STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted 4/29/19 to 5/1/19. The facility was found in compliance with the requiremet CFR 483.73, Emergency Preparedness. Event ID# ON4711.	E 000		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		5/29/19

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

Electronically Signed | 05/24/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 1 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to provide a copy of the baseline care plan to 3 of 3 residents (Residents #54, #55 and #56) reviewed for baseline care plans. The facility also failed to individualize the baseline care plans to include physician orders. Findings included: 1. Resident #54 was admitted to the facility on 04/23/19 with multiple diagnoses that included left tibial (big bone in lower leg) fracture secondary to fall. Review of a nursing assessment dated 04/23/19 indicated Resident #54 required staff assistance with bathing, dressing, toileting, transfers, and ambulation. Review of Resident #54's baseline care plan, initiated on 04/23/19, included interventions for fall risk, pain, delirium and bleeding risk. The baseline care plan did not include interventions	F 655	Transylvania Regional Hospital (TRH) Transitional Care Unit (TCU) holds the safety of all patients, staff, and visitors as its highest priority. TRH has developed a robust system of reporting and investigating safety issues and concerns. This Plan of Correction constitutes TRH□s written allegation of compliance and correction of the deficiencies cited. This Plan of Correction is submitted to meet the requirements established by state and federal law. Following the survey on 5/1/19, The Chief Nursing Officer, Manager of Transitional Care Unit (TCU), Quality and Safety Manager, Transylvania Regional Hospital (TRH) Educator and Accreditation Specialist met to review and develop the improvements needed to ensure compliance with the areas of deficiency noted at the time of survey. TAG F655: Baseline Care plan (Date of compliance: 5/27/19) The following action items were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 2 that addressed Resident #54's need for staff assistance with Activities of Daily Living (ADL). An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on 04/30/19 at 9:57 AM revealed standard baseline care plans were initiated upon a resident's admission that typically included pressure ulcers, pain, fall risk/prevention, bleeding risk, and delirium. She added the care plans were updated as the resident's needs were assessed and Care Area Assessments (CAA) were completed. During an interview on 04/30/19 at 12:05 PM, Resident #54 indicated she was not provided a copy of her baseline care plan. A follow-up telephone interview was conducted with the MDS RN on 05/01/19 at 3:08 PM. The MDS RN reiterated the standard baseline care plans initiated upon a resident's admission included interventions for pain, fall risk/prevention, bleeding risk, and delirium. She confirmed problem areas such as ADL, nutrition, behaviors and discharge planning, varied with each resident and were not added to the baseline care plans but were discussed during the weekly care plan meetings. The MDS RN was unaware of the regulation that residents or their representative receive a written summary or copy of the baseline care plan. She confirmed one was not provided to Resident #54. An interview with the Director of Nursing (DON) on 05/01/19 at 4:04 PM revealed he would expect for baseline care plans to be individualized based on the resident's needs. The DON added the facility was unaware of the regulation that residents or their representative receive a written	F 655	developed to ensure compliance with the areas of deficiency with TAG F655. On 5/8/19, education (Interdisciplinary Plan of Care (IPOC), educating the Family) was created by Nursing Educator and Quality and Safety Manager, which was delivered by facility leadership to all clinical staff on the Transitional Care Unit. Education consisted of 1:1 education with documented completion. Education is 100% complete on 5/24/19 for all scheduled clinical Staff that were not scheduled are required to complete the education when working next scheduled shift. Staff floating to TCU will have 1:1 education completed prior to the start of their shift. New employees will have this education completed as part of their initial competency training. The Power Point: Interdisciplinary Plan of Care (IPOC), Educating the Family included the following: " The importance of educating the patient and the family related to their individualized plan of care. " The education focused on utilization of the basic care plan information sheet. The importance of providing the plan of care to the patient and family. " The importance of addressing MD orders during individualization of the care plan. In addition to the above, effective the week of 5/27/19, the Interdisciplinary Team (IDT) has added a required element to review during the weekly meetings to ensure all requirements associated with baseline and comprehensive care plans are addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 3 summary or copy of the baseline care plan. 2. Resident #55 was admitted to the facility on 04/23/19 with multiple diagnoses that included left-sided hemiparesis (partial paralysis to one side of the body), left femur neck fracture, depression, and anxiety disorder. Review of a nursing assessment dated 04/23/19 indicated Resident #55 required staff assistance with bathing, dressing, toileting, transfers, and ambulation. Review of Resident #55's medical record revealed a physician's order dated 04/23/19 that read, "Ativan (medication to treat anxiety) 0.5 milligrams three times a day as needed for anxiety." Review of Resident #55's medication administration record revealed doses were administered daily 04/23/19 to 04/29/19. Review of Resident #55's baseline care plan, initiated on 04/23/19, included interventions for fall risk, pain, delirium and bleeding risk. The baseline care plan did not include interventions to address Resident #55's needs related to staff assistance with Activities of Daily Living (ADL) or mood and behavior. An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on 04/30/19 at 9:57 AM revealed standard baseline care plans were initiated upon a resident's admission that typically included pressure ulcers, pain, fall risk/prevention, bleeding risk, and delirium. She added the care plans were updated as the resident's needs were assessed and Care Area Assessments (CAA) were completed.	F 655	To ensure ongoing compliance, the Manager of TCU (or designee) will review a minimum of 5 patient records weekly (or 100% patient sampling, based on census) to ensure the following measures: " Numerator = Admitted resident and his or her representative received a summary of the baseline care plan within 48 hours of admission. " Denominator= Admitted resident. " Numerator = Admitted resident baseline summary completed within 48 hours and includes minimum healthcare information: 1) Initial goals based on admission orders, 2) Physician orders, 3) Dietary orders, 4) Therapy services, 5) Social services, 6) PASARR recommendation (if applicable) and 7) applicable ADLs related to resident staff assistance need. " Denominator= Admitted resident. The quality monitoring will begin June 2019 and will occur for a minimum of 3 consecutive months of >95 % compliance. Data will be reported by the Manager of TCU to Transylvania Regional Hospital Patient Quality and Safety Meeting for oversight and additional actions as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 4	F 655		

