E 000 Initial Comments

An unannounced Recertification survey and complaint investigation was conducted on 04/25/2021 thru 04/29/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness.
Event ID # F15511

F 000 INITIAL COMMENTS

A recertification survey and complaint investigation was conducted 04/25/2021 thru 04/29/2021. Event ID # F15511.

34 of the 34 complaint allegations were unsubstantiated.

F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records
SS=E CFR(s): 483.45(a)(b)(1)-(3)

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all...
**F 755 Continued From page 1**

Aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews the facility failed to have 2 nurses or a nurse and a medication aide sign the narcotic count card in 6 out of 6 narcotic books.

The findings included:

1. a. Observation on 4/28/21 at 3:40 PM of the 100 Hall Cart 1 narcotic book revealed 14 out of 27 narcotic cards did not have two nursing staff members signatures documented to verify the narcotic medication was received and the count was correct.

Observation on 4/28/21 at 3:43 PM of the 100 Hall Cart 2 narcotic book revealed 12 out of 39 narcotic cards did not have two nursing staff members signatures documented to verify the narcotic medication was received and the count was correct.

b. Observation on 4/28/21 at 3:47 PM of the 200 Hall Cart 1 narcotic book revealed 20 out of 26 narcotic cards did not have two nursing staff members signatures documented to verify the narcotic medication was received and the count was correct.

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

F755-Pharmacy Services

1. On 5/13/2021 the Director of Nurses (DON) and Assistant Director of Nurses (ADON) conducted a narcotic card count review of all six narcotic books. All controlled medication utilization record cards were verified to have two signatures in all six books. All licensed nurses and certified medication aides (CMAs) have been reeducated to the facility’s policy on Accepting Delivery of Medications and Controlled Substances, and the expectation upon receiving a narcotic from the courier that two nurses or a nurse/med aide confirm and sign the controlled medication utilization record per the facility’s policy and processes by the
### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**F 755** Continued From page 2

was correct.

Observation on 4/28/21 at 3:50 PM of the 200 Hall Cart 2 narcotic book revealed 3 out of 11 narcotic cards did not have two nursing staff members signatures documented to verify the narcotic medication was received and the count was correct.

Interview on 4/28/21 at 9:33 AM with Nurse #1 revealed 2 nurses must sign each narcotic card when they are received from pharmacy to verify the narcotic count was correct.

c. Observation on 4/28/21 at 10:29 AM of the 300 Hall narcotic book revealed 11 out of 18 narcotic cards did not have two nursing staff members signatures documented to verify the narcotic medication was received and the count was correct.

Interview on 4/28/21 at 10:29 AM with Nurse #2 revealed there was a narcotic card with the narcotic medication received from pharmacy that was reviewed by the receiving nurse to make sure the quantity matched what was on the card and a second nurse would sign the narcotic card to verify the amount was correct. Nurse #2 confirmed some of the 300 hall narcotic cards that she had signed did not have a second signature but could not explain why.

d. Observation on 4/28/21 at 3:55 PM of the 400 Hall Cart narcotic book revealed 14 out of 22 narcotic cards did not have two nursing staff members signatures documented to verify the narcotic medication was received and the count was correct.

**F 755**

Don and ADON on 5/17/2021.

2. All residents have the potential to be impacted. On 5/13/2021 the Director of Nurses (DON) and Assistant Director of Nurses (ADON) conducted a narcotic card count review of all six narcotic books. All controlled medication utilization record cards were verified to have two signatures in all six books, per the facility’s policy and protocols. Findings will be addressed promptly with findings forward to the QAA committee.

3. The facility has reviewed its policy on Accepting Delivery of medications and Controlled Substances, ensuring clarity and comprehensiveness. No revisions are needed. The facility reviewed its procedure on accepting pharmacy courier delivered medications to the facility. The DON spoke to the facility pharmacist on 5/13/2021 at 1029 to verify procedure. Beginning 5/13/202 the DON and/or ADON will conduct weekly controlled medication utilization record on all six narcotic books for the next 8 weeks. During orientation and annually, the DON and/or ADON will educate all facility nurse and CMAs, (which includes fulltime, part time and active per diem nurse and CMAs), on the above policy and procedure which addresses the receiving of all courier medications and two signatures verifying narcotics on controlled medication utilization record. On 5/13/2021 the DON/ADON in-serviced all nursing staff on the above policy. All new hired staff will be educated during
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** VERO HEALTH & REHAB OF SYLVA  
**Street Address, City, State, Zip Code:** 417 CLOVERDALE ROAD, SYLVA, NC 28779

