STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345302	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD , SYLVA, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/11/25 through 8/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D3061-H1.	E0000		08/26/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/11/15 through 8/14/25. Event ID# 1D3061-H1. The following intakes were investigated 2564626, 2565097, 2561898, 788428, 788409, 788408, and 788406. 21 of the 21 complaint allegations did not result in deficiency.	F0000		08/26/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and interviews with staff and residents, the facility failed to keep a pull cord for the light above the bed within reach for 2 of 2 residents reviewed for accommodation of needs (Residents #92 and #41). a. Resident #92 was originally admitted to the facility on 7/1/24. The quarterly Minimum Data Set (MDS) assessment dated 7/18/25 indicated Resident #92 had moderate cognitive impairment and had no impairment of her upper extremities.	F0558	F558 - Accommodation of Needs - Light Cords The light cord for Resident #41 and #92 was replaced by the Maintenance staff on 8/14/25. An observational audit of resident light cords will be completed on or before 8/27/25 by the maintenance staff to ensure residents can easily reach their light cords. Concerns identified will be corrected at the time of identification. Facility Maintenance staff will be re-educated by the Administrator on or before 8/20/25 regarding the requirements to maintain light cords within the residents' reach. An audit of the light cords will be completed by the Administrator/designee to validate light cords remain in place. These audits will begin the week of 8/8/25 and be completed weekly for 4 weeks and monthly for 2 months. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Administrator is responsible for ongoing compliance.	09/08/2025

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 reverse for further 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.

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

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F0558 SS = D	Continued from page 1 On 8/11/25 at 10:10 AM an observation and interview were conducted with Resident #92. It was observed in her room that her bed was moved towards the center of the room with the headboard up against the wall and the pull cord for the light above her bed hung against the wall on her right side. The pull cord was approximately 15 inches long and was not within reach of Resident #92 when she was in the bed. Resident #92 was asked about the light and if she would like to be able to turn the light on and off herself, and she stated she wanted to but couldn't reach the pull cord. Resident #92 was unsure when she last used the pull cord since it had not been in her reach for some time. b. Resident #41 was admitted to the facility on 3/9/21. The quarterly MDS assessment dated 7/8/25 revealed that Resident #41 had moderate cognitive impairment and had no impairment of her upper extremities. On 8/13/25 at 3:15 PM an observation and interview were conducted with Resident #41. It was observed that the pull cord for Resident #41's light above her bed hung against the wall on the right side of the bed and was out of reach. When interviewed Resident #41 stated that she liked to be able to use the pull cord for the light, but she couldn't reach it. On 8/13/25 at 2:02 PM an interview was conducted with the Maintenance Director. He stated that the facility had a computer system the staff used to enter any maintenance issues. He reviewed the computer system daily and prioritized what needed to be fixed. The Maintenance Director was shown the pull cord for Resident #92. He agreed that the pull cord did not reach Resident #92's bed. He stated that he had recently started employment at the facility and prior to his employment, an audit on the pull cords had been conducted and pull cord extensions and clips had been ordered and received. Additionally, the Maintenance Director was unaware Resident #41 was unable to reach her pull cord from the bed. On 8/14/25 at 1:58 AM an interview was conducted with the Corporate Nurse Consultant. She agreed that if a resident wanted and was able to use a pull cord for a light that the cord should be within their reach to be used.	F0558	Continued from page 1 Date of Compliance: 09/04/2025	