A follow-up telephone interview was conducted with the MDS RN on 05/01/19 at 3:08 PM. The MDS RN reiterated the standard baseline care plans initiated upon a resident's admission included interventions for pain, fall risk/prevention, bleeding risk, and delirium. She confirmed problem areas such as ADL, nutrition, behaviors and discharge planning, varied with each resident and were not added to the baseline care plans but were discussed during the weekly care plan meetings. The MDS RN was unaware of the regulation that residents or their representative receive a written summary or copy of the baseline care plan. She confirmed one was not provided to Resident #55.

An interview with the Director of Nursing (DON) on 05/01/19 at 4:04 PM revealed he would expect for baseline care plans to be individualized based on the resident's needs. The DON added the facility was unaware of the regulation that residents or their representative receive a written summary or copy of the baseline care plan.

3. Resident #56 was admitted to the facility on 04/26/19 with multiple diagnoses that included urethral stricture (narrowing of the tube that connects to the urinary bladder), diabetes, neuropathy, anxiety, and depressive disorder.

Review of a nursing assessment dated 04/26/19 indicated Resident #56 required staff assistance with bathing, dressing, toileting, transfers, and ambulation. Further review revealed Resident #56 used oxygen while at home via nasal cannula at 2 liters per minute.

Review of Resident #56's medical record revealed the following physician orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 5	F 655		

04/26/19: Amitriptyline (medication used to treat depression) 25 milligrams (mg) at bedtime.
04/26/19: Buspar (medication used to treat anxiety) 10mg three times a day.
04/26/19: Alprazolam (medication used to treat anxiety) 0.25 mg three times a day as needed for depression.

Review of Resident #56's baseline care plan, initiated on 04/26/19, included interventions for fall risk, diabetes, pain, delirium and bleeding risk. The baseline care plan did not include interventions to address Resident #56's needs related to staff assistance with Activities of Daily Living (ADL), mood and behavior or oxygen use.

An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on 04/30/19 at 9:57 AM revealed standard baseline care plans were initiated upon a resident's admission that typically included pressure ulcers, pain, fall risk/prevention, bleeding risk, and delirium. She added the care plans were updated as the resident's needs were assessed and Care Area Assessments (CAA) were completed.