<table>
<thead>
<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Completion Date</th>
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<tr>
<td>F 755</td>
<td>Continued From page 3</td>
<td>Interview on 4/28/21 at 2:00 PM with the Pharmacist revealed the pharmacy’s courier delivered medication to the facility and the staff member meeting the courier checks the medication against the manifest the courier had in their possession. There is a triplicate form that is signed by staff, one copy goes to the facility, one copy goes to the pharmacy, and one gets filed. The Pharmacist stated there was also an electronic signature obtained as well from the staff member receiving the medications. Interview on 4/28/21 at 3:15 PM with the Director of Nursing (DON) revealed when a courier brings medications from the pharmacy, a nurse would sign for them and then check any narcotic medication with another nurse or medication aide to verify the correct amount of narcotic was present upon being received. The DON stated the nurses or nurse and medication aide would both sign the card for the narcotic medication and that card would go into the narcotic book on the medication cart.</td>
<td>F 755</td>
<td>their department orientation. 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. Beginning 5/13/2021, daily during medication administration, the assigned staff (the nurse/med aide on the cart that day) will review all the controlled medication utilization record in the narcotic book on their assigned cart ensuring they are cosigned. b) Beginning 5/21/2021, weekly thereafter, DON or ADON will conduct reviews of all six narcotic books ensuring all controlled medication utilization records are cosigned. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. The completion date is 5/27/2021</td>
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<tr>
<td>F 761</td>
<td>Label/Store Drugs and Biologicals</td>
<td>CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals</td>
<td>F 761</td>
<td>their department orientation. 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. Beginning 5/13/2021, daily during medication administration, the assigned staff (the nurse/med aide on the cart that day) will review all the controlled medication utilization record in the narcotic book on their assigned cart ensuring they are cosigned. b) Beginning 5/21/2021, weekly thereafter, DON or ADON will conduct reviews of all six narcotic books ensuring all controlled medication utilization records are cosigned. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. The completion date is 5/27/2021</td>
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| F 761 | Continued From page 4 | | $\S$483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. $\S$483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to remove expired medication from 3 of 3 medication carts and 1 of 1 medication bulk storage room. Findings included: 1. a. Observation on 4/28/21 at 9:25 AM with the Assistant Director of Nursing (ADON) of the 100 Hall medication cart revealed the following expired medications opened and available for use: Adult Liquid Extra Strength Pain Relief 8 fluid ounces expired 9/2020 Regular Strength Antacid Original Flavor 12 fluid ounces expired 3/2021 Interview on 4/28/21 at 9:25 AM with the ADON revealed she wasn't sure why the expired medication was not removed | F 761 | Label/Store Drugs and Biologicals (Prescription Medication) 1. On 5/03/2021 the Director of Nurses (DON) and Assistant Director of Nurses (ADON) conducted a medication storage review of all prescribed medications. This included all 6 medication carts. All expired medications were immediately removed per the facility’s Storage of Medications policy and protocols. All licensed nurses and certified medication aides (CMAs) have been reeducated to the facility’s policy on Storage of Medication and the expectation that all expired medications are disposed of per the facility’s policy and processes by the Don and ADON on 5/17/2021 2. All residents have the potential to be impacted. On 5/03/2021 the Director of
### Statement of Deficiencies and Plan of Correction

- **Provider/Supplier/CLIA Identification Number:** 345302
- **Multiple Construction:**
  - **Building:**
  - **Wing:**
- **Date Survey Completed:** 04/29/2021
- **Name of Provider or Supplier:** VERO HEALTH & REHAB OF SYLVA
- **Street Address, City, State, Zip Code:**
  - 417 CLOVERDALE ROAD
  - SYLVA, NC 28779

### Summary Statement of Deficiencies

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**F 761** Continued From page 5

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medications were in the cart, she stated they should have been removed.

b. Observation on 4/28/21 at 9:33 AM with Nurse #1 of the 200 Hall medication cart revealed the following expired medications labeled for a resident and available for administration:

- Zofran 8 milligram (mg) tablet medication card expired 3/27/2021
- Catapres 0.3 mg 24-hour patch, 4 full boxes total expired 3/2021

Interview on 4/28/21 at 9:33 AM with Nurse #1 revealed whomever was working the medication cart was responsible for checking the medication expiration dates. Nurse #1 stated it would have been her fault there were expired medications in the cart.

