DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES						M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(OMB NO	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		COMF	E SURVEY PLETED
		345302	B. WING					С
NAME OF P	ROVIDER OR SUPPLIER	0.0002			STREET ADDRESS, CITY, STATE, ZIP CODE		UT	/20/2023
				4	417 CLOVERDALE ROAD			
VERO HE	ALTH & REHAB OF SYL	Α		5	SYLVA, NC 28779			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
E 004 SS=F	Develop EP Plan, Re CFR(s): 483.73(a)	view and Update Annually	E	004	ł			2/17/23
	§403.748(a), §416.54 §441.184(a), §460.84 §483.475(a), §484.10 §485.542(a), §485.62 §485.920(a), §486.36 §494.62(a).	(a), §482.15(a), §483.73(a),)2(a), §485.68(a), 25(a), §485.727(a),						
	Federal, State and loo preparedness require develop establish and emergency prepared requirements of this s	ments. The [facility] must d maintain a comprehensive ness program that meets the section. The emergency m must include, but not be						
	and maintain an eme	The [facility] must develop rgency preparedness plan d], and updated at least lan must do all of the						
	CAH] must comply wi State, and local emer requirements. The [h develop and maintain	ency Plan. The [hospital or th all applicable Federal, gency preparedness ospital or CAH] must a comprehensive ness program that meets the section, utilizing an						
	Plan. The LTC facility	It §483.73(a):] Emergency must develop and maintain redness plan that must be ed at least annually.						
	 DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE			(X6) DATE
	cally Signed		-					02/13/2023

Electronically Signed

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.

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	MPLETED
						С
		345302	B. WING			01/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
VERO HE	ALTH & REHAB OF SYLV	Α		417 CLOVERDALE ROAD SYLVA, NC 28779		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 004	Continued From page		EO	04		
	Plan. The ESRD facil maintain an emergen	s at §494.62(a):] Emergency ity must develop and cy preparedness plan that and updated at least every 2				
	by: Based on record revi Maintenance Director facility failed to mainta preparedness (EP) pr annual review of the p	is not met as evidenced ew and interviews with the and Administrator the ain the emergency rogram by not completing an program. This practice had all residents and staff.		Disclaimer notice: Preparati execution of this plan of corre- not constitute admission or a the provider of alleged deficie prepared for the sole purpose compliance with State and Fe Regulations.	ection does greement by encies but is e of	
	A review of the facilitier revealed no annual re	es EP program on 1/20/23 eview or revisions had been		No specific residents were ci alleged deficient practice.		
	last reviewed.	ting when EP program was		All residents had the potentia affected by this alleged defic However, there were no neg- outcomes as the energency plan had current infoamiton a	ient practice . ative preparedness	
	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			date. The facility emergency prepa	aredness plan	
	reviewed or revised.	ne EP program had been ted on 1/20/23 at 3:49 PM		was reviewed on January 23 Administrator, the Mainenand and the Director of Nursing.		
	that she was unaware was last reviewed or reviewed since she ha	e of when the EP program revised, and it had not been		The Administrator educated f Maintenance Director who is for the emergency plan on Ja 2023 to enusre the emergen	responsible anuary 23,	
	EP program should h or when updates occu	ave been reviewed annually urred.		preparedness plan is reviewe		

Facility ID: 923046

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345302	B. WING		C 01/20/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	01/20/2023		
				417 CLOVERDALE ROAD			
VERO HE	ALTH & REHAB OF SYL\	Ά		SYLVA, NC 28779			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTIO		
E 004	Continued From page	2	E 004	The Maintenance Director will revi emergency preparedness plan mo the safety meeting providing upda month. The Maintenance Director provide summary of updates to the committee for six months and ong	onthly in tes each ∵will e QAPI oing.		
F 000	INITIAL COMMENTS		F 000	The completion date is 2/17/2023.			
	investigation survey v through 01/20/23. The investigated: NC0019 NC00196745, NC001 were 11 allegations n substantiated. Event	95518, NC00195174. There one of which were ID #XF4E11.					
F 689 SS=D	Free of Accident Haza CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 689	3	2/17/23		
	§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:						
				Resident #43 and #28 smoking assessments were completed on by the Unit Coordinator. All residents who smoke have the	1/18/23		
				potential to be affected by this alle deficient practice.	ged		