A telephone follow-up interview was conducted with the MDS RN on 05/01/19 at 3:08 PM. The MDS RN reiterated the standard baseline care plans initiated upon a resident's admission included interventions for pain, fall risk/prevention, bleeding risk, and delirium. She confirmed problem areas such as ADL, nutrition, behaviors and discharge planning, varied with each resident and were not added to the baseline care plans but were discussed during the weekly care plan meetings. The MDS RN was unaware of the regulation that residents or their representative receive a written summary or copy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 6 of the baseline care plan. She confirmed one was not provided to Resident #56. An interview with the Director of Nursing (DON) on 05/01/19 at 4:04 PM revealed he would expect for baseline care plans to be individualized based on the resident's needs. The DON added the facility was unaware of the regulation that residents or their representative receive a written summary or copy of the baseline care plan.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		5/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7	F 656		

rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to develop comprehensive care plans for activities of daily living (ADL) for 3 of 3 residents reviewed for care plan development (#3, #104, and #1).

Findings included:

1. Resident #3 was admitted to the facility on 3/8/19 with diagnoses which included arthritis and cerebrovascular accident (CVA).

The admission Minimum Data Set (MDS) dated 3/15/19 revealed that Resident #3 was cognitively intact. He was coded as requiring 2 person extensive assistance with transfers, dressing, toileting, and bathing and 1 person extensive assistance with hygiene.

A review of Resident #3's care plan revealed no care plan was initiated for assistance with ADL. There were no ADL interventions in any other

TAG F656: Develop/Implement Comprehensive Care Plan (Date of compliance: 5/24/19)
The following action items were developed to ensure compliance with the areas of deficiency with TAG F656. On 5/8/19, education ("Interdisciplinary Plan of Care (IPOC), educating the Family") was created by Nursing Educator and Quality and Safety Manager, which was delivered by facility leadership to all clinical staff on the Transitional Care Unit. Education consisted of 1:1 education with documented completion. Education is 100% complete for all scheduled clinical staff on 5/24/19. Staff that were not scheduled prior to 5/29/19, are required to complete the education when working next scheduled shift. Staff floating to TCU will have 1:1 education completed prior to the start of their shift. New employees will have this education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 care plan areas. An interview with Nurse Aide (NA) #1 on 4/29/19 at 4:00 PM revealed she received ADL care report information for the residents verbally from the other NAs and nurses during the shift change report at the beginning of each shift. She further stated that she provided extensive assistance for transfer to wheelchair, toilet and bed as well as dressing and bathing for Resident #3. An interview with NA #2 on 4/30/19 at 8:40 AM revealed she received ADL care report information for the residents verbally from the other NAs and nurses during the shift change report at the beginning of each shift. She further revealed that she provided extensive assistance for Resident #3 for all transfers and dressing but he was independent for eating. An interview with NA #3 on 5/1/19 at 2:32 PM revealed she received ADL care information for the residents by observation of the color magnet signs on the doors which indicate the level of assistance the resident needs. She further revealed she did review the progress notes in the computer if she had time and Resident #3 had a red magnet which indicated he they required ADL assistance. An interview with Nurse #1 on 4/29/19 at 4:23 PM revealed he received ADL care information for the residents by shift report and the daily team meetings and he was unaware of any ADL care plans for the residents. An interview with the MDS Coordinator on 5/1/19 at 3:07 PM revealed she had not created an ADL care plan for Resident #3. She further stated it	F 656	completed as part of their initial competency training. The Power Point: "Interdisciplinary Plan of Care (IPOC), educating the Family" included the following: • The utilization of specific IPOC's for the resident including Activities of Daily Living (ADL) and Mood and Behavior Symptoms. • The importance of the care plan and it's use for care of the resident including short term and long term goals. • Review of Policy: Inpatient Interdisciplinary Plan of Care-IPOC [1PC.NRS.0009]. In addition to the above, effective 5/24/19, the Interdisciplinary Team (IDT) will add a required element to the weekly meetings to ensure all requirements associated with baseline and comprehensive care plans are addressed. To ensure ongoing compliance, the Manager of TCU (or designee) will review a minimum of 5 patient records weekly (or 100% patient sampling, based on census) to ensure the following measures: • Numerator = Admitted resident comprehensive care plan includes measurable objectives and timeframes associated with activities of daily living (ADL), regarding staff assist with transfers, dressing, toileting, hygiene, and bathing. • Denominator= Admitted resident. The quality monitoring will begin June 2019 and will occur for a minimum of 3 consecutive months of > 95 % compliance. Data will be reported by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9	F 656		

should have been created and she did not know why it had not been done. She confirmed she was responsible for this MDS and the care plan.
An interview with the Director of Nursing (DON) on 5/1/19 at 4:06 PM revealed there was a daily team meeting with disciplines that included Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, and the MDS Coordinator. The DON explained during this team meeting each resident's goals and progress were discussed and this included ADL care. He further stated each resident should have an individualized care plan which included resident specific ADL care. He was not aware that Resident #3 did not have an ADL care plan.