c. Observation on 4/28/21 at 10:29 AM with Nurse #2 of the 300 Hall medication cart revealed the following expired medications were available for administration:

- Sucralfate 1- gram (gm) medication card, labeled for a resident, expired 10/2020
- Aspirin 325 mg tablets one bottle, stock medication, expired 10/2020
- Geri-Mox Antacid Regular Strength 12 fluid ounces expired 2/2021
- Regular Strength Antacid 12 fluid ounces, 2 opened bottles and 1 sealed bottle expired 3/2021
```

Nurses (DON) and Assistant Director of Nurses (ADON) conducted a medication storage review of all prescribed medications. This included all 6 medication carts. All expired medications were immediately removed per the facility’s Storage of Medications policy and protocols. Findings will be addressed promptly with findings forward to the QAA committee.

3. The facility has reviewed its policy on Storage of Medications ensuring clarity and comprehensiveness. No revisions are needed. Beginning 5/24/2021, The DON and/or ADON will conduct weekly prescribed medication storage reviews of med carts; ensuring all medications are in date. During orientation and annually, the DON and/or ADON will educate all facility nurse and CMAs, (which includes fulltime, part time and active per diem nurse and CMAs), on the above policy which addresses expiration dates on the prescription cards. On 5/13/2021 the DON/ADON in-serviced all nursing staff on the above policy. All new staff will be educated during their department orientation.

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: a) Beginning 5/17/2021, daily x one week, then during medication...
F 761 Continued From page 6

Interview on 4/28/21 at 11:13 AM with Nurse #2 revealed whoever was working the medication cart would be responsible for checking for expired medications. Nurse #2 stated she was not sure why there were expired medications on the medication cart.

d. Observation on 4/28/21 at 11:13 AM with Nurse #2 of the Medication Bulk Storage room revealed the following expired medications, all were available for use:

- Vitamin B-6 100 mg capsules, 2 unopened bottles expired 3/2020
- Vitamin B-6 100 mg capsules, 1 unopened bottle expired 6/2020
- Vitamin E 200 international unit (IU), 2 unopened bottles expired 6/2020
- Vitamin E 200 IU, 1 unopened bottle expired 7/2020
- Fiber Laxative 625 mg tablets, 2 unopened bottles expired 1/2021
- Geri-Mox Regular Strength 12 fluid ounces, 7 unopened bottles expired 2/2021
- Regular Strength Antacid 12 fluid ounces, unopened, expired 3/2021
- Junior Strength Fever All Acetaminophen Suppositories 325 mg, one box unopened, expired 10/2020

Interview on 4/28/21 at 3:15 PM with the Director of Nursing (DON) revealed it was every nurse's administration, the assigned staff (nurses/med aides assigned to that med cart) will review all prescription medications; ensuring they are free from expiration. This is monitored for compliance utilizing a daily log sheet that will be in the narcotic book on each medication cart stating they checked all medications prescribed for initials and expiration dates. b) Beginning 5/24/2021, weekly thereafter, DON or ADON will conduct reviews of all six medication carts for the next 8 weeks, confirming all medications are free of expiration. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring.

Completion date 5/27/2021

F761- Label/Store Drugs and Biologicals (OTC Medications)

1. On 5/03/2021, The Director of Nurses (DON) and Assistant Director of Nurses (ADON) conducted a medication storage review of all over the counter medications. This included the medication storage cabinet and all 6 medication carts; removing and discarding expired or outdated medications. All licensed nurses and certified medication aides (CMAs) have been reeducated to the facility’s policy on Storage of Medication and the expectation upon opening a new OTC medication and discarding expired medications per the facility’s policy and processes by the DON and ADON.
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information. No revisions are needed.

**F 761**

1. **and medication aide’s responsibility to check their medication carts for expired medications daily and remove any expired meds.** The DON stated the Central Supply staff was responsible for ordering stock medications and was expected to check the medication expiration dates and circle those dates when the medication comes to the facility. It was further revealed by the DON that when the nurse or medication aide went to pull the stock medication from the bulk medication supply room, they should check the expiration date again to make sure the medication was not out of date before administering the medication. In addition, nurses and medications aides were to be checking medication expiration dates on the first on the first of every month on the medication carts. The DON was not sure why there were expired medications in the medication carts and bulk medication storage room.

2. **All residents have the potential to be impacted.** On 5/03/2021 the Director of Nurses (DON) and Assistant Director of Nurses (ADON) conducted a medication storage review of all over the counter medications. This included the medication storage cabinet and all 6 medication carts; removing and discarding any expired or undated medications. Findings will be addressed promptly with findings forward to the QAA committee.

