STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	07/10/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff, and physician interviews the facility failed to complete weekly skin assessments, identify and provide treatment to reddened areas that developed on the buttocks for 1 of 3 residents reviewed for pressure ulcers (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A skin assessment dated [DATE] revealed a healing surgical incision site located on the left femur was present upon admission. There were no other areas noted per the nurse's documentation. A care plan, initiated on 05/15/20, identified Resident #1 as having the potential for skin integrity impairment related to a [MEDICAL CONDITION], incontinence, and impaired mobility due to [MEDICAL CONDITIONS]. The goal was to be free from injury through the review date. Interventions included to monitor and document location, size and treatment of [REDACTED]. The admission Minimum (MDS) data set [DATE] assessed the cognition of Resident #1 as being moderately impaired for making daily decisions. Resident #1 required extensive assistance for bed mobility, transfers, and toilet use. Resident #1 was incontinent of bowel and continent of bladder. No pressure ulcer injuries were present during the lookback period. A surgical wound was identified with no skin or ulcer injury treatments in place. Resident #1's weekly skin assessments, from 05/15/20 to 07/03/20, revealed only two weekly assessments were completed during this time period. The first assessment was completed upon the resident's admission and dated 05/15/20. The second assessment was dated 06/20/20 and identified a right front knee abrasion and a healed scar located at the left femur surgical site. The nurse documented no open skin only redness. There were no skin assessments completed for the following weeks: 5/22/20, 5/29/20, 6/5/20, 6/12/20, 6/26/20, and 7/3/20. A review of the Treatment Administration Record (TAR) for Resident #1 revealed for the months of May and June 2020 no treatments were in place for the red areas located on the buttocks. A review of the current physician orders [REDACTED]. An interview with the Registered Nurse (RN) Unit Manager on 07/07/20 at 10:32 AM revealed the nurses were responsible for completing the weekly resident skin checks. The RN Unit Manager indicated Resident #1's skin was in good condition. An observation of Resident #1's skin was made on 07/07/20 at 10:47 AM with the RN Unit Manager present and revealed 2 areas on the left buttocks and 3 areas on the right buttocks which were red in color. All areas were approximately 2 to 3 centimeters in size with no drainage and blanchable skin. One area on the left buttocks appeared to have a scab with peeling skin. During an interview on 07/07/20 at 10:58 AM the RN Unit Manager indicated the areas on Resident #1's buttocks were red but not open and the skin was blanchable. She said the protocol for redden areas was to use the physician's standing order for a barrier cream. The RN Unit Manager reviewed the physician orders [REDACTED]. She also confirmed there was no documentation of staff providing any treatment to the red areas that were observed on Resident #1's buttocks. During an interview on 07/07/20 at 3:01 PM Nurse Aide #1 (NA) explained during care if skin issues were noted such as bruises, a skin tear, or an area of redness she would notify the nurse. The system in place was to use the skin inspection form, New Skin Conditions/Wounds/Pressure Ulcers to document the location of the affected area on the resident's body. She gives the form to the nurse who then checks the resident's skin. NA #1 was aware of the use of a barrier cream to prevent and/or heal red areas on the skin and implied she applied after each incontinence episode. During an interview on 07/08/20 at 3:09 PM Nurse #1 indicated she was scheduled to work Monday through Thursday from 7:00 PM to 7:00 AM and was assigned to Resident #1 during the month of June. Nurse #1 explained if a weekly skin assessment for a resident was due to be performed it would flag red on the resident's Treatment Administration Record (TAR) and the nurse would complete the assessment. Nurse #1 did not recall completing any skin assessments for Resident #1. To complete a skin assessment Nurse #1 indicated she would check for areas of redness and if any were present she would initiate physician standing orders as needed for the use of a barrier cream. Nurse #1 stated she was not aware Resident #1 had reddened areas on his buttocks and these areas were currently not being treated. Nurse #1 was unsure who was responsible for adding the weekly skin assessments to the TAR so they were done in a timely manner. During an interview on 07/08/20 at 11:32 AM the Director of Nursing (DON) explained upon admission a nurse does a head to toe skin assessment to ensure a resident does not have an issue. After the initial assessment, the skin is monitored as needed and weekly by the nurses using an assessment tool. A weekly skin assessment was scheduled for each resident as a reminder for the nurse to complete. The weekly assessment will appear with a red flag on the resident's computer generated TAR when it was due. The DON recognized weekly skin assessments were not completed as scheduled for Resident #1. During a second interview on 07/09/20 at 1:35 PM the DON explained if weekly skin assessments for Resident #1 were completed as scheduled the red areas on the buttocks might have been identified and a physician's standing order for barrier cream added to the resident's list of medications for treatment. During an interview on 07/10/20 at 10:01 AM the Medical Doctor (MD) considered a skin assessment an important tool used to protect residents from developing skin issues and pressure ulcers and should be done in a timely manner. The facility's protocol was for the nurse to initiate standing orders for reddened skin areas and begin treatment using a barrier cream. The MD expected when reddened areas on the skin were discovered the nurse notified the Wound Practitioner and the DON. The nurse would document the size and location of the areas to ensure the treatment was effective and the area was healing. The MD was familiar with Resident #1 and considered him to be at high risk for the development of a pressure ulcer.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy on, Foods Brought by Family/Visitors, the facility failed to label food items with a use by date, dispose of spoiled food, and store food at the appropriate temperature for 1 of 1 resident in room refrigerator reviewed for safe food storage (Resident #1). Findings included: A review of the facility's policy titled, Foods Brought by Family/Visitors, revised on 2017 stated containers will be labeled with the resident's name, the item, and with a use by date. The nursing staff is responsible for discarding perishable foods on or before the use by date. The nursing and/or food service staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger for example: mold growth or a foul odor. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview on [DATE] at 3:21 PM Nurse Aide (NA) #1 explained last Sunday she noticed a foul odor coming from the resident's refrigerator and found and threw away spoiled food items. The NA noted there continued to be a foul odor coming from the refrigerator when it was open but was unsure where it was coming from. When asked about safe storage of food in a resident's refrigerator, NA #1 was unsure about the facility's policy regarding who was responsible to label food items being stored in a resident's personal in room refrigerator but did confirm she was to throw away any spoiled or expired food. NA #1 indicated she was responsible for providing Resident #1 food from his refrigerator upon request and explained he required extensive assistance with activities of daily living but was able to feed himself with setup. An observation on [DATE] at 3:23 PM revealed Resident #1 had a small personal

