CENTERS FOR MEDICADE SERVICES OMB NO 9838-0391 STATEMENT OF DEFINITION (1) (PROVIDER UNPURFICUE) (2) (PROVIDER UNPURFICUE) (2) (PROVIDER UNPURFICUE) TANSELVANIA REGIONAL HOSPITAL INC 345434 R. WNO (2) (PROVIDER UNPURFICUE) TRANSPLANIAR REGIONAL HOSPITAL INC STREET ADORESS CITY, STATE, 2P CODE (PROVIDER OR SUPPLER TRANSPLANIAR REGIONAL HOSPITAL INC STREET ADORESS CITY, STATE, 2P CODE (PROVIDER OR SUPPLER) PROVIDER OR SUPPLER STREET ADORESS CITY, STATE, 2P CODE (PROVIDER OR NOT COLSECTION FULL) (PROVIDER OR NOT COLSECTION FULL)<	DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES						M APPROVED
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MOSPITAL INC MOSPITAL DRIVE BREAKD, NC 28712 CAN UP CONCENT PLAN OF CONFECTION (CAULDER/CIANY MUST BLAREDED OF VILL) (CAULDER/CIANY MUST BLAREDED OF VILL) TAG DIM DIM F 156 433.10(b)(5) - (10), 483.10(b)(1) NOTICE OF SS-86 F 156 F 156 F 156 F 156 SS-86 RIGHTS, RULES, SERVICES, CHARGES F 156 F 156 F 156 The facility must inform the resident the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also role the resident with the notice (if any) of the State developed under § 1919(e)(6) of the ACL. Such notification must be made prior to or upon admission and during the resident stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. F 156 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility services under the State plan and for which the resident may not be charged; those other thems and services that the facility or, when the resident becomes encipte for those services, and inform each resident who hanges are made to the them and services that the facility or services and inform each resident when any be charged, and the amount of charges for those services, including any charges for those services, including any charges for those services, including any charges for services and the facility of services and periodicaily during the resident stay. Correct services, including any charges for services and to the facility must furnish a written description of leaf rights writish includes: A description of the m			345484	B. WING				09/	/15/2015
TRANSVLANA REGIONAL HOSPITAL INC BREVARD, NC 28712 (%4)10 PRETX NG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE MERCED BY FULL REQUILITION OF LISC DENTIFIANTS INFORMATION) IP PRETX NG PROVIDER'S FLAN OF CORRECTION (EACH DEPICIENCY MUST BE MERCED BY FULL REQUILITION OF LISC DENTIFIANTS INFORMATION) IP PRETX NG PROVIDER'S FLAN OF CORRECTION (EACH DEPICIENCY MUST BE MERCED BY FULL REQUILITION OF LISC DENTIFIANTS INFORMATION) IP PRETX NG PROVIDER'S ACTION SHOULD BE CROSS-MERCENCED CONSTITUTION (EACH DEPICIENCY) SP25/15 F156 F156 F156 F156 F156 SP25/15 SP25/15 F156 The facility must inform the resident MERCENALIN, The facility and in writing, at the facility, rethen	NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PREFX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR US.DENTIFYING INFORMATION) PRETX TAG CACH CORRECT & CTON SHOULD BE CROSS REFERENCED TO THE APPROPRIATE COMPLETION DEFICIENCY F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF REFIGENCY F 156 F 156 9/25/15 S 5=6 RIGHTS, RULES, SERVICES, CHARGES F 156 F 156 9/25/15 Image: The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and regulations governing resident conduct and resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. F 156 9/25/15 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission on the prayed, and the amount of charges for those services, and inform each resident before, or at the time and services specified in paragraphs (5) (I(A) and (8) of this section. The facility must firform each resident before, or at the time and services not covered under Medicare or by the facility prediem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal The facility must furnish a written description of legal rights whi	TRANSYL	VANIA REGIONAL HOSP	PITAL INC						
SS=8 RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under St1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident ses that are included in nursing facility services under the State plan and for which the resident may to be charged, and the amount of charges for those services; and inform each resident before, or at the time of admission, and pregos provices envices, including any charges for services available in the facility of the resident's services. Name theore, or at the time of admission, and periodically during the resident's stay, of services available in the facility and inderges for those services, including any charges for those services, including any char	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE		COMPLETION
legal rights which includes: A description of the manner of protecting personal	F 156	483.10(b)(5) - (10), 44 RIGHTS, RULES, SE The facility must infor and in writing in a lan understands of his or regulations governing responsibilities during facility must also prov notice (if any) of the S §1919(e)(6) of the Ac made prior to or upon resident's stay. Rece any amendments to it writing. The facility must infor entitled to Medicaid b of admission to the nu- resident becomes elig items and services th facility services under which the resident ma other items and service and for which the resid the amount of charge inform each resident of the items and service (i)(A) and (B) of this s The facility must infor at the time of admissi the resident's stay, of facility and of charges including any charges	83.10(b)(1) NOTICE OF RVICES, CHARGES m the resident both orally guage that the resident her rights and all rules and president conduct and president who is enefits, in writing, at the time prise facility or, when the gible for Medicaid of the at are included in nursing the State plan and for ay not be charged; those ces that the facility offers ident may be charged, and s for those services; and when changes are made to s specified in paragraphs (5) section. m each resident before, or on, and periodically during services available in the s for those services, s for services not covered			DEFICIENCY)			9/25/15
		legal rights which incl A description of the m	udes: nanner of protecting personal						

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.

