PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345484	B. WING			09/25/2024	
NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL			260 HOSP	DDRESS, CITY, STATE, ZIP CODE ITAL DRIVE D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	conducted on 09/24/2 posting of the 2567 w in the region which gr communication efforts completed on 10/22/2 compliance with the re	ertification survey was 4 through 09/25/24. The as delayed due a hurricane eatly impacted internet and s. The posting was 4. The facility was found in equirement CFR 483.73, ness. Event ID# INHU11.	FO	00			
F 812	conducted on 09/24/2 posting of the 2567 w in the region which gr communication efforts completed on 10/22/2		F 8	12			10/28/24
SS=E	CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must -	2)	FC	12			10/20/24
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using progradens, subject to consider a growing and food (iii) This provision doe from consuming foods	ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. It is not prohibit or prevent roduce grown in facility compliance with applicable dehandling practices. It is not procured by the facility.					
ADODATOS	serve food in accorda	prepare, distribute and nce with professional SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed 10/29/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484		B. WING	09/25/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00:20:202:
				260 HOSPITAL DRIVE	
TRANSYLVANIA REGIONAL HOSPITAL			BREVARD, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 812	Continued From page	e 1	F 812	2	
	by:	is not met as evidenced			
	facility failed to store surface and maintain storage area and faile as indicated by the exdeficiencies occurred storage area and had served to residents at	a clean floor in the dry food ed to discard thickened fluids opiration date. These in the kitchens dry food the potential to affect food		During survey, opportunities related beyond use dating and cleanliness food and nutrition department were observed. Staff reinforcement of remonitoring of expired dates and ke food and nutrition areas clean was determined to be needed to ensure deficient practice does not recur.	of the e equired eeping
		ne kitchen on 09/24/24 at ector of Dining Services g:		 Immediately during survey, on 09/25/2024, expired food items we disposed of and food and nutrition was cleaned to remove spills and c On 9/26/2024, Hurricane Hele struck the Western North Carolina 	re area debris. ne
		oris on the plastic shelf od storage area where food red.		including Transylvania Regional Ho (TRH) Transitional Care Unit (TCU significantly impacted hospital open This contributed to a delay in action	ospital l) and rations.
	b. Dark colored stains covering in the dry for appeared as if a liquid where food items wer	od storage area that d was spilled and left to dry		planning and implementation On, 10/14/24, the TRH TCU leadership team met to review the opportunities and began action pla development.	survey
	noted to have food cr	food storage area was umbs and other debris ackets of condiments and		 On 10/20/2024, the environmed services team deep cleaned the flot the dry storage and food preparation areas. Beginning on 10/23/2024, edu 	oors in on
	date of February 2022 removed by the Direct e. Six (6) 46 ounce co	ounce containers of y for use with an expiration 4. The expired water was stor of Dining Services. ontainers of thickened sweet an expiration date June		was developed by a multidisciplina including TCU Administrator, Direct Nursing, Quality Director, Infection Prevention Specialist, Dietitian, Fo Nutrition Manager, and Clinical Edand reviewed with Food and Nutriti Services staff. The Dietitian and F	ory team od and ucator ion

	DE AN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345484	B. WING			09/	/25/2024	
NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL				26	TREET ADDRESS, CITY, STATE, ZIP CODE 50 HOSPITAL DRIVE REVARD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812	2024. The expired sw Director of Dining Ser During an interview of Director of Dining Ser schedule of the dry for wipe clean the plastic water every other morand mopped twice a water the shelving and floor Director of Dining Ser thickened liquids were residents at the facility those were not discart expiration date on the During an interview of Administrator revealed the dry food storage as more often as needed revealed expired items	veet tea was removed by the rvices. In 09/24/24 at 9:01 AM the rvices revealed the cleaning od storage area included to a shelf cover with soap and onth and the floor was swept week and confirmed both reded to be cleaned. The rvices revealed the eavailable for use for the y and it was an oversight reded as indicated by the excontainer. In 09/25/24 at 4:42 PM the ext the shelving and floor in area should be cleaned did and kept clean. She is should not be stored and	F	812	and Nutrition Manger completed in-per education with the food and nutrition st and reviewed with Food and Nutrition Services staff. Education included: o Requirements for monitoring beyouse dates and discarding past due item o Requirements for keeping food storage and preparation areas clean, for spills, and debris. On 10/28/2024, education was complete for 100% of active assigned Food and Nutrition Services staff. Additionally, to support continued oversight a process was developed for checking expiration dates using a focus review tool. An audit tool was developed to monitor food safety requirements and environmental cleanliness. To ensure ongoing compliance, weekly audits of food safety requireme will be completed. Any non-compliance identified during audits will be addresse through immediate re-education. Audit began 10/30/2024 by the Director of Formation Services, Infection Preventionist, or designee: NUMERATOR: Number of food items within usable date DENOMINATOR: Number of food and nutrition areas observed clean DENOMINATOR: Number of food and nutrition areas observed	nd ns. ree sed nts ed s		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345484	B. WING _			09/25/2024	
NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL		PITAL		26	TREET ADDRESS, CITY, STATE, ZIP CODE 50 HOSPITAL DRIVE REVARD, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 F 880 SS=F	- 3	& Control		3312 3880	Data related to the measures associate with this standard will be reported to the Transylvania Hospital Patient Safety ar Quality Committee monthly for 3 consecutive months for 95% compliance Data will also be reported to the TCU Quality Committee quarterly. The Director of Food and Nutrition Services is responsible for implementing and overseeing the actions taken with the plan. All actions outlined above were completed by 10/28/2024.	e nd ce.	10/23/24
	development and trar diseases and infection §483.80(a) Infection program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visitiproviding services un arrangement based un	blish and maintain an and control program a safe, sanitary and bent and to help prevent the asmission of communicable ans. Drevention and control blish an infection prevention and PCP) that must include, at a ving elements: Improvement of the prevention and control blish an infection prevention and control at a ving elements: Improvement of the prevention and controlling infections are assess for all residents, or and other individuals and contractual pon the facility assessment to §483.71 and following					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED		
		345484	B. WING _			09	/25/2024
NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL			•	260 H	ET ADDRESS, CITY, STATE, ZIP CODE OSPITAL DRIVE /ARD, NC 28712	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	procedures for the probut are not limited to (i) A system of surverpossible communical infections before the persons in the facility (ii) When and to who communicable disear eported; (iii) Standard and trait to be followed to preversident; including but (A) The type and dur depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstances must prohibit employ disease or infected so contact with resident contact will transmit (vi)The hand hygiene by staff involved in disease of the factor of the provision of the	n standards, policies, and rogram, which must include, it illance designed to identify ble diseases or y can spread to other or, impossible incidents of se or infections should be insmission-based precautions went spread of infections; colation should be used for a sut not limited to: action of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the insulation of the isolation should be the item of the isolation should be the ible for the resident under the insulation of the isolation should be the item of the isolation.	F	380	DEFICIENCY		
		den by the facility. dle, store, process, and s to prevent the spread of					

	A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
345484	B. WING _		09	/25/2024	
		STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE BREVARD, NC 28712	, ,		
IENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
and review. Induct an annual review of its Itheir program, as necessary. ENT is not met as evidenced Vations, record review and staff cility failed to develop and Inced Barrier Precautions policy Inat included the use of Personal Innent (PPE) during high-contact Iresidents with indwelling Induction a gown while providing Infor residents with indwelling Infor 2 of 2 nursing staff observed Intolor practices (Nurse #1 and Intellity's infection control policy and Intellity's infection control policy and Intellity's infections (EBP). Intolor on 09/25/24 at 10:51 AM Intellity's pripherally Intolor on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity on a gown. Nurse #1 Intolor on the lity of the	F 8	During survey, opportunities relack of implementation of enhal barrier precautions (EBP) were Staff lack of knowledge of (EBF determined to be the reason for deficient practice. - Immediately during survey 9/24/2024, Transitional Care Urleadership including Nurse Ma Quality Director, Infection Preves Specialist, and Clinical Educate just in time education to review Additionally, EBP signs and perprotective equipment (PPE) we and implemented on the unit. The Leadership Team reviewed resi and #57 and identified no additions were needed other than immediately implementing EBP Leadership Team reviewed the of the TCU residents and conclusional actions were need than immediately implementing - On 9/26/2024, Hurricane Hestruck the Western North Carol including Transylvania Regional (TRH) TCU and significantly im hospital operations. This contridelay in action planning and	identified. P) was r the , on nit (TCU) nager, ention or created with staff. rsonnel ere obtained the idents #4 ional n The remainder uded that ded other u EBP. Helene ina area, al Hospital upacted		
	RY STATEMENT OF DEFICIENCIES EIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) page 5 al review. Induct an annual review of its etheir program, as necessary. ENT is not met as evidenced evations, record review and staff cility failed to develop and need Barrier Precautions policy that included the use of Personal ment (PPE) during high-contact residents with indwelling and chronic wounds. In addition, not don a gown while providing for 2 of 2 nursing staff observed rol practices (Nurse #1 and d: cility's infection control policy and aled no policy and procedure for recautions (EBP). In on 09/25/24 at 10:51 AM 11 sanitized his hands and put on did not put on a gown. Nurse #1 sh Resident #4's Peripherally Catheter line (abbreviated as to a long flexible tube that is ein in the arm and threaded into a ne heart). Nurse #1 on 09/25/24 at 10:55 the only wore gloves to flush the other stated that when the PICC the PICC line itself needed e a mask, gown and gloves.	