2. Resident #104 was admitted to the facility on 4/6/19 with diagnoses which included hip fracture and cancer.

The admission Minimum Data Set (MDS) dated 4/11/19 revealed that Resident #104 was cognitively impaired. She was coded as requiring 2 person extensive assistance with bed mobility, transfers, dressing, and toileting, and limited assistance with hygiene.

A review of Resident #104's care plan revealed no care plan was initiated for assistance with ADL. There were no ADL interventions in any other care plan areas.

An interview with Nurse Aide (NA) #1 on 4/29/19 at 4:00 PM revealed she received ADL care report information for the resident verbally from the other NAs and nurses during the shift change report at the beginning of each shift. She further stated that for Resident #104 she provided extensive assistance for transfer to wheelchair,

Manager of TCU to Transylvania Regional Hospital Patient Quality and Safety Meeting for oversight and additional actions as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10	F 656		

toilet and bed.

An interview with NA #2 on 4/30/19 at 8:40 AM revealed she received ADL care report information for the residents verbally from the other NAs and nurses during the shift change report at the beginning of each shift. She further revealed that she provided extensive assistance for Resident #104 for all transfers and dressing.

An interview with NA #3 on 5/1/19 at 2:32 PM revealed she received ADL care information for the residents by observation of the color magnet signs on the doors which indicate the level of assistance the resident needs. She further revealed she did review the progress notes in the computer if she had time and Resident #104 had a red magnet which indicated she required assistance with ADL.

An interview with Nurse #1 on 4/29/19 at 4:23 PM revealed he received ADL care information for the residents by shift report and the daily team meetings and he was unaware of any ADL care plans for the residents.

An interview with the MDS Coordinator on 5/1/19 at 3:07 PM revealed she had not created an ADL care plan for Resident #104. She further stated it should have been created and she did not know why it had not been done. She confirmed she was responsible for this MDS and the care plan.

An interview with the Director of Nursing (DON) on 5/1/19 at 4:06 PM revealed there was a daily team meeting with disciplines that included Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, and the MDS Coordinator. The DON explained during this team

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11	F 656		

meeting each resident's goals and progress were discussed and this included ADL care. He further stated each resident should have an individualized care plan which included resident specific ADL care. He was not aware that Resident #3 did not have an ADL care plan.

3. Resident #1 was admitted to the facility on 3/16/19 with diagnoses which included: hip fracture and cerebrovascular accident (CVA).

The admission Minimum Data Set (MDS) dated 3/22/19 revealed that Resident #1 was cognitively impaired. She was coded as requiring 2 person extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene.

A review of Resident #1's care plan revealed no care plan was initiated for assistance with ADL. There were no ADL interventions in any other care plan areas.

An interview with Nurse Aide (NA) #1 on 4/29/19 at 4:00 PM revealed she received ADL care report information for the resident verbally from the other NAs and nurses during the shift change report at the beginning of each shift. She further stated that for Resident #1 she provided extensive assistance for transfer to wheelchair, toilet and bed.