Event ID: XF4E11

Facility ID: 923046

If continuation sheet Page 3 of 10

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 11/02/2023 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345302	B. WING _				C /20/2023
	ROVIDER OR SUPPLIER	/A		41	REET ADDRESS, CITY, STATE, ZIP CODE 7 CLOVERDALE ROAD YLVA, NC 28779		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	 a. A review of the f revised on 05/27/201 review the status of a privileges periodically the Director of Nursin Physician. Resident #43 admitte with diagnosis include pulmonary disease (0 The annual Minimum assessment dated 12 with intact cognition. user without depende assessment. A review of Resident required supervision facility policy. The go smoking. Intervention supervision when he designated times and appropriately before go A review of the smoki Resident #43 reveale assessment was com During an interview c 5:02 PM, Resident #4 smoked since he had could not recall any s smoking assessment 	acility's Smoking Policy 7 revealed the staff would a resident's smoking 7 and consult as needed with 9 (DON) and the Attending ad to the facility on 01/10/20 ed chronic obstructive COPD). Data Set (MDS) 2/16/22 coded Resident #43 He was coded as a tobacco ency on oxygen during the #43's care plan revealed he when smoking cigarettes per al was to remain safe when as included providing smoked within the d ensuring he dressed up going out to smoke.	F6	89	An audit was completed by the ADON the Unit Coordinator on 1/18/2023 to ensure all other assessments were completed for residents who smoke. The ADON, Unit Coordinator and MD were educated by the DON on 1/18/2 to ensure smoking assessments are completed as per facility policy. ADON and Unit Coordinator will audit residents who smoke each week for 4 weeks, then each month for six month ensure smoking assessments are completed timely. The results of the audits will be prese by the ADON to the QAPI Committee monthly for 3 months or until the committee determines complinace. The completion date is 2/17/2023.	S 023 all hs to	

