by the DON/Infection Control Preventionist. No facility staff will be scheduled to work after 9/21/2020 until the above education is completed. The facility has enhanced is infection control practices to include daily infection control rounds with a focus on COVID 19 screening, PPE usage-donning & doffing, PPE coaching, signage, hand hygiene, and cleaning and disinfecting of equipment. These infection control rounds	

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 08/17/2020

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
F 880	Continued From page 5	F 880		

signs for Resident #1, recorded them on the clipboard, then exited the room. NA #1 then entered and approached Resident #2's bed, placed the clipboard on the residents' bed, and obtained his vital signs. NA #1 then recorded the vital signs on the clipboard and exited Resident #2's room. NA #1 entered Resident #3 and #4's room, placed the clipboard on Resident #3's bedside table, obtained her vital signs, recorded them on the clipboard, and walked directly over to Resident #4 to obtain her vital signs. NA #1 was not observed to perform hand hygiene, change gloves, or clean and disinfect any of the multi-use equipment used between Resident #1, Resident #2, Resident #3, or Resident #4 who resided on the quarantine unit in the facility.

An interview with NA #1 on 08/03/20 at 12:07 PM revealed he had entered the quarantine unit to perform every 4-hour vital sign checks. NA #1 said he was assigned to float in the facility and he donned a KN95 face mask, face shield, gown, and gloves when he entered the unit, but acknowledged he failed to change gloves between Resident's #1-4 and failed to sanitize the multi-use equipment between residents when he used it to obtain vital signs and the clipboard and pen which made contact with potentially contaminated objects in the resident rooms who were located on the quarantine unit.

An interview with Nurse #2 on 08/03/20 at 1:00 PM revealed she was the unit manager for day shift. Nurse #2 indicated vital signs were taken by staff every 4 hours on the quarantine unit. Nurse #2 stated full PPE to include a gown, KN95 mask, a face shield and gloves were to be worn when in resident rooms on the quarantine unit. Nurse #2 elaborated that NA #1 should have doffed his

were explained to those performing them and are assigned to various department directors daily for completion. Upon completion they are submitted to the Licensed Nursing Home Administrator and Infection Preventionist for review and responsive action necessary to ensure infection control practice compliance. These infection control rounds will be reviewed Monday through Friday in morning stand up meeting to enhance educational awareness and ensure compliance. Findings will result in prompt re education and correction.
4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process and the measures the facility will take to ensure that the problem does not recur as follows: A) Beginning 9/21/2020, daily, Monday-Friday x one (1) month, then weekly x four (4) weeks, then monthly x three (3) months using Infection Control Observation Report, the DON and UMs will conduct infection control observations of 1) all care units and departments and assigned personnel to ensure PPE usage-donning & doffing, PPE coaching, signage, hand hygiene, and cleaning and disinfecting of equipment; ensuring infection control practice compliance and 2) infection control observations of COVID 19 screening at points of entry; ensuring compliance with COVID 19 Screening policy; ensuring compliance with the

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 08/17/2020

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
F 880	Continued From page 6 gloves between residents, performed hand hygiene, and donned clean gloves before NA #1 entered each resident room and between residents who resided in semi-private rooms on the quarantine unit. Nurse #2 explained the multi-use equipment to include the blood pressure cuff, thermometer, pulse oximeter, clipboard, and ink pen should be sanitized after contact with the resident or potentially contaminated objects in the resident's room before NA #1 approached another resident room. Nurse #2 stated she was unaware the recommended isolation signage for a COVID-19 quarantine unit was Enhanced Droplet Contact Precautions and indicated she did not know why there was no signage on individual resident doors in the quarantine unit that indicated any form of isolation precautions. An interview with the Director of Nursing (DON) on 08/03/20 at 2:42 PM revealed a staff member was assigned each shift to obtain vital signs on all residents whom resided on the quarantine unit. The DON explained all staff who enter the quarantine unit must wear full PPE to include a gown, face shield, a KN95 face mask, and gloves. The DON indicated gloves were to be worn when in a resident room and were to be changed between residents and hand hygiene was to be performed every time gloves were removed. The DON expressed all multi-use equipment should be sanitized between each use and NA #1's clipboard and pen must be sanitized if it is placed in contact with an object in a resident's room who was on the quarantine unit. An interview with the Administrator on 08/03/20 at 3:27 PM revealed NA #1 should have changed his gloves between contact with each resident,	F 880	facility□s COVID 19 Risk and Response Plan B) Every Saturday, Sunday and holidays x 4 weeks, then monthly, the Manger on Duty will conduct targeted infection control observations for three (3) residents on each care unit; ensuring staff are compliant with PPE usage, donning and doffing and mask usage along with hand hygiene and the cleaning and disinfecting of equipment between residents using the facility□s Infection Control Observation Report; ensuring compliance with the facility□s COVID 19 Risk and Response Plan C) Daily, Monday-Friday x one (1) month, then weekly x four (4) weeks, then monthly x three (3), the night shift charge nurse/designated Night PPE coach will conduct targeted observations for three (3) residents on each care unit; ensuring staff are compliant with PPE usage, donning and doffing and mask usage along with hand hygiene and the cleaning and disinfecting of equipment between residents using the facility□s Infection Control Observation Report; ensuring compliance with the facility□s COVID 19 Risk and Response Plan. The Infection Control Preventionist, or staff educator will conduct targeted observations throughout the facility; ensuring PPE compliance; COVID 19 precautions signage is posted on all units; staff are performing hand hygiene between residents□ care and multi-use equipment is being disinfected between residents once a quarter after that yearly. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the	