3. **The facility has reviewed its policy on Storage of Medications ensuring clarity and comprehensiveness.** No revisions are needed. Finding will be promptly addressed and forwarded to QAA team for processing. Beginning 5/03/2021 the DON and/or ADON will conduct weekly OTC medication storage reviews of med carts and the storage room, for the next 8 weeks; ensuring the in the storage room, all medications have circled expirations dates; ensuring on the med carts that all OTC have dated upon opening while ensuring all are free from expiration. During orientation and annually, the DON and/or ADON will educate all facility nurse and CMAs, (which includes fulltime, part time and active per diem nurse and CMAs), on the above policy which addresses dating of opening OTC medications, and following the expiration dates made per the manufacture. On 5/13/2021 the DON/ADON in-serviced all nursing staff on the above policy. All new staff will be educated during their department orientation.
### F 761

**Continued From page 8**

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: a) Starting 5/17/2021, daily during medication administration, the assigned staff (nurse/med aide assigned to cart) will review all open OTC medications; ensuring they are dated and free from expiration. This is monitored for compliance utilizing a daily log sheet that will be in the narcotic book on each medication cart stating they checked all OTC prescribed for initials and expiration dates b) Starting 5/24/2021, weekly the DON or ADON will conduct reviews of all six medication carts and the medication storage closet confirming all medications be dated upon opening and free of expiration. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring.

Completion date 5/27/2021

### F 801

**Qualified Dietary Staff**

CFR(s): 483.60(a)(1)(2)

§483.60(a) Staffing

The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity

Completion date 5/27/2021
F 801 Continued From page 9
and diagnoses of the facility's resident population
in accordance with the facility assessment
required at §483.70(e)

This includes:
§483.60(a)(1) A qualified dietitian or other
clinically qualified nutrition professional either
full-time, part-time, or on a consultant basis. A
qualified dietitian or other clinically qualified
nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by
a regionally accredited college or university in the
United States (or an equivalent foreign degree)
with completion of the academic requirements of
a program in nutrition or dietetics accredited by
an appropriate national accreditation organization
recognized for this purpose.
(ii) Has completed at least 900 hours of
supervised dietetics practice under the
supervision of a registered dietitian or nutrition
professional.
(iii) Is licensed or certified as a dietitian or
nutrition professional by the State in which the
services are performed. In a State that does not
provide for licensure or certification, the individual
will be deemed to have met this requirement if he
or she is recognized as a "registered dietitian" by
the Commission on Dietetic Registration or its
successor organization, or meets the
requirements of paragraphs (a)(1)(i) and (ii) of
this section.
(iv) For dietitians hired or contracted with prior to
November 28, 2016, meets these requirements
no later than 5 years after November 28, 2016 or
as required by state law.

§483.60(a)(2) If a qualified dietitian or other
clinically qualified nutrition professional is not
F 801 Continued From page 10

employed full-time, the facility must designate a
person to serve as the director of food and
nutrition services who-
(i) For designations prior to November 28, 2016,
meets the following requirements no later than 5
years after November 28, 2016, or no later than 1
year after November 28, 2016 for designations
after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food
service management and safety from a  national
certifying body; or
D) Has an associate's or higher degree in food
service management or in hospitality, if the
course study includes food service or restaurant
management, from an accredited institution of
higher learning; and
(ii) In States that have established standards for
food service managers or dietary managers,
meets State requirements for food service
managers or dietary managers, and
(iii) Receives frequently scheduled consultations
from a qualified dietitian or other clinically
qualified nutrition professional.
This REQUIREMENT is not met as evidenced
by:
Based on record review and interview with staff
interviews and the nutrition services contracted
staff, the facility did not employ a qualified director
of food and nutrition services with the
competencies and skills required to carry out food
and nutrition services for 75 of 75 residents.
Findings included:

On 4/25/21 at 11:45 AM the person in charge of
the Dietary Department said she was the Dietary
Manager (DM) and had been in the role of DM for

1. The unqualified manager relieved of her duties from Vero Sylva on 4/30/2021
for performance issues.

2. An HCSG District Manager with appropriate certification, (CFPM & CFSM
certifications), assumed responsibility of the dietary department on 4-30-21. The
District Manager will remain in place until
a new manager is hired and qualified. A Replacement Manager with SERV Safe
F 801 Continued From page 11

6 months since the last Certified Dietary Manager (CDM) resigned. She stated she had received no training pertaining to the dietary manager role since she took over. On 4/25/21 at 10:45 AM, the DM stated she did not currently have her CDM certification and had not yet started schooling for this training. She stated she had printed the paperwork for admission to CDM training and was waiting for the Registered Dietitian (RD) to sign the preceptor form, who visits the facility weekly. She stated she had never been a kitchen manager in healthcare previously. On 4/26/21 at 2:18 PM, the DM revealed she only held a food and beverage safety training and certificate program and had no other education, licenses or qualifications related to food service management.