An interview with NA #2 on 4/30/19 at 8:40 AM revealed she received ADL care report information for the residents verbally from the other NAs and nurses during the shift change report at the beginning of each shift. She further revealed that she provided extensive assistance for Resident #1 for all transfers, toileting, and dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 An interview with NA #3 on 5/1/19 at 2:32 PM revealed she received ADL care information for the residents by observation of the color magnet signs on the doors which indicate the level of assistance the resident needs. She further revealed she did review the progress notes in the computer if she had time and Resident #1 had a red magnet which indicated she required assistance with ADL. An interview with Nurse #1 on 4/29/19 at 4:23 PM revealed he received ADL care information for the residents by shift report and the daily team meetings and he was unaware of any ADL care plans for the residents. An interview with the MDS Coordinator on 5/1/19 at 3:07 PM revealed she had not created an ADL care plan for Resident #1. She further stated it should have been created and she did not know why it had not been done. She confirmed she was responsible for this MDS and the care plan. An interview with the Director of Nursing (DON) on 5/1/19 at 4:06 PM revealed there was a daily team meeting with disciplines that included Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, and the MDS Coordinator. The DON explained during this team meeting each resident's goals and progress were discussed and this included ADL care. He further stated each resident should have an individualized care plan which included resident specific ADL care. He was not aware that Resident #3 did not have an ADL care plan.	F 656		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		5/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 13 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to assess the need for side rails for 1 of 1 resident who was using half side rails on both sides of the bed (Resident #54). Findings included: Resident #54 was admitted to the facility on 04/23/19 with multiple diagnoses that included left tibial (big bone in lower leg) fracture secondary to fall. Review of a nursing assessment dated 04/23/19	F 700	TAG F700: Bedrails (Date of compliance: 5/29/19) The following action items were developed to ensure compliance with the areas of deficiency with TAG F700. On 5/21/19, education (“Risks and Benefits of Bedrails”) was created by the TCU Manager and Quality and Safety Manager, which was delivered by facility leadership to all nursing staff on the Transitional Care Unit. Education consisted of 1:1 education with documented completion. This education focused on: 1) use of alternatives to bed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 14 indicated Resident #54 required staff assistance with transfers. Review of Resident #54's fall prevention care plan, initiated on 04/23/19, included the following interventions: bed locked and in low position, both bed side rails in up position and call light within reach. Review of Resident #54's medical record revealed there was no side rail assessment. Observations conducted on 04/29/19 at 9:33 AM and 04/30/19 at 8:08 AM revealed Resident #54 was lying in bed with half side rails in the upright position on both sides of the bed. An interview on 04/30/19 at 9:57 AM with the Minimum Data Set (MDS) Registered Nurse (RN) revealed side rails were used on all residents for bed mobility and safety. The MDS RN confirmed there was no formal side rail assessment completed for any resident and explained fall risk assessments were completed instead that included patient education on the use of side rails. She added different components for the need for side rail use, such as cognition and medical diagnosis, were included in the fall risk, patient education and safety risk assessments that were completed for each resident. The MDS RN was unaware if the benefits or potential risks, such as entrapment, associated with side rail use were assessed or discussed with Resident #54. During an interview on 04/30/19 at 12:05 PM, Resident #54 confirmed both side rails were raised any time she was lying in bed. Resident #54 added the bed side rails were for "safety and me to use when I need to move around in bed."	F 700	rails, 2) benefits/risks to utilization of bed rails 3) risk of entrapment from bed rails, and 4) requirement to review risks and benefits with resident or resident representative and obtain informed consent. On 5/23/19, Quality and Safety, Accreditation, and Legal Services developed and implemented a consent for the use of bed rails. The Quality and Safety Manager immediately completed education on the use of the consent to all working nursing staff at that time. Education is required by all nursing staff and required when working next scheduled shift. Education will be 100% complete for all scheduled clinical staff on 5/29/19. Staff floating to TCU will have 1:1 education completed prior to the start of their shift. New employees will have this education completed as part of their initial competency training. • On 5/24/19, the Quality and Safety Manager confirmed the newly created consent was complete for all residents (or if applicable resident representative) with side rails in place. On 5/23/19, Quality and Safety Manager, Accreditation, and TCU Manager developed an evaluation form titled “Side Rail Evaluation” to assess risk and alternative interventions for resident use. Effective 5/24/19, this form is evaluation is required to be completed prior to use of bed rails. The Quality and Safety Manager immediately completed education on the use of the evaluation form to all working nursing staff at that time. Education is required by all nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 15 An interview on 05/01/19 at 1:32 PM with the RN assigned to provide care to Resident #54 revealed half side rails were routinely used for all residents on the unit for bed mobility and safety. The RN stated he reviewed with Resident #54 how to use the buttons located on the side rails to raise or lower the head of the bed but did not discuss the benefits or potential risks to using side rails or assess for entrapment risk. An interview on 05/01/19 at 4:04 PM with the Director of Nursing (DON) revealed bed side rails were used on all residents for safety and fall prevention. He confirmed there was no formalized assessment completed on any resident, including Resident #54, for the use of side rails. The DON explained components that assessed the need for side rail use were addressed under other assessments such as fall risk and patient education but there was nothing currently on any of the assessments that addressed assessing for the risk of entrapment or discussing the potential risks and benefits of side rail use with residents.	