If continuation sheet Page 4 of 10

					FOR	M APPROVED D. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE SURVE COMPLETED	
	345302	B. WING				/20/2023
ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
ALTH & REHAB OF SYLV	Ά					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
 b. Resident #28 admi 03/16/21 with diagnos The quarterly MDS as coded Resident #28 with bilateral impairments She used wheelchair mobility devices. She user and dependent of assessment. A review of Resident she required supervisicigarettes per facility remain safe when smi included providing su within the designated dressed up appropriation smoke. A review of the smoki Resident #28 reveale assessment was como on 04/13/21. During an interview of 5:02 PM, Resident #22 roommate of Resident she smoked since she facility. She could not conducted smoking a past one year. On 01/18/23 at 9:39 A observed smoking in other smokers under staffs. The oxygen tag 	tted to the facility on sis included COPD. seessment dated 12/01/22 with intact cognition with of her lower extremities. as her primary mode of was coded as a tobacco on oxygen during the #28's care plan revealed sion when smoking policy. The goal was to oking. Interventions pervision when she smoked times and ensuring she tely before going out to ng assessments for d the last smoking upleted during her admission onducted on 01/17/23 at 28 who was also the at #43 acknowledged that e had admitted to the recall any staff had ever ssessment for her in the AM, Resident #28 was the courtyard along with 6 the supervision of 2 activity nk was not attached to her	F	689			
	S FOR MEDICARE & S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ALTH & REHAB OF SYLM SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page b. Resident #28 admi 03/16/21 with diagnos The quarterly MDS as coded Resident #28 admi 03/16/21 with diagnos The quarterly MDS as coded Resident #28 to bilateral impairments She used wheelchair mobility devices. She user and dependent of assessment. A review of Resident she required supervis cigarettes per facility remain safe when smi included providing su within the designated dressed up appropria smoke. A review of the smoking Resident #28 reveale assessment was com on 04/13/21. During an interview c 5:02 PM, Resident #27 roommate of Resident she smoked since shi facility. She could not conducted smoking and past one year. On 01/18/23 at 9:39 A observed smoking in other smokers under staffs. The oxygen tar	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345302 ROVIDER OR SUPPLIER ALTH & REHAB OF SYLVA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 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	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A BUILD 345302 B. WING ROVIDER OR SUPPLIER 345302 B. WING ALTH & REHAB OF SYLVA IDENTIFICATION NUMBER: ID PREF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAGE Continued From page 4 F F b. Resident #28 admitted to the facility on 03/16/21 with diagnosis included COPD. F 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. Second as to bacco 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 #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	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 345302 B. WING ROVIDER OR SUPPLIER 345302 ROVIDER OR SUPPLIER ID ALTH & REHAB OF SYLVA ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 4 F 683 D. Resident #28 admitted to the facility on 03/16/21 with diagnosis included COPD. F 683 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 R	S FOR MEDICARE & MEDICAID SERVICES 9F DEFICIENCIES (x1) PROVIDEROUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING AB302 B WING ROMDER OR SUPPLIER 345302 B WING ALTH & REHAB OF SYLVA STREET ADDRESS, CITY, STATE, ZIP CODE ROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALTH & REHAB OF SYLVA STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) ID PREFX Continued From page 4 F 689 b. Resident #28 admitted to the facility on 03/16/21 with diagnosis included COPD. F 689 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 she smoked within the designated times and ensuring she dressed up appropriately before going out to smoke. A review of the smoking assessment was completed during her admission on 04/13/21. During an interview conducted on 01/17/23 at 50:2 PM, Resident #28 two was also the roommate of Resident #28 who was also the roommate of Resident #28 was observed smoking in the courty and along with 6 aher smokers under the supervision of 2 activity staffs. The oxygen tank was not attached ther	MENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICALD SERVICES OME N SPOR MEDICARE & MEDICALD SERVICES OME N protenciencies (X1) PROVIDERSUPPLENCIA: IDENTIFICATION NUMBER: 445302 B: WING (X1) ROWDER OR SUPPLER ALTH & REHAB OF SYLVA ALTH & REHAB OF SYLVA ALTH & REHAB OF SYLVA ALTH & REHAB OF SYLVA Continued From page 4 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 admitted to the facility on 03/16/21 with diagnosis included COPD. The quarterly MDS assessment dated 12/01/22 coded Resident #28 admitted to the subceco sessessment. A review of Resident #28's care plan revealed she required supervision when smoked within the designated times and ensuing she dressed up appropriately before going out to smoke. A review of the smoking assessment for Resident #28 revealed the last smoking cigareties per leadily pole; A review of the smoking assessment for Resident #28 admitted to the sincluded providing supervision when smoked within the designated times and ensuing she dressed up appropriately before going out to smoke. A review of the smoking assessment for Resident #28 two was to the remain safe when smoking assessments for Resident #28 admitted to the since and depart who was asso the roommate of Resident #28 who was also the roommate of Resident #38 admitted to the facility. She could not recall any steff Ad ever conducted smoking in the coursy ad anog with 6 other smokers under the supervision of 2 activity

Facility ID: 923046

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SU COMPLE	
		345302	B. WING				C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
VERO HE	ALTH & REHAB OF SYLV	ΙΑ			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	3:50 PM, the Medical expectation for all the least once quarterly. An interview was com- Director on 01/19/23 a when a smoker admit refer the smoker to m smoking assessment. the smoker in-person was a safe or unsafe allow any resident to smoking area without assessment in place. with changes in smok would notify the nursi re-assessment. She s be assessed at least to ensure the assess the safety of smokers During an interview w she had ever complet for Resident #42 and one year. She stated assessed at least once in functions, capabiliti An interview conducte at 11:11 AM revealed the smokers to be ass or as needed, especial changes in condition. During an interview con 11:12 AM, the Admini to follow facility's smo	onducted on 01/18/23 at Director stated it was her smokers to be assessed at ducted with the Activity at 10:48 AM. She stated ted to the facility, she would ursing department for initial . Nursing staff would assess to determine if the smoker smoker. She would not smoke in the designated the initial smoking If she noticed any smoker sing pattern or habits, she ng department for a stated each smoker should once quarterly or as needed ment was up-to-date and for and residents in the facility. with Nurse #1, she denied ted a smoking assessment Resident #28 in the past all smokers should be se yearly to reflect changes es, and smoking habits. ed with the DON on 01/20/23 it was her expectation for all sessed at least once yearly ally when the smoker had	F	689			

