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 ______	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSYLVANIA REGIONAL HOSPITAL	260 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 on 09/24/24 through 09/25/24. The posting of the 2567 was delayed due a hurricane in the region which greatly impacted internet and communication efforts. The posting was completed on 10/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# INHU11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 09/24/24 through 09/25/24. The posting of the 2567 was delayed due a hurricane in the region which greatly impacted internet and communication efforts. The posting was completed on 10/22/24. Event ID: INHU11.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		10/28/24

LABORATORY DIRECTOR'S OR PROVIDER/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.

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F 812	Continued From page 1 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store food items on a clean surface and maintain a clean floor in the dry food storage area and failed to discard thickened fluids as indicated by the expiration date. These deficiencies occurred in the kitchens dry food storage area and had the potential to affect food served to residents at the facility. Findings included: During initial tour of the kitchen on 09/24/24 at 9:01 AM with the Director of Dining Services revealed the following: a. Crumblike food debris on the plastic shelf covering in the dry food storage area where food items were being stored. b. Dark colored stains on the plastic shelf covering in the dry food storage area that appeared as if a liquid was spilled and left to dry where food items were being stored. c. The floor in the dry food storage area was noted to have food crumbs and other debris including unopened packets of condiments and other paper trash. d. Thirteen (13) four ounce containers of thickened water ready for use with an expiration date of February 2024. The expired water was removed by the Director of Dining Services. e. Six (6) 46 ounce containers of thickened sweet tea ready for use with an expiration date June	F 812	During survey, opportunities related to beyond use dating and cleanliness of the food and nutrition department were observed. Staff reinforcement of required monitoring of expired dates and keeping food and nutrition areas clean was determined to be needed to ensure deficient practice does not recur. - Immediately during survey, on 09/25/2024, expired food items were disposed of and food and nutrition area was cleaned to remove spills and debris. - On 9/26/2024, Hurricane Helene struck the Western North Carolina area, including Transylvania Regional Hospital (TRH) Transitional Care Unit (TCU) and significantly impacted hospital operations. This contributed to a delay in action planning and implementation. - On, 10/14/24, the TRH TCU leadership team met to review the survey opportunities and began action plan development. - On 10/20/2024, the environmental services team deep cleaned the floors in the dry storage and food preparation areas. - Beginning on 10/23/2024, education was developed by a multidisciplinary team including TCU Administrator, Director of Nursing, Quality Director, Infection Prevention Specialist, Dietitian, Food and Nutrition Manager, and Clinical Educator and reviewed with Food and Nutrition Services staff. The Dietitian and Food	

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F 812 Continued From page 2

2024. The expired sweet tea was removed by the Director of Dining Services.

During an interview on 09/24/24 at 9:01 AM the Director of Dining Services revealed the cleaning schedule of the dry food storage area included to wipe clean the plastic shelf cover with soap and water every other month and the floor was swept and mopped twice a week and confirmed both the shelving and floor needed to be cleaned. The Director of Dining Services revealed the thickened liquids were available for use for the residents at the facility and it was an oversight those were not discarded as indicated by the expiration date on the container.

During an interview on 09/25/24 at 4:42 PM the Administrator revealed the shelving and floor in the dry food storage area should be cleaned more often as needed and kept clean. She revealed expired items should not be stored and available for use and expected they were discarded based on the expiration date on the container.

F 812

and Nutrition Manger completed in-person education with the food and nutrition staff and reviewed with Food and Nutrition Services staff. Education included:

o Requirements for monitoring beyond use dates and discarding past due items.
o Requirements for keeping food storage and preparation areas clean, free of 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 focused review tool.
- An audit tool was developed to monitor food safety requirements and environmental cleanliness.
- To ensure ongoing compliance, weekly audits of food safety requirements will be completed. Any non-compliance identified during audits will be addressed through immediate re-education. Audits began 10/30/2024 by the Director of Food and Nutrition Services, Infection Preventionist, or designee:

NUMERATOR: Number of food items within usable date
DENOMINATOR: Number of food items observed

NUMERATOR: Number of food and nutrition areas observed clean
DENOMINATOR: Number of food and nutrition areas observed

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F 812	Continued From page 3	F 812	Data related to the measures associated with this standard will be reported to the Transylvania Hospital Patient Safety and 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 this plan. All actions outlined above were completed by 10/28/2024.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		10/23/24

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F 880	Continued From page 4	F 880		

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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F 880	Continued From page 5 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop and implement Enhanced Barrier Precautions policy and procedures that included the use of Personal Protective Equipment (PPE) during high-contact care activities for residents with indwelling medical devices and chronic wounds. In addition, nursing staff did not don a gown while providing high-contact care for residents with indwelling medical devices for 2 of 2 nursing staff observed for infection control practices (Nurse #1 and Nurse Aide #1). Findings included: Review of the facility's infection control policy and procedures revealed no policy and procedure for Enhanced Barrier Precautions (EBP). a. An observation on 09/25/24 at 10:51 AM revealed Nurse #1 sanitized his hands and put on clean gloves but did not put on a gown. Nurse #1 proceeded to flush Resident #4's Peripherally Inserted Central Catheter line (abbreviated as PICC and refers to a long flexible tube that is inserted into a vein in the arm and threaded into a large vein near the heart). An interview with Nurse #1 on 09/25/24 at 10:55 AM revealed that he only wore gloves to flush the PICC line. He further stated that when the PICC line dressing or the PICC line itself needed changed, he wore a mask, gown and gloves. Nurse #1 stated that he had never heard of or	F 880	During survey, opportunities related to lack of implementation of enhanced barrier precautions (EBP) were identified. Staff lack of knowledge of (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. The Leadership Team reviewed the remainder of the TCU residents and concluded that 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 opportunities and began action plan	

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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 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 presence of a Multi Drug Resistant Organism

F 880

development.

- On 10/23/2024, education was developed by a multidisciplinary team including TCU Administrator, Director of Nursing, Quality Director, Infection Prevention Specialist, and Clinical Educator and was assigned to clinical and non-clinical staff on TCU via the electronic learning module system. Education included:
  - o Requirements for EBP 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 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 implemented

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F 880	Continued From page 7 (MDRO) an alert was sent to the nurse indicating the type of isolation precautions needed and it was the nurse's responsibility to implement the type of precautions by placing a sign on the resident's room door and bin of personal protective equipment by the door. An interview with the Administrator on 09/25/24 at 4:52 PM revealed she would expect staff had received education about EBP and were implementing the necessary precautions for indwelling medical devices.	F 880	Data related to the measures associated with this standard will be reported to the TRH Patient Safety and Quality Committee monthly for 3 consecutive months for 95% compliance. Data will also be reported to the TCU Quality Committee quarterly. The Director of Nursing is responsible for implementing and overseeing the actions taken with this plan. All actions outlined above were completed by 10/23/2024.	