DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345484	B. WIN	B. WING		04/12/2011	
NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL INC				Н	REET ADDRESS, CITY, STATE, ZIP CODE IOSPITAL DRIVE BREVARD, NC 28712		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 371 SS=E			F S	371	The Transylvania Regional Hospital Food and Nutrition Staff practices have been updated. A Food and Nutrition Staff have been reeducated ensure the following: 1. The Transylvania Regional Hospit Dietary Policy and Procedure "Lat and Dating of Food" has been revito direct staff to dispose of any foon not utilized by the "use by" date.	All I to al's bel sed	4/22/11
					2. Review of Transylvania Regional Hospital's revised Dictary Policy a Procedure for "Label and Dating o Food." 3. All foods shall be utilized or discar prior to the expiration of their specified manufacturer's "use by" date. 4. The Transylvania Regional Hospita Director of Food and Nutrition Services, along with the Transylvan Regional Hospital Director of Elde Care Services, shall conduct weekl audits of proper food labeling, datin and disposal, utilizing Transylvania Regional Hospital's Quality Performance Measurement Tool. These audits shall be completed weekly, and will continue until a period of three consecutive months audits reflect 100% compliance rate 5. The results of these Food and Nutrition audits shall be reported to the staff of the Food and Nutrition Services Department at monthly star meetings, and to the Transylvania Regional Hospital Patient Safety Committee at the monthly committee at t	of rded al nia r y ng a	4/22/11 and ongoing 4/22/11 and ongoing 5/12/11 and ongoing
ABODATODY		ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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.

Facility ID: 923509

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F 371	items. The FSD pro- specified the kitche dry goods storage of concerns with outdat goods storage area explanation why the	ge 1 r outdated and expired food ovided a document that n supervisor last audited the on 3/28/11 and found no ated food items in the dry . The FSD offered no e outdated cans of evaporated ady for use despite current	F 3	71			