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 08/17/2020

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
F 880	Continued From page 7 performed hand hygiene, and applied clean gloves between each resident contact while he obtained vital signs. The Administrator explained multi-use equipment is required to be sanitized between each resident contact. The Administrator acknowledged NA #1's clipboard and pen should not have contacted a surface in a resident's room without sanitation performed in order to prevent cross contamination in the quarantine unit. 2. According to the facility's protocol document titled "Personal Protective Equipment- Using Face Masks" revised 2010, face masks are to be used to protect the wearer from inhaling droplets and to prevent transmission of some infections that are spread by direct contact with mucous membranes. It further indicated the wearer must ensure the face mask covers the nose and mouth while performing treatments or services for the patient and do not remove the face mask while performing treatment or services for the patient. The facility did not have a policy addressing the use of face covering for all staff during the COVID-19 pandemic to include use by non-clinical staff. a. An observation on 08/03/20 at 10:45 AM revealed the Activity Director opened the front entrance of the facility for a visitor and had her mask placed only over her mouth. The mask was not observed to cover her nose according to the CDC guidelines for face mask usage. An interview with the Activity Director on 08/03/20 at 10:45 AM revealed she acknowledged her face mask should always cover both her mouth and nose when in the facility. The activity director stated she approached the front door where	F 880	frequency of ongoing monitoring.	

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 08/17/2020

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
F 880	Continued From page 8	F 880		

families are allowed to bring personal belongings and leave them for the residents to allow the surveyor to enter. The activity director stated she had been educated she was to wear her mask over her nose and mouth at all times when in the facility.

b. An observation on 08/03/20 at 10:47 AM revealed the Receptionist who greeted a visitor (surveyor) upon entrance to the facility wore his face mask placed only over his mouth. The mask was not observed to cover his nose according to the CDC guidelines for face mask usage.

An interview on 08/03/20 at 10:47 AM revealed Receptionist who greeted the visitor (surveyor) acknowledged he had received education and should have worn his face mask that fully covered his mouth and nose when in the building.

c. An observation on 08/03/20 at 10:55 AM revealed Nurse #1 stood in the hallway at the nurses' station with her mask placed around her chin while she spoke to another nurse on the unit. The mask was not observed to cover her mouth or nose according to the CDC guidelines for face mask usage.

An interview on 08/03/20 at 11:20 AM revealed Nurse #1 acknowledged she had worn her face mask around her chin. She stated she was educated that her mask was always to be worn over her mouth and nose, but she had removed it to speak to another employee about a lab to be drawn that morning.

d. An observation on 08/03/20 at 11:17 AM revealed NA #2 stood in the hallway next to Resident #5 who was seated at the central

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 08/17/2020

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
F 880	Continued From page 9	F 880		

nurses' station for observation from a recent fall. NA #2 wore her face mask placed around her chin while she spoke to Resident #5, but did not return the mask to the proper position after speaking to Resident #5. The mask was not observed to cover her mouth or nose according to the CDC guidelines for face mask usage. Due to the residents' medical condition, a mask was not on Resident #5 who was seated in the hallway.

An interview on 08/03/20 at 11:17 AM revealed NA #2 acknowledged she should have worn her mask over her mouth and nose and stated she pulled it down around her chin to speak loud enough for Resident #5 to hear her clearly, but forgot to return the mask to cover her mouth and nose.

e. An observation on 08/03/20 at 11:25 AM revealed Physical Therapy Assistant (PTA #1) was in Resident #6's room as she conducted a lower body exercise treatment with Resident #6. PTA #1 pulled down her mask to tell Resident #6 to continue to pedal the foot bike as she had instructed but was not observed to return her mask to the correct position until after she completed the treatment and exited Resident #6's room. The mask was not observed to cover her mouth and nose according to the CDC guidelines for face mask usage. PTA #1 was not observed to attempt to increase the volume of her voice before she pulled the mask down and began to speak to Resident #6 who had not worn a mask. An interview on 08/03/20 at 11:27 AM revealed PTA #1 stated she was educated she was always to wear her mask, but she removed it to speak to Resident #6. She indicated she must remove the mask to speak to many residents due to the

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 08/17/2020

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
F 880	Continued From page 10	F 880		

difficulty in a resident's comprehension of words through the mask. PTA #1 stated she had not attempted to increase her volume before she removed her mask.

