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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #92 had moderate cognitive impairment and had no impairment of her upper extremities. 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 [DATE]. The quarterly MDS assessment dated [DATE] 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.

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.

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. Review of the facility's Surety Bond Continuation Certificate provided by the Corporate Nurse Consultant on [DATE] revealed the amount of the bond was for $90,000 and was effective starting on [DATE] and terminated at midnight on [DATE]. During an interview on [DATE] 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 [DATE] 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 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 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE].Resident #12's advance directive care plan, initiated on [DATE], 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 [DATE] assessed Resident #12 with moderate impairment in cognition. Review of Resident #12's electronic health record (EHR) revealed a physician's order dated [DATE] for a code status of Do Not Resuscitate (DNR). The profile section of Resident #12's EHR also indicated a code status of DNR.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 [DATE].During an interview on [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 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 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 contraindicated or the resident has already been vaccinated. Resident #15 was admitted to the facility on [DATE]. The 5-day Minimum Data Set, dated [DATE] 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. The 5-day Minimum Data Set assessment dated [DATE] 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 improvement in the immunization process but had not yet had time to initiate a new process.