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

PRINTED: 10/09/2023 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL (X4 ID) PREFIX TAG (FO00) INITIAL COMMENTS A paper follow up was conducted on 10/6/23 and the facility is back in compliance effective 7/13/23.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER TRANSYLVANIA REGIONAL HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) [F 000] INITIAL COMMENTS A paper follow up was conducted on 10/6/23 and the facility is back in compliance effective							R	
TRANSYLVANIA REGIONAL HOSPITAL (X4) ID PREFIX TAG (F 000) INITIAL COMMENTS A paper follow up was conducted on 10/6/23 and the facility is back in compliance effective	345484			B. WING			10/06/2023	
TRANSYLVANIA REGIONAL HOSPITAL (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 000) INITIAL COMMENTS A paper follow up was conducted on 10/6/23 and the facility is back in compliance effective BREVARD, NC 28712 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS (F 000) (F 000	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [F 000] INITIAL COMMENTS A paper follow up was conducted on 10/6/23 and the facility is back in compliance effective					260 HOSPITAL DRIVE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [F 000] INITIAL COMMENTS A paper follow up was conducted on 10/6/23 and the facility is back in compliance effective [F 000] INITIAL COMMENTS [F 000] (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TRANSYLVANIA REGIONAL HOSPITAL				BREVARD, NC 28712			
A paper follow up was conducted on 10/6/23 and the facility is back in compliance effective	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
the facility is back in compliance effective	{F 000}	INITIAL COMMENTS		{F 0	00}			
		the facility is back in						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE							(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.