Facility ID: 923046

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	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345302	B. WING			С		
	ROVIDER OR SUPPLIER	040002			REET ADDRESS, CITY, STATE, ZIP CODE	01/20/20	23	
				7 CLOVERDALE ROAD				
VERO HE	ALTH & REHAB OF SYL	Α			/LVA, NC 28779			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) PLETION DATE	
F 689	Continued From page	e 6	F	689				
	policy. Food Procurement,Si CFR(s): 483.60(i)(1)(tore/Prepare/Serve-Sanitary 2)	F	812		2/17/	23	
	§483.60(i) Food safety requirements. The facility must -							
	state or local authorit (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and foo (iii) This provision doe from consuming food	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility.						
	serve food in accorda standards for food se This REQUIREMENT by: Based on observatio facility failed to maint	is not met as evidenced ns and staff interviews the ain a clean walk-in			No residents were cited in this alleged deficient practive.			
	matter and a sticky fle for 1 of 1 walk-in refri facility failed to date of	ccumulation of a grayish bor with black stained areas gerators. Additionally, the opened food in 1 of 1 walk-in actice had the potential to			All residents have the potential to be affected by this alleged deficient practiv The walk-in refrigerator, ceiling, walls, a food storage racks were cleaned on			
	The Findings include				1/17/23 by the Dietary Manager. The undated food located in the walk-in refrigerator was immedidately discarde	d		
	1. On 1/17/23 at 9:26	AM an observation of the			on 1/17/2023 by the Dietary Manager.			