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

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

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) refrigerator in his room. The refrigerator was opened, with the resident's permission, which revealed a foul odor that resembled spoiled food. Multiple food items stored in the refrigerator were not labeled with a use by date. During an observation on [DATE] at 4:02 PM when the Registered Nurse (RN) Unit Supervisor opened the personal refrigerator of Resident #1 a strong foul odor resembling spoiled food was noted. When the lid was removed from a container of fresh fruit a foul odor was noted and there were multiple pieces of cantaloupe with brown colored edges. The RN supervisor removed 2 turkey sandwiches, 6 granola muffins, 5 herbed biscuits from the refrigerator. All items had no use by date. An opened package of ,[DATE] microwavable fish sticks contained 1 with visible white, furry spots resembling mold. There were 5 other unopened microwaveable meals in the refrigerator containing fish sticks, beef and chicken patties. All the meals were labeled keep frozen on the product package. None of the meals were being stored in the freezer per the instructions on the package nor did they have a used by date to show when they had been unfrozen. The RN supervisor explained Resident #1 needed extensive with activities of daily living and his mobility had recently declined. Staff assisted with getting his food from the refrigerator in the room. During an interview on [DATE] at 4:02 PM the RN supervisor acknowledge the label on the unopened microwavable meals read keep frozen and was unable to provide a date of when they were thawed or brought into the facility. The RN supervisor observed the white spots on the fish stick and noted the strong odor coming from the refrigerator which smelled of spoiled food. The RN supervisor explained when food was brought from outside by family or a visitor it should be labeled with the resident's name and a use by date and if a foul odor was present or signs of spoilage the food should be discarded. During an interview on [DATE] at 11:44 AM the Director of Nursing (DON) stated food stored in a resident's personal refrigerator should be labeled with a use by date and if not discarded. Foods should be thrown away if there were visible signs or odors to indicate it was spoiled. The DON revealed it was the responsibility of nursing staff to correctly label and dispose of expired and spoiled food from a resident's personal refrigerator. The DON thought nursing staff were relying on family members or the resident to dispose of the expired or spoiled food.