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F0558 SS-D F0570 SS = C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to provide a surety bond that covered the total account balance for 55 of 55 residents with funds deposited in the resident trust fund account. The findings included: Review of the Resident Fund Management Service document provided by the Business Office Manager revealed the total balance in the Resident Trust Fund Account was $63,647.25 as of 08/13/25. Review of the facility's Surety Bond Continuation Certificate provided by the Corporate Nurse Consultant on 08/14/25 revealed the amount of the bond was for $90,000 and was effective starting on 03/01/23 and terminated at midnight on 03/01/24. During an interview on 08/14/25 at 2:58 PM, the Business Office Manager revealed the corporate office handled the renewal of the surety bond and she was not sure why the surety bond had expired or what had happened. During an interview on 08/14/25 at 2:26 PM, the Corporate Nurse Consultant revealed there were 55 residents who had funds deposited in the Resident Trust Fund account. The Corporate Nurse Consultant stated she was unaware that the facility's surety bond had expired and now that they were aware, they were actively working on getting a surety bond in place. The Administrator was out of the facility during the survey and unavailable for an interview.	F0558 F0570	F570 - Surety Bond A current surety bond was obtained by the Business Office Manager on 8/15/25. An audit of the surety bond and the Resident Funds Management System balance will be completed on or before 9/3/25 by the Business Office Manager. The Administrative Staff were re-educated on or before 8/20/25 by the Nurse Consultant regarding the requirements to maintain a surety bond. An audit of the surety bond will be completed monthly for 3 months by the Administrator to validate a current surety bond remains in place. These audits will begin the week of 9/8/25. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Administrator is responsible for ongoing compliance. Date of Compliance:09/04/25	09/08/2025
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to-	F0577	F577 - Survey Binder The survey binder was made available for residents and visitors by the Social Services Office by the Administrative Assistant on or before 8/26/25.	09/08/2025

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F0577 SS = C	Continued from page 3 (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff and resident interviews the facility failed to post survey results in a location accessible to all residents. This deficient practice occurred for 3 out of 4 days of the recertification survey. The findings included: Observations made on 8/12/25 at 4:40 PM, 8/13/25 at 7:55 AM and 8/14/25 at 8:24 AM revealed the survey results located in the first-floor lobby of the facility in a binder placed in a wall file pocket. The wall file pocket with the binder was located approximately five feet high on the wall. All resident rooms were located on the second floor of the facility which was only accessible by a secured elevator making it difficult for residents to have access to the first floor and survey results located there. The stairwell door on the second floor was locked and required a code to unlock the door again	F0577	Continued from page 3 An observational audit of survey results accessibility will be completed by the Administrator on or before 9/3/25. The Administrative Team will be re-educated by the Administrator/designee on or before 8/20/25 regarding the requirements to maintain survey results in a resident accessible area. Observational audits will be completed by the Administrator/designee to validate survey results remain in a resident accessible area. These audits will begin the week of 9/8/25 and be completed weekly for 4 weeks and monthly for 2 months. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Administrator is responsible for ongoing compliance. Date of Compliance:09/04/25	

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F0577 SS = C	Continued from page 4 making it difficult for residents to have access to the first floor and survey results. A Resident Council Meeting held on 8/13/25 at 11:07 AM revealed 5 of 5 residents who attended the meeting did not know where the survey results book was located (Resident #37, Resident #41, Resident #18, Resident #62 and Resident #77). After the residents were informed of the location of the survey results binder, all five residents indicated if they wanted to get to the lobby where the survey results binder was located, they would have to ask a staff member to unlock the elevator and accompany them down to the lobby. One resident in a wheelchair indicated she would not be able to reach the binder on her own. An interview with the Social Services Director on 8/14/25 at 8:53 AM revealed the only survey results binder was located in the first-floor lobby. She indicated residents were not allowed to use the elevator on their own, and she considered the location of the survey results binder not accessible to residents without having to ask for assistance. An interview with the Corporate Nurse Consultant on 8/14/25 at 1:07 PM revealed the survey results binder observed in the first-floor lobby was the only survey results binder in the facility. She indicated it was not accessible to the residents due to the locked elevator and because of the height of the file holder on the wall.	F0577		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents	F0578	F578 - Advance Directives The Advance Directive care plan for Resident #12 was reviewed and revised on 8/13/25 by the Licensed Nurse to reflect the residents' wishes regarding Advance Directives. An audit of resident Advance Directive documentation will be completed on or before 8/22/25 by the Social Service Director to ensure Advance Directive documentation reflects the residents wishes. No additional concerns were identified. The Social Service Director and the Licensed Nursing staff were re-educated on or before 9/3/25 by the Director of Nursing/designee regarding the requirements of Advance Directive documentation. Audits will be completed by the Social Services Director/designee to validate advanced directive care plans continue to be updated as required. These audits	09/08/2025