ROSPITAL RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) Page 5 al review. Induct an annual review of its their program, as necessary. ENT is not met as evidenced Vations, record review and staff cility failed to develop and need Barrier Precautions policy hat included the use of Personal ment (PPE) during high-contact residents with indwelling and chronic wounds. In addition, not don a gown while providing of for residents with indwelling for 2 of 2 nursing staff observed rol practices (Nurse #1 and d: cility's infection control policy and alled no policy and procedure for r Precautions (EBP). In on 09/25/24 at 10:51 AM Et sanitized his hands and put on did not put on a gown. Nurse #1 sh Resident #4's Peripherally Catheter line (abbreviated as to a long flexible tube that is sin in the arm and threaded into a ne heart). Nurse #1 on 09/25/24 at 10:55 The only wore gloves to flush the rither stated that when the PICC he PICC line itself needed e a mask, gown and gloves.	AND SPITAL RY STATEMENT OF DEFICIENCIES BIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) Page 5 If review. Page 5 If review. Pating in the arm and threaded into a lie heart). Page 7 Page 7 STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE BREVARD, NC 28712 PREFIX TAG PALIS PALI	STREET ADDRESS, CITY, STATE, ZIP CODE 280 HOSPITAL DRIVE BREVARD, NC 28712 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PAGE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 F 880 F 880 F 880 During survey, opportunities related to lack of implementation of enhanced barrier precautions (EBP) was determined to be the reason for the deficient practice. During survey, opportunities related to lack of implementation of enhanced barrier precautions (EBP) was determined to be the reason for the deficient practice. - Immediately during survey, on 9/24/2024, Transitional Care Unit (TCU) Leadership including Nurse Manager, Quality Director, Infection Prevention Specialist, and Clinical Educator created just in time education to review with staff. Additionally, EBP signs and personnel protective equipment (PPE) were obtained and implemented on the unit. The Leadership Team reviewed residents #4 and #57 and identified no additional actions were needed other than immediately implementing EBP. On 9/26/2024, Hurricane Helene struck the Western North Carolina area, including Transylvania Regional Hospital (TRH) TCU and significantly impacted hospital operations. This contributed to a delay in action planning and implementation. On 10/14/2024, the TRH TCU leadership team met to review the survey	

NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL SUMMANY STATEMENT OF DEPOLACIONS (CAD CONCECTION MUST OR PROCEDED BY THILL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 6 received any education on BEP. b. During an observation on 09/25/24 at 110:06 AM Nurse Aide (NA) #I provided urinary catheter care for Resident #57. NA #I washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #I did not don a gown. NA #I held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventions (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. Internalize with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed staff to implement EBP during high-contact care activities with a PICC line or indvelling medical device. The DON revealed she had not informed staff to implement EBP for residents with a PICC line or indvelling unitary catheter and was not farmiliar with the guidance for EBP related to indvelling medical device. The DON revealed she had not informed staff to implement EBP for residents with a least farmiliar with EBP and would need to update herself on the guidance for implementing EBP during high-contact ca	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
TRANSYLVANIA REGIONAL HOSPITAL TRANSYLVANIA REGIONAL HOSPITAL ENDANGERS CITY, STATE, JP CODE 260 HOSPITAL DRIVE BREVARD, NC 29712 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY VOR LSC IDENTIFYING INFORMATION) F 880 Continued From page 6 received any education on EBP. b. During an observation on 09/25/24 at 10:06 AM Nurse Aide (NA) #1 provided urinary catheter care for Resident #57. NA #1 washed her hands. with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed is the guidance for EBP related to indwelling medical device. The DON revealed if a resident is bid identified the stated to individe the propriate implementation of EBP and signage posted DENOMINATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of Observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in whic		345484 B. WING			09	/25/2024		
TRANSTVANIAN REGIONAL HOSPITAL ONLY ONL	NAME OF P	ROVIDER OR SUPPLIER			STREET	Γ ADDRESS, CITY, STATE, ZIP CODE		
Summary Statement of Deficiencies ID PREFIX EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG					260 HO	SPITAL DRIVE		
F 880 Continued From page 6 received any education on EBP. b. During an observation on 09/25/24 at 10:06 AM Nurse Aide (NA) #1 provided urinary catheter care for Resident #57. NA #1 washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care NA #1 discarded her gloves and washed the provided catheter care Na #1 discarded her gloves and washed the provided catheter care activities and not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 110:73 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. A track of the properties of the provided catheter care in the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP residuation included: DEPO To residents with a PICC line or indwelling medical devices. The DON revealed if a resident she lad not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not fa	TRANSYL	VANIA REGIONAL HO	SPITAL		BREVA	ARD, NC 28712		
received any education on EBP. b. During an observation on 09/25/24 at 10:06 AM Nurse Aide (NA) #1 provided urinary catheter care for Resident #57. NA #1 washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The DN revealed she had not informed runsing staff to implement EBP for residents with a PICC line or indwelling medical device. The DON revealed if a resident's lab identified the residents with a PICC line or indwelling medical device. The DON revealed if a resident's lab identified the residents in which EBP should be	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		IEFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