F 700	staff and required when working next scheduled shift. Education will be 100% complete for all scheduled nursing staff on 5/29/19. Staff floating to TCU will have 1:1 education completed prior to the start of their shift. New employees will have this education completed as part of their initial competency training. • On 5/24/19, the Quality and Safety Manager confirmed that the newly created "side rail evaluation" form was completed for all currently admitted residents with side rails in use. On 5/23/19, Policy, "Bed Rail Policy [3PC.TCU.056] was updated to include regulatory requirements associated with Resident Assessment and informed consent. Effective 5/24/19, this consent is required prior to use of bed rails. The Quality and Safety Manager immediately completed education on the updated policy changes all working nursing staff at that time. Education is required by all nursing staff and required when working next scheduled shift. Education will be 100% complete for all scheduled nursing staff on 5/29/19. Staff floating to TCU will have 1:1 education completed prior to the start of their shift. New employees will have this education completed as part of their initial competency training. To ensure ongoing compliance, the Manager of TCU (or designee) will review a minimum of 5 patient records weekly (or 100% patient sampling, based on census) to ensure the following measures: • Numerator = Admitted resident has bed side rail evaluation form completed prior to use of bed rails	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 16	F 700	• Denominator= Admitted resident with bed side rails in use. • Numerator = Admitted resident has bed side rail consent documented prior to use of bed rails • Denominator= Admitted resident with bed side rails in use. The quality monitoring will begin June 2019 and will occur for a minimum of 3 consecutive months of > 95 % compliance. Data will be reported by the Manager of TCU to Transylvania Regional Hospital Patient Quality and Safety Meeting for oversight and additional actions as indicated.	
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to include the ongoing monitoring of bed side rails as part of their routine maintenance program for 6 of 6 beds observed with side rails in 6 of 6 sampled resident rooms (Rooms 52, 53, 55, 56, 57, and 59). Findings included:	F 909	TAG F909: Resident Bed (Date of compliance: 5/24/19) The following action items were developed to ensure compliance with the areas of deficiency with TAG F909. On 5/8/19, education was developed and delivered by the Facility Manager and Quality and Safety Manager for all nursing	5/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 17 During the initial tour on 04/29/19 at 9:30 AM, observations of rooms 52, 53, 55, 56, 57, and 59 revealed the beds all had half side rails in use on both sides of the bed. Observations conducted throughout the remainder of the survey revealed the side rails remained in use. An interview with the Facility Manager of Plant Operations (FMPO) on 05/01/19 at 2:17 PM revealed weekly, routine maintenance rounds were conducted on the unit which included checking the water temperature and functioning of call bells in each resident room. The FMPO confirmed the residents' bed side rails were not inspected or monitored as part of the facility's weekly or monthly routine maintenance program. The FMPO explained side rails came preassembled on the bed frames and were monitored as needed. The FMPO added they relied on staff to notify them when there was an issue that needed to be addressed with a bed side rail. An interview on 05/01/19 at 4:04 PM with the Director of Nursing (DON) revealed bed side rails were used on all residents for safety and fall prevention. The DON confirmed there was no plan currently in place for the ongoing maintenance of bed side rails and he would be working on a solution for compliance.	F 909	staff on the TCU. Education consisted of the requirement to conduct regular inspections of all bed rails to identify possible entrapment. Education is 100% complete for all scheduled clinical staff on 5/24/19. Staff that were not scheduled prior to 5/24/19, are required to complete the education when working next scheduled shift. Staff floating to TCU will have 1:1 education completed prior to the start of their shift. New employees will have this education completed as part of their initial competency training. Additionally, a checklist, Bed Safety Checklist was developed on 5/20/19 by the Quality and Safety Manager and the TCU Manager to ensure an ongoing monitoring of bed rails as part of the routine maintenance program. On 5/24/19, this checklist was used by the Facility Manager to complete an initial maintenance review of side rails for all patient beds to assess risk of entrapment. No concerns or needed repairs were identified during this assessment. Beginning June 2019, this checklist will be completed by the nursing staff on a monthly basis, with necessary follow-up as indicated. On 5/24/19, all beds were added to a preventative maintenance schedule per manufacturer□s recommendations. To ensure ongoing compliance, the Manager of TCU (or designee) will verify monthly completion of bed safety checklist for all in-service beds with side rails installed and report the following. " Numerator = Number of beds with side rails installed with bed safety	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345484	A. BUILDING _____ B. WING _____	05/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL INC	HOSPITAL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 18	F 909	checklist completed " Denominator= Number of beds with side rails installed. The quality monitoring will begin June 2019 and occur for a minimum of 3 consecutive months of 100% compliance. Data will be reported by the Manager of TCU to Transylvania Regional Hospital Patient Quality and Safety Meeting for oversight and additional actions as indicated.	