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F0578 SS = D	Continued from page 5 concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure code status information was accurate throughout the medical record for 1 of 1 resident reviewed for advance directives (Resident #12). The findings included: Resident #12 was admitted to the facility on 05/15/25. Resident #12's advance directive care plan, initiated on 05/15/25, indicated she was a full code. Interventions included to perform cardiopulmonary resuscitation (CPR) if the resident's heart stopped beating and the medical record would indicate the resident's wishes. The admission Minimum Data Set (MDS) assessment dated 05/22/25 assessed Resident #12 with moderate impairment in cognition. Review of Resident #12's electronic health record (EHR) revealed a physician's order dated 05/28/25 for a code status of Do Not Resuscitate (DNR). The profile section of Resident #12's EHR also indicated a code status of DNR.	F0578	Continued from page 5 will begin the week of 9/8/25 and be completed weekly for 4 weeks and monthly for 2 months. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Director of Nursing is responsible for ongoing compliance. Date of Compliance: 09/04/25	

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F0578 SS = D	Continued from page 6 Review of the Code Status binder kept at the nurses' station revealed Resident #12 had a DNR form signed by the physician with an effective date of 05/28/25. During an interview on 08/13/25 at 10:40 AM, the Social Worker (SW) revealed she reviewed advance directives with the resident and/or Responsible Party. The SW stated either she or the MDS Nurse were responsible for updating a resident's advance directive care plan when their code status had changed. The SW confirmed Resident #12 had a code status of DNR and was not sure why the care plan still had her listed as a full code. The SW recalled during a care plan meeting on 05/28/25 with Resident #12's family member, advance directives was reviewed and the family member requested a code status of DNR for Resident #12. The SW did not recall Resident #12's advance directives paperwork coming back to her once the form(s) were signed by the family member which was why the care plan did not get updated. During an interview on 08/13/25 at 10:55 AM, the MDS Nurse explained upon admission, all residents were listed as a full code until advance directives were reviewed with the resident and/or family and the paperwork signed. The MDS Nurse stated when there was a change in a resident's code status, the advance directives paperwork was returned to the SW who would then update the care plan. During an interview on 08/13/25 at 4:40 PM, the Director of Nursing (DON) revealed the SW was responsible for reviewing advance directives with the resident and/or family and maintaining the code status binders. The DON stated a resident's code status on the care plan should match the code status listed in the resident's EHR and code status binder. The DON stated she would expect for care plans to be updated as needed and the SW was responsible for updating a resident's care plan when there was a change to a resident's code status. The Administrator was out of the facility during the survey and unavailable for an interview.	F0578		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing	F0851	F851 - PBJ The Administrator identified why PBJ data was not submitted accurately on 8/27/25 and notified the payroll vendor. The identified concerns were corrected on 8/27/25 by the payroll vendor. An audit of July 2025 staffing will be completed by the	09/08/2025

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F0851 SS = F	Continued from page 7 information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.	F0851	Continued from page 7 Administrator/designee on or before 9/3/25 to ensure PBJ documentation reflects staffing as worked. The Nurse Managers and the Human Resource Director will be re-educated by the Administrator/designee on or before 8/20/25 regarding the requirements of PBJ submissions. An audit of staffing will be completed monthly for 3 months by the Administrator/designee to validate PBJ documentation accurately reflects staffing as worked. These audits will begin the week of 9/8/25. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Administrator is responsible for ongoing compliance. Date of Compliance: 09/04/25	