received any education on EBP. b. During an observation on 09/25/24 at 10:06 AM Nurse Aide (NA) #1 provided urinary catheter care for Resident #57. NA #1 washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The DN revealed she had not informed runsing staff to implement EBP for residents with a PICC line or indwelling medical device. The DON revealed if a resident's lab identified the residents with a PICC line or indwelling medical device. The DON revealed if a resident's lab identified the residents in which EBP should be	E 880	Continued From no	a 6		100			
b. During an observation on 09/25/24 at 10:06 AM Nurse Aide (NA) #1 provided urinary catheter care for Resident #57. NA #1 washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed and informed staff to implement EBP for residents with a pit contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling medical device. The DON revealed if a resident's lab identified the residents in which the BP should be	F 000	· ·	-	F8				
b. During an observation on 09/25/24 at 10:06 AM Nurse Aide (NA) #1 provided urinary catheter care for Resident #57. NA #1 washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high-contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling uninary catheter and was not familiar with the guidance for EBP related to indwelling uninary catheter and was not familiar with the guidance for EBP related to indwelling uninary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified durined to included: DENOMINATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be		received any educa	ition on EBP.		de	•		
AM Murse Aide (NA) #1 provided urinary catheter care for Resident #57. NA #1 washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate prevaultions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities. The IP stated she was not familiar with teBP and not informed nursing staff to implement EBP for residents with a PICC line or indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling uninary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the residents in which EBP should be					-			
care for Resident #57. NA #1 washed her hands with soap and water and donned a pair of gloves prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 1:07 AM. The IP stated she was not familiar with teBP and would need to update herself on the guidance for implementing EBP during high-contact care activities. The IP stated she was not familiar with teBP and would need to update herself on the guidance for exidents with a PICC line or indwelling medical devices. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the resident's lab identified the resident's which EBP should be								
with soap and water and donned a pair of gloves prior to the procedure. NA #1 dind not don a gown. NA #41 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with teguidance for EBP related to indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the		,	· · ·			•	OT	
prior to the procedure. NA #1 did not don a gown. NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP stated she was not familiar with the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP recipility in the proportion of the guidance for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the						-		
NA #1 held the catheter tubing approximately one inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement to informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed she had not informed nursing staff to implement to to impleme						and		
inch away from the insertion site and wiped the tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the					•			
tubing in the direction away from Resident #57. When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement table for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the				- 1		OHIC		
When finished with catheter care NA #1 discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementation and utilization o New EBP signage to be utilized as indicated - Additionally, to support continued education reminders, the education was printed and placed in the TCU resource manual for staff reference located at the TCU nursing station. - To ensure ongoing compliance, weekly audits of appropriate implementation on utilization o New EBP signage to be utilized as indicated - Additionally, to support continued education reminders, the education was printed and placed in the TCU resource manual for staff reference located at the TCU nursing station. - To ensure ongoing compliance, weekly audits of appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be					-			
discarded her gloves and washed her hands. During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the implementation and utilization o Nev EBP signage to be utilized as indicated - Additionally, to support continued education reminders, the education was printed and placed in the TCU resource manual for staff reference located at the TCU nursing station. - To ensure ongoing compliance, weekly audits of appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of tCU residents in which EBP should be		_						
During an interview on 09/25/24 at 10:15 AM, NA #11 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the				l l				
During an interview on 09/25/24 at 10:15 AM, NA #1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the indicated - Additionally, to support continued education reminders, the education was printed and placed in the TCU resource manual for staff reference located at the TCU nursing station. - To ensure ongoing compliance, weekly audits of appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be						•'	ıs	
#1 revealed she did not wear a gown when she provided catheter care for Resident #57 because she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the		During an interview		ind				
she did not receive instructions about EBP. She had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the		_			_	Additionally, to support continued		