On 4/26/21 at 2:36 PM, the RD was interviewed. She stated she had been working at the facility since mid-March of 2021 and did not work full-time at this facility under a contracted service. The RD stated she and the DM stayed in touch several times per week and they discussed specific residents, inventory, and textures. She further stated she covered duties and did not hold any job responsibility in the kitchen. The RD indicated she provided the DM guidance and performed monthly sanitation checks in the kitchen.

The dietary services contractor job description for Dining Services Director/Account Manager was reviewed. Under the knowledge, skills and abilities section, it stated the following certificates were required:

1) A certified dietary manager; or
2) A certified food service manager; or

Manager Certification was hired on 5-10-21. The new manager is currently enrolled in a Certified Food Safety Management Course and is scheduled to sit for her exam on 5/25/2021.

3. The facility has reviewed the job description for certified dietary manager. No revisions are needed. A Replacement Manager with SERV Safe Manager Certification was hired on 5-10-21. The new manager is enrolled in a Certified Food Safety Management Course and is scheduled to sit for her exam on 5/25/2021. The entire dietary department will remain under the supervision of the Qualified District Manager until she has successfully completed the course and passed the exam needed to become certified under state guidelines and regulations. The Administrator will review the course completion along with the District & Regional Managers before the new manager is placed in the permanent position. Any changes in the dietary manager position will be reviewed by the Administrator, the District and Regional Managers of Health Care Services Group (HCSG) prior to being placed in the position. If at any time in the future, an individual is hired for the position that does not possess the required qualifications, the Qualified District Manager will assume the management responsibilities of the department until the new candidate has completed and passed the necessary course(s) of study to become qualified.
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 801</td>
<td>Continued From page 12</td>
<td><strong>3) Has similar national certification for food service management and safety from a national certifying body; or</strong>&lt;br&gt;4) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and&lt;br&gt;5) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers.</td>
<td><strong>4. The Administrator 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. The Administrator will present the qualifications of the Dietary Manager to the QAPI Committee for review at the May 2021 meeting. The Committee will ensure that the Dietary Manager meets state requirements. For any future changes in the dietary manager position the Committee will review the qualifications to ensure compliance with the state regulations. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring.</strong></td>
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## Statement of Deficiencies and Plan of Correction

### A. Building

**Provider/Supplier/CLIA Identification Number:**

345302

**State Name of Provider or Supplier:**

VERO HEALTH & REHAB OF SYLVA

**Street Address, City, State, Zip Code:**

417 CLOVERDALE ROAD
SYLVA, NC 28779

### B. Wing

**Date Survey Completed:**

04/29/2021

### Summary Statement of Deficiencies

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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Reference to the Appropriate Deficiency)</th>
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<td>have a CDM license the training had to be completed within 15 months. He further stated the DM was currently enrolled in the CDM training. He indicated the RD was not employed full time at the facility.</td>
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<td>Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</td>
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### Provider's Plan of Correction

**F 812-Food Procurement, Store/Prepare/Serve-Sanitary**

1. All out of date items were immediately removed when identified during survey.

2. From 5/10/2021 through 5/13/2021, the Qualified District Manager and staff inventoried all food items in the freezer, coolers and dry storage to ensure all expired items had been discarded.
**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>F 812</td>
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<td>F 812</td>
<td>Findings will be addressed promptly with findings forward to the QAA committee.</td>
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3. The facility has reviewed its policy and procedures for Safe Food Storage Guidelines. No revisions were needed. On the week of 5/10/2021, the Qualified District Dietary Manager in-serviced all dietary staff on Safe Food Storage Guidelines. The training included properly dating and labeling of food and all food items as well as discarding items that have expired. The initial training started 5/10/2021 and the training will continue weekly for the next six weeks (which includes full time, part time and active per diem staff). All new staff will be trained during orientation prior to starting work.