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F0851 SS = F	Continued from page 8 §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) related to Registered Nurse (RN) and licensed nursing coverage 24 hours per day for 1 of 1 Federal Fiscal Year quarter reviewed for sufficient nurse staffing (Quarter 2: January 1 – March 31, 2025). The findings included: The PBJ report for the Federal Fiscal Year Quarter 2 2025 (January 1 through March 31) revealed there were no Registered Nurse (RN) hours for 01/09/25, 02/21/25, 02/22/25, 02/23/25, 02/24/25, 02/25/25, 02/26/25, 02/27/25, 02/28/25, and the entire month of March 2025. The PBJ report also noted the facility failed to have licensed nursing coverage 24-hours a day for 02/21/25, 02/22/25, 02/23/25, 02/24/25, 02/25/25, 02/26/25, 02/27/25, 02/28/25, and the entire month of March 2025. Review of the daily staff schedule for 01/09/25 revealed there was no RN onsite. Review of the daily staff schedules and associated time clock detailed reports for 02/21/25, 02/22/25, 02/23/25, 02/24/25, 02/25/25, 02/26/25, 02/27/25, 02/28/25, and the entire month of March 2025 revealed there was a RN onsite for at least 8 hours a day every 24 hours and there was licensed nursing coverage at the facility 24 hours a day. During an interview on 08/13/25 at 2:15 PM, the Human Resources (HR) Director revealed she was responsible for submitting PBJ data to CMS and had done so since the first of the year (2025). The HR Director confirmed she submitted the PBJ data for the CMS Federal Fiscal Quarter 2 (January 1-March 31, 2025) and was not sure why the dates triggered for no RN or licensed nursing coverage. She stated for the triggered date of 01/09/25, the Director of Nursing (DON) would have been in the building; however, the DON was a salaried position and her hours would not show on a time clock punch report. The HR Director explained the process was to upload the data directly from the payroll system, review for accuracy and then submit to CMS. She stated they had started the process of changing payroll	F0851		

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F0851 SS = F	Continued from page 9 systems toward the end of February 2025 and the payroll data submitted to CMS was coming from 2 separate payroll systems which she could only assume was part of the reason the dates in question triggered for no RN and no licensed nursing coverage. The HR Director stated when she submitted the payroll data to CMS for January 1-March 31, 2025, she received notification that the data was received and did not recall getting any error messages. She stated the only thing she could recall that was done differently was that the payroll data was not reviewed for accuracy prior to submitting to CMS. She explained because of the change in payroll systems, they were running out of time to get the PBJ data submitted and they felt it was more important to have the information submitted to CMS on time. During interviews on 08/13/25 at 9:30 AM and 08/14/25 at 8:30 AM, the Corporate Nurse Consultant revealed for overall staffing, there was always a RN for at least 8 hours per day and typically 4 Nurses, one for each unit, every shift. She stated for the date of Thursday 01/09/25, the former Director of Nursing had worked onsite but did not clock in/out because her position was salaried. The Corporate Nurse Consultant explained around March 2025, they switched to a new payroll system which she felt contributed to the PBJ information not being accurate since no RN and no licensed nursing coverage triggered.	F0851		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F0883	F883 - Influenza/Pneumoccocal Consents Residents #15 was discharged from the facility on 8/14/25. An audit of resident vaccine consents and declinations was completed on or before 8/26/25. Concerns identified were addressed at the time of identification. Licensed Nursing staff and Medical Records staff were re-educated on or before 9/3/25 regarding the requirements to obtain and upload vaccine consents/declinations. An audit of resident vaccine consent/declination documentation will be completed by the Infection Preventionist/designee to validate resident vaccine consent/declination documentation continues to reflect the vaccine status of the residents. The audits will begin the week of 9/8/25 and will be completed weekly for 12 weeks. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Infection Preventionist is responsible for ongoing compliance.	09/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345302	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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

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F0883 SS = D	Continued from page 10 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff interviews, the facility failed to offer, administer, or document the Pneumococcal vaccine for 1 of 5 residents reviewed for immunizations (Resident #15). The facility policy for Pneumococcal Vaccine revised October 2019 read prior to upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically	F0883	Continued from page 10 Date of Compliance: 09/04/25	