had not used EBP for residents with indwelling medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident had a specific organism that required it. To ensure ongoing compliance, weekly audits of appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed. So proposed in					ed	· · · · · · · · · · · · · · · · · · ·		
medical devices during high contact care activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary cattheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the TCU nursing station. - To ensure ongoing compliance, weekly audits of appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be		she did not receive	instructions about EBP. She		pri	nted and placed in the TCU resourc	ce	
activities and revealed the appropriate precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident had a specific organism that required it. - To ensure ongoing compliance, weekly audits of appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be		had not used EBP f	for residents with indwelling		ma	anual for staff reference located at the	he	
precautions were implemented if a resident had a specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the weekly audits of appropriate implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be		medical devices du	ring high contact care		TC	U nursing station.		
specific organism that required it. A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the implementation of EBP and signage will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be					-	To ensure ongoing compliance,		
be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the		•	•					
A joint interview with the Director of Nursing (DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the identified during audits will be addressed through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be		specific organism th	nat required it.				/ill	
(DON) and the Infection Preventionist (IP) was conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the through immediate re-education. Audits will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be								
conducted on 09/25/24 at 11:07 AM. The IP revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the will be completed by the Director of Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be								
revealed she had not informed staff to implement EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the Nursing, Infection Preventionist, or designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be		` '	` ,			•	ts	
EBP during high-contact care activities. The IP stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the designee: NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of opportunities for EBP observed NUMERATOR: Number of opportunities with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be								
stated she was not familiar with EBP and would need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of opportunities for EBP observed			•					
need to update herself on the guidance for implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the NUMERATOR: Number of observations with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of opportunities for EBP observed					de	signee:		
implementing EBP during high-contact care activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the with appropriate EBP utilized DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be						IMEDATOR: Novele and find a second for		
activities when a resident had an indwelling medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of opportunities for EBP observed NUMERATOR: Number of opportunities for EBP observed DENOMINATOR: Number of opportunities for EBP observed NUMERATOR: Number of opportunities for EBP observed		•			- 1		ns	
medical device. The DON revealed she had not informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the for EBP observed NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be							vition	
informed nursing staff to implement EBP for residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be					- 1		iiues	
residents with a PICC line or indwelling urinary catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the NUMERATOR: Number of observations with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be					ior	EDF ODSEIVEU		
catheter and was not familiar with the guidance for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the with appropriate EBP signage posted DENOMINATOR: Number of TCU residents in which EBP should be					NII.	IMERATOR: Number of observation	ne	
for EBP related to indwelling medical devices. The DON revealed if a resident's lab identified the DENOMINATOR: Number of TCU residents in which EBP should be							13	
The DON revealed if a resident's lab identified the residents in which EBP should be			<u> </u>					
					l l			
presence of a Multi Drug Resistant Organism implemented					l l	plemented		

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345484	B. WING _			09/25/2024	
NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL			•	STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE BREVARD, NC 28712	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	(MDRO) an alert was the type of isolation p was the nurse's responsible type of precautions by resident's room door a protective equipment. An interview with the 4:52 PM revealed she received education at	sent to the nurse indicating recautions needed and it onsibility to implement the placing a sign on the and bin of personal by the door. Administrator on 09/25/24 at a would expect staff had bout EBP and were essary precautions for	F8	Data related to the measures a with this standard will be report TRH Patient Safety and Quality Committee monthly for 3 conse months for 95% compliance. Dalso be reported to the TCU Quality Committee quarterly. The Director of Nursing is resp implementing and overseeing to taken with this plan. All actions above were completed by 10/2	ted to the y ecutive lata will uality onsible for the actions outlined		