4. The Administrator 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: a) Beginning the week of 5/10/2021, a food storage audit will be conducted 5 days a week for the next 4 weeks by the Qualified Food Service Manager and/or the District Manager; ensuring food storage is compliant with safe food storage practices which include foods to be covered, labeled and dated (inclusive of a use by date) then weekly x 3 months; b) Beginning the week of 5/17/2021 the Registered Dietician will audit monthly for (2) months then quarterly x (1) year which includes the monitoring of foods stored in the refrigerator and freezer will be covered.
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honey thickened dairy drink.

During an interview with the Dietary Manager (DM) on 04/25/21 at 10:35 AM, the DM stated her expectation was that everything in the refrigerators and dry storage area should be fully covered, labeled and dated. She stated if there was no date recorded on an opened container, it should have been thrown away. She stated any expired foods or beverages must have been disposed of immediately.

An interview with the DM on 4/25/21 at 10:47 AM revealed all opened cereal bags should have been labeled, dated and sealed and if not, then they were to be thrown away.

On 4/25/21 at 10:47 AM, the Dietary Aide (DA) #1 stated the cereal bags were opened that morning and left open because there were only 2 people working the day shift when there are usually 3 dietary staff.

During an interview with the DM on 4/25/21 at 10:50 AM, she stated the loaves of bread in the side preparation area were brought in from the dry storage area to be used and should have been thrown away due to being expired. On 4/25/21 at 10:55 AM, the DM stated bread is kept no longer than 7-10 days.

An interview with the nutrition services contractor District Manager on 4/26/21 at 2:18 PM revealed all bread was delivered frozen and when pulled out of the freezer to be used and a “pull date” should have been recorded on the package. The bread was then good for 7 days from the pull date. If there was no pull date, then the bread should have been thrown away.

labeled and dated (use by date); c) Beginning the week of 5/17/2021 the Qualified Food Service Manager and/or the District Manager will review all findings with the Administrator weekly for the next month. The Administrator will present the results of the audits to the QAPI Committee for the next two months. The QAPI Committee will determine if any changes, additional monitoring and/or training is needed to obtain and maintain substantial compliance. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring.

Completion date 5/27/2021
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An interview with the Registered Dietitian (RD) on 4/26/21 at 02:36 PM revealed she had been working for the facility under contract since mid-March of 2021 and visited weekly. She stated she provided guidance to the DM as needed and performed monthly kitchen sanitation checks.

During an interview with the Administrator on 4/28/21 at 2:58 PM, he stated his expectation were for the dietary department to follow policy and procedures.

### F 908
**Essential Equipment, Safe Operating Condition**

CFR(s): 483.90(d)(2)

§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:

Based on record review, observations and staff interviews the facility failed to maintain the dish machine in safe operating condition for 75 of 75 residents.

The findings included:

The Installation and Operation Manual for the dishwasher was reviewed. It stated the water requirements (hot water sanitizing) were wash temperature 160 degrees Fahrenheit (F) and rinse temperature 180 degrees F with a note that temperatures listed were minimums.

An observation on 4/25/21 at 11:15AM was made of the dish machine in the kitchen, the rinse cycle gauge read 136 degrees F and the wash cycle gauge read 170 degrees F during use with the
Dietary Manager (DM) present.

During an interview on 4/25/21 at 11:15 AM, Dietary Aide #1 stated the gauges had been broken "every now and then, sometimes it goes and sometimes it sticks." He stated there was no other way to read the dishwasher temperatures and demonstrated how he used a food thermometer (put the device on the exit side of the machine during rinse cycle) to test the water temperature. The thermometer he used read 96.2 degrees F during the rinse cycle. The dish machine temperature log was filled out to date and on 4/25/21 the wash cycle was recorded at 175 degrees F and the rinse cycle at 180 degrees F. Dietary Aide #1 stated he obtained those temperatures with the same food thermometer.

On 4/28/21 at 1:47 PM, Dietary Aide #2 stated the dish machine needed a new motor, which had been ordered, and one of the temperature gauges was still not working.

4. The Administrator 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: a) Beginning the week of 5/10/2021 the temperature log will be monitored daily for the next month by the Qualified Dietary Manager; b) Beginning the week of 5/17/2021, the Registered Dietician will review the dish washer temp log weekly for one month to ensure compliance to the above processes. The Qualified Food Service Manager and/or the District Manager will review the findings with the Administrator weekly for the next month. The Administrator will present the results of the audits to the QAPI Committee for the next two months. The QAPI Committee will determine if any changes, additional monitoring and/or training is needed to obtain and maintain substantial compliance. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring.
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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