09/25/2015

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345484	B. WING			09/	15/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSYL	VANIA REGIONAL HOSP	ITAL INC			IOSPITAL DRIVE BREVARD, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 156	funds, under paragran A description of the re- for establishing eligibilithe right to request ar 1924(c) which determ non-exempt resource institutionalization and spouse an equitable sc cannot be considered toward the cost of the medical care in his or down to Medicaid eliging A posting of names, a numbers of all pertine groups such as the S agency, the State lice ombudsman program advocacy network, ar unit; and a statement complaint with the Sta agency concerning re- misappropriation of re- facility, and non-comp directives requirement The facility must infor name, specialty, and physician responsible The facility must pron- written information, and applicants for admiss information about how Medicare and Medica	bh (c) of this section; equirements and procedures lity for Medicaid, including assessment under section ines the extent of a couple's s at the time of d attributes to the community share of resources which available for payment institutionalized spouse's her process of spending jibility levels. Addresses, and telephone ent State client advocacy tate survey and certification insure office, the State , the protection and ad the Medicaid fraud control that the resident may file a ate survey and certification sident abuse, neglect, and esident property in the oliance with the advance ts. m each resident of the way of contacting the for his or her care.	F	156			

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345484	B. WING		09/15/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/13/2013
				HOSPITAL DRIVE	
TRANSYL	TRANSYLVANIA REGIONAL HOSPITAL INC			BREVARD, NC 28712	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 156	Continued From page	2	F 1	56	
	by: Based on observatio facility failed to post the information and teleph to access. Findings included: On 09/14/15 an initial Unit had been conduct Complaint Intake Unit number had not been Transitional Care Unit An interview with the at 9:30 AM revealed a posted on the bulletin hall of the Transitional An observation of the 09/15/15 at 9:00 AM to to the Complaint Intake telephone number an Care Unit. An interview with the at 5:15 PM revealed as Ombudsman telephone bulletin board and the telephone numbers in were the contact for the She verified the Com- number had not been	REQUIREMENT is not met as evidenced ed on observation and staff interview the y failed to post the Complaint Intake Unit nation and telephone number for residents cess. ags included: 9/14/15 an initial tour of the Transitional Care had been conducted at 8:30 AM. The blaint Intake Unit information and telephone her had not been observed anywhere in the bitional Care Unit. terview with the Nurse Manager on 09/14/15 0 AM revealed all State information was d on the bulletin board located on the front f the Transitional Care Unit. eservation of the Transitional Care Unit on 1/15 at 9:00 AM revealed no postings related a Complaint Intake Unit information or none number anywhere in the Transitional		This Plan of Correction constitutes Transylvania Regional Hospital's writ allegation of compliance for the deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state ar federal law. 483.10(b)(5)-(10). 483.10 (b) (1) NO OF RIGHTS, RULES, SERVICES, CHARGES Transylvania Regional Hospital's Transitional Care Unit (TCU) and Mis Health provides for the rights and responsibilities of all residents by establishing a system to ensure all patients are informed of their right to complaint. Action Plan In response to the finding that Transitional Care Unit (TCU)failed to the Complaint Intake Unit contact nu for patients to access and file a comp the following corrective actions were taken: a) The State Complaint Intake Unit p number, along with additional contact information, was immediately posted TCU's patient care bulletin board at	tion that d TICE ssion file a

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) D A. BUILDING A. BUILDING (X3) D A. BUILDING B. WING (X4) ID NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HOSPITAL DRIVE BREVARD, NC 28712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	<u>3 NO. 0938-0391</u> DATE SURVEY COMPLETED 09/15/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TRANSYLVANIA REGIONAL HOSPITAL INC BREVARD, NC 28712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREVARD, NC 28712	09/15/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TRANSYLVANIA REGIONAL HOSPITAL INC HOSPITAL DRIVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	
TRANSYLVANIA REGIONAL HOSPITAL INC BREVARD, NC 28712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
DEFICIENCY)	(X5) COMPLETION DATE
F 156 Continued From page 3 F 156 Wheelchair level during the survey on September 16, 2015. The telephone numbers posted are: 1- (800)824:3004 and (919) 855-4500. The sign was issued by the North Carolina Department of Health and Human Services Regulation. Monitoring b) To maintain compliance with requirements for the state and federal regulation to post the State Complaint Intake Unit contact number, a monthly visual check will be performed by the nurse manager or designee. Compliance with the posting of the State Complaint Unit contact number will be documented monthly for three months. The first monthly visual check occurred September 25, 2015. c) TOU Staff were educated by the Nurse Manager during an all staff meeting held on September 16, 2015. On September 25, 2015. c) TOU Staff were educated by the Nurse Manager during on all staff meeting held on September 16, 2015. nor they visual check so the laster Complaint Intake Unit contact information, location of the number, and implementation of monthly checks by the nurse manager of the unit. Responsible Persons The nurse manager of the TCU is responsible Persons The nurse manager will report this Plan of Correction to the Transylvania Regional Hospital Quality	

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