Facility ID: 923046

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STATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		E SURVEY PLETED
		345302	B. WING		01	C / 20/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		/20/2020	
VERO HEA	ALTH & REHAB OF SYLV	VA		417 CLOVERDALE ROAD SYLVA, NC 28779		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 812	(DM) revealed the cerracks contained gray to touch. The floor of sticky when walked of were visible under the same observation with air bag of chopped le open date and 1 open sealable plastic bag of Additionally, one 7.5- with a lid was expired "fortified pudding" and date of 1/13. The DM items from the walk-in items from the walk-in the DM stated in an AM the walk-in refrigen weekly basis on Wed cleaned the previous staff shortage. The D looked like dust. The DM stated the le and used on 1/16 and the cook who opened facility uses the fortifit the fortified pudding wo old label should have replaced with the corr cook was responsible the cooler and she wa today. She was respon	A should have been dated by dithem. The DM said the grayish matter	F 8	 An audit of the refrigerate was conducted by the Din 1/17/2023 to ensure clear refrigerators, food storag ceiling and walls and unla outdated food products in have been discarded. The Regional Dietary Mathe dietary staff on 1/23/2 the walk-in refrigerator, fl walls are kept clean and is dated and labeled prop. The Dietary Manager/Ma will monitor/audit the walls, fo are clean, and the food is properly. The results of the audits by the Dietary Manager t committee each month for the QAPI committee will compliance. The compeltion date is 2. 	etary Manager on nliness of the e racks, floors, abeled or n the refrigerator mager educated 2023 to ensure oors, ceilings, that left over food berly. mager in Training k-in refrigerator ensure the floor od storage racks a dated/labeled will be presented o the QAPI or 12 months until determin	
		ated on 1/20/23 at 3:49 PM in refrigerator should be				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-03				
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
	345302		B. WING		0	C 01/20/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO		1120/2020		
				417 CLOVERDALE ROAD				
VERO HE	ALTH & REHAB OF SYL	VA		SYLVA, NC 28779				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 812	Continued From pag	e 8	F 81	2				
	dated when it was op							
		the food storage racks						
F 867			F 86	7		2/17/23		
SS=E	CFR(s): 483.75(g)(2)	(ii)						
	§483.75(g) Quality as	ssessment and assurance.						
		ality assessment and						
	assurance committee	e must: ement appropriate plans of						
	action to correct iden	tified quality deficiencies; Γ is not met as evidenced						
	by:							
	Based on observation facility's Quality Assu	on and staff interviews the irance Activity (QAA)		No residents were cited in the deficient practice.	ne alleged			
	committee failed to n	•						
	•	itor interventions that the		All residents have the potent				
		ously put into place following recertification and complaint		affected by this alleged defic	cient practice.			
	-	elated to a deficiency that		The walk-in refrigerator, ceili	ng walls and			
		uring the 7/10/20 complaint		food storage racks were clea				
		the 04/29/21 recertification		1/17/2023 by the Dietary Ma	nager. The			
		/ and was cited on the		undated food located in the				
		and complaint survey of		refrigerator was immediately				
		d deficiency was in the area ements and store, prepare,		1/17/2023 by the Dietary Ma	nager.			
		food in accordance with		An audit of the refrigerators	in the kitchen			
		ds for food service safety.		were conducted by the Dieta				
		of the facility during two		on 1/17/2023 to ensure clear				
		he same area showed a		refrigerators, and food storage				
		s inability to sustain an		well as ensure the food is da	ited/labeled			
	effective Quality Assu	urance program.		properly.				
	The Findings include	d:		The Regional Dietary Manag				
	This tag is areas aft	ranaad ta:		the dietary staff on 1/23/202				
	This tag is cross refe	renced to:		the walk-in refrigerator, floor	s, ceilings,			

Event ID: XF4E11

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-		ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) [DATE SURVEY OMPLETED	
		345302	B. WING			C 01/20/2023		
NAME OF PROVIDER OR SU	PPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
VERO HEALTH & REHA	B OF SYL	Α			17 CLOVERDALE ROAD YLVA, NC 28779			
PREFIX (EACH	I DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
the facility f refrigerator matter and for 1 of 1 w facility failed refrigerators affect food s During the 04/29/21 th discard exp food storag dating oper During the was cited F a use by da food at the resident in the food storag On 01/20/22 interviewed committee	ed on obse ailed to m from an a a sticky fle alk-in refri d to date of s. This pra- served to recertificat e facility w ired perisl e guidelin- ned/prepar complaint 812 for fa tte, dispos appropriat room refrig e (Reside 3 at 5:00 f and expla- met month	ervations and staff interviews aintain a clean walk-in ccumulation of a grayish por with black stained areas gerators. Additionally, the opened food in 1 of 1 walk-in actice had the potential to residents. tion and complaint survey of vas cited for F-812 failure to hable foods and follow safe es by properly labeling and red foods. survey of 7/10/20 the facility ilure to label food items with the of spoiled food, and store te temperature for 1 of 1 gerator reviewed for safe	F	867	 is dated and labeled properly. The Dietary Manager/Manager in Trawill monitor/audit the walk-in refrigera 3x/week and ongoing to ensure the fluis clean, ceiling, walls, food sotrage raare clean, and the food is dated/label properly. The Management staff received eduction QAPI to include process and plan review data collected from the audits ensure systems are maintained to accompliance by the Administrator to be completed by 2/17/2023. The Administrator will review the food procurement, store/prepare/serve-sar audit data weekly for three months are then monthly for nine months with the dietary manager to ensure compliance with cleanliness of the refrigerator, floc ceilings, and that left over food is date and labeled properly. The results of the audits will be presere by the Dietary Manager to the QAPI committee each month for 12 months the QAPI committee will determine compliance. The completion date is 2/17/2023. 	tor oor acks ed ation to to hieve hitary nd e pors, ed		

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