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F0883 SS = D	Continued from page 11 contraindicated or the resident has already been vaccinated. Resident #15 was admitted to the facility on 6/10/25. The 5-day Minimum Data Set dated 6/17/25 indicated he was cognitively intact. The pneumococcal vaccine section was coded as offered and declined. Review of Resident #15's electronic health record revealed no signed consent, administration, or refusal documentation for the Pneumococcal vaccine. An interview on 8/14/25 at 12:52 PM with Resident #15 revealed he usually kept his immunizations up to date and had not been offered the pneumococcal vaccine since his admission to the facility. An interview on 08/13/2025 at 9:29AM with the Director of Nursing (DON) revealed she was the facility Infection Preventionist. She stated she had been at the facility a few weeks and was unable state if Resident #15 had received or been offered the pneumococcal vaccine. She was also unable to locate any documentation for Resident #15's pneumococcal vaccine status in the paper records located in the DON office, medical records or the electronic health records. An interview on 8/14/25 at 11:49 AM with the Corporate Nurse Consultant revealed there was no reason that Resident #15's pneumococcal vaccine had not been given or documented. She stated she believed it had been completed, and the documentation was unavailable. She stated she was aware there were some areas for improvement in the immunization process but had not yet had time to initiate a new process.	F0883		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility,	F0887	F887 - COVID Vaccines Residents #15 was discharged from the facility on 08/14/25. An audit of resident vaccine consents and declinations was completed on or before 8/26/25. Concerns identified were addressed at the time of identification. Licensed Nursing staff and Medical Records staff were	09/08/2025

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F0887 SS = D	Continued from page 12 each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease	F0887	Continued from page 12 re-educated on or before 9/3/25 regarding the requirements to obtain and upload vaccine consents/declinations. An audit of resident vaccine consent/declination documentation will be completed by the Infection Preventionist/designee to validate resident vaccine consent/declination documentation continues to reflect the vaccine status of the residents. The audits will begin the week of 9/8/25 and will be completed weekly for 12 weeks. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Infection Preventionist is responsible for ongoing compliance. Date of Compliance: 09/04/25	

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F0887 SS = D	Continued from page 13 Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to determine the status of Resident #15's Covid-19 vaccination to determine if Resident #15 was eligible to receive a dose of the Covid-19 vaccine for 1 of 5 residents reviewed for immunizations (Resident #15). Resident #15 was admitted to the facility on 6/10/25. The 5-day Minimum Data Set assessment dated 6/17/25 indicated Resident #15 was cognitively intact. The Covid-19 vaccine section was coded as the resident was not up to date. Review of Resident #15's electronic health record revealed no signed informed consent, record of administration, or documentation of refusal for the Covid-19 vaccine. The medical record also contained no evidence of past Covid-19 vaccinations that had been administered. An interview on 8/14/25 at 12:52 PM with Resident #15 revealed he usually kept his immunizations up to date and had received prior Covid-19 vaccines. He also revealed he had not been offered the Covid-19 vaccine since his admission to the facility. Resident #15 could not say if he was up to date with the Covid-19 vaccine. An interview on 08/13/2025 at 9:29AM with the Director of Nursing (DON) revealed she was the facility Infection Preventionist. She stated she had been at the facility a few weeks and was unable state if Resident #15 had received or been offered the Covid-19 vaccine. She was also unable to locate any documentation for Resident #15's Covid-19 vaccine status in the paper records located in the DON office, medical records or the electronic health records. An interview on 8/14/25 at 11:49 AM with the Corporate Nurse Consultant revealed there was no reason that Resident #15's Covid-19 vaccine had not been given or documented. She stated she believed it had been completed, and the documentation was unavailable. She stated she was aware there were some areas for	F0887		

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F0887 SS = D	Continued from page 14 improvement in the immunization process but had not yet had time to initiate a new process.	F0887		