An interview with Nurse #2 on 08/03/20 at 1:00 PM revealed she was the unit manager for day shift. Nurse #2 indicated face masks were always to be worn to cover the mouth and nose when on duty. The face mask was not to be handled without hand hygiene performed and the standard surgical mask must be exchanged with a KN95 face mask if the individual entered the COVID-19 quarantine unit.

An interview with the DON on 08/03/20 at 2:42 PM revealed all employees were to wear a surgical face mask when on duty except when an employed entered the COVID-19 unit and then the surgical face mask must be exchanged for a KN95 mask while on the unit. The DON indicated a face mask must always be worn to cover the mouth and nose and were not to be pulled down to speak to other individuals. She stated hand hygiene was to be performed anytime the facemask was touched with the bare hand.

An interview with the Administrator on 08/03/20 at 3:27 PM revealed all staff were always to mask when on duty. Each staff member had received education on proper application and removal of all PPE to include a face mask. The Administrator stated staff should not remove the mask to talk to other staff nor residents to decrease the risk of potential transmission of infection.

3. According to the facility protocol document titled, "Visitation, COVID-19" revised 07/20/20 indicated under the section titled exception to

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 08/17/2020

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
F 880	Continued From page 11	F 880		

visitor limitations that the nursing home must confirm the health care personnel's temperature upon arrival. The worker's temperature must be below 100.0 degrees F for him or her to enter the facility and provide care. It further indicated screening and temperature checks also apply to other health care personnel, such as hospice workers, dialysis technicians, nurse aides and nursing students, Emergency Medical Services (EMS) personnel in non-emergency situations that provide care to residents. All health care personnel are permitted to come into the facility if they meet the CDC guidelines for health care personnel.

According to the CDC, the screening process should consist of questions such as does the visitor have any symptoms such as fever, sore throat, cough, shortness of breath, nausea, vomiting, or diarrhea. In the past 14 days, has the visitor been in close physical contact with a person with a known lab confirmed case of COVID-19 or anyone with symptoms consistent with COVID-19, was the visitor self-isolated or quarantined, or did the visitor have a pending COVID-19 test result.

A continuous observation on 08/03/20 began at 10:45 AM and ended at 4:00 PM revealed a visitor (surveyor) was not screened upon arrival nor after multiple staff learned the visitor had entered the facility without being screened despite contact with residents on every unit in the facility.

Attempts x 3 were made to contact the receptionist without success.

An interview with Nurse #2 on 08/03/20 at 1:00

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 08/17/2020

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
F 880	Continued From page 12	F 880		

PM revealed she was the day shift unit manager. She stated all employees and visitor were to be asked symptom and exposure questions and the individuals' temperature must be taken before allowed to enter the facility. Nurse #2 indicated an individuals' temperature must be less than 100 degrees and they must exhibit no symptoms to enter. If entry was allowed, a mask was always to be worn when in the facility. Nurse #2 made no attempt to screen the visitor (surveyor) once she obtained knowledge the visitor (surveyor) was not screened upon entry to the facility.

An interview with the Director of Nursing (DON) on 08/03/20 at 2:42 PM revealed she was also the Infection Control
Coordinator for the facility. The DON mentioned the facility screening for visitors was conducted at the receptionist desk on the lower level entrance to the facility and employees enter through a door on the upper level and were screened by an COVID screener from the clinical department. The DON indicated everyone who entered the facility was to be screened each time they came into the facility. The DON explained a visitor or employee's temperature must be no greater than 100 degrees Fahrenheit and they must not exhibit symptoms of COVID-19 or entry can be denied. The DON had been notified that the visitor (surveyor) was not screened on arrival, but she did not attempt to screen the visitor once she had gained knowledge of the situation.

An interview with the Administrator on 08/03/20 at 3:27 PM revealed all visitors and employees were to be screened
at the time of arrival to the facility and should not be permitted to enter if the individual has any COVID-19 symptoms or a fever greater than 100

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 08/17/2020

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
F 880	Continued From page 13 degrees Fahrenheit. The Administrator indicated the receptionist was expected to perform the screening for the visitor (surveyor) upon arrival and he was unsure why the screening was not conducted for the visitor.	F 880		