

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Transylvania Regional Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Hospital Drive Brevard, NC 28712	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to assess a resident to keep over-the-counter hydrogen peroxide and lubricating eye drops in the resident's room for 1 of 1 resident reviewed for self-administration (Resident #8).The findings included:Resident #8 was admitted to the facility on [DATE].The Physician Assistant admission history and physical progress note dated 11/14/25 noted Resident #8 was alert and oriented with intact functional cognition.Review of Resident #8's medical record revealed he had not been assessed for self-administration of medication.An observation of Resident #8's room on 11/24/25 at 3:09 PM revealed one 32 fluid (fl.) ounce (oz) brown bottle of 3% hydrogen peroxide (over-the-counter antiseptic) on the overbed table and one 0.5 fl. oz bottle of lubricating eye drops (over-the-counter eye drops used to relieve eye dryness and irritation) on the counter by the sink.An observation of Resident #8's room during medication administration with Nurse #1 on 11/25/25 at 8:36 AM revealed one 32 fl. oz brown bottle of 3% hydrogen peroxide on the overbed table and one 0.5 fl. oz bottle of lubricating eye drops on the counter by the sink.During an interview on 11/25/25 at 11:06 AM, Nurse #1 revealed when he administered Resident #8's medications this morning, he did not notice the bottle of hydrogen peroxide on the overbed table, or the bottle of lubricating eye drops on the counter by the sink, or he would have removed them at that time. Nurse #1 stated residents were not allowed to keep medications or medicated liquids in their room.During an observation and interview on 11/25/25 at 9:45 AM, on Resident #8's overbed table was one 32 fl. oz brown bottle of 3% hydrogen peroxide and one 0.5 fl. oz bottle of lubricating eye drops on the counter by the sink. Resident #8 explained at times, he used the hydrogen peroxide to gargle and rinse his mouth when his mouth was sore which was what he did at home. Resident #8 also stated he kept lubricating eye drops on hand to use when his eyes were red and/or itching but had not had to use the eye drops since being at the facility. Resident #8 could not recall if he had brought the bottle of hydrogen peroxide and lubricating eye drops with him from home or if his family brought them to him at the facility.During an interview on 11/25/25 at 10:03 AM, the Director of Nursing (DON) confirmed Resident #8 had not been assessed for self-administration of medications. The DON stated residents were not allowed to keep medications or medicated liquids, such as hydrogen peroxide and lubricating eye drops, at bedside. The DON stated the items should have been removed by nursing staff and not left in Resident #8's room.During an interview on 11/24/25 at 1:54 PM, the Administrator stated nurses kept and administered all resident medications and residents were not allowed to keep medications or medicated liquids in their rooms.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interviews, the facility failed to discard expired food items, label and date food items, and remove food items with signs of spoilage in 1 of 1 walk-in cooler; label and date a food item in 1 of 1 walk-in freezer; and label, date, and cover food items in 1 of 1 reach-in freezer. These failures had the potential to affect food served to residents. Findings included: 1. An initial observation of the walk-in cooler on 11/24/25 at 9:47 AM revealed the following: a. a 5-pound bag of peeled garlic with a use by date of 11/20/25 sitting on a shelfb. Seven pints of grape tomatoes that contained scattered shriveled tomatoes and tomatoes with a white fuzzy substance sitting on a shelfc. an opened and undated bag of spinach that was wilted and contained a small amount of liquid sitting on a shelfd. a 5-pound bag of jalapeno peppers containing scattered shriveled peppers sitting on a shelfe. a bunch of fresh cilantro wrapped in plastic wrap with a use by date of 11/22/25 sitting on a shelf. The cilantro leaves had yellow and brown discoloration. f. Four bags of unopened and undated romaine lettuce containing scattered brown and watery leaves sitting on a shelfg. a bag of coleslaw mix with a use by date of 11/23/25 sitting on a shelfh. a box of limes with scattered brown spots sitting on a shelfi. an opened and undated 5-pound container of sour cream sitting on a shelf A telephone interview with the Dietary Manager on 11/25/25 at 12:47 PM revealed she expected all opened food to be labeled and dated, expired food to be discarded, and food with signs of spoilage to be discarded. She stated the supervisor who worked on 11/23/25 was responsible for checking the cooler to ensure all items were labeled and dated, no food items were expired, and all food items with signs of spoilage were discarded. The Dietary Manager stated she also checked for expired food items, unlabeled or undated food items, and signs of spoilage each time she worked, and she had been out sick 11/24/25 and 11/25/25. An interview with the Administrator on 11/25/25 1:56 PM revealed she expected food to be labeled and dated when opened, expired food to be used or discarded on or before the expiration date, and food with signs of spoilage to be discarded. 2. An observation of the walk-in freezer on 11/24/25 at 10:12 AM revealed an opened and undated bag of butternut squash sitting on a shelf. A telephone interview with the Dietary Manager on 11/25/25 at 12:47 PM revealed she expected all opened food to be labeled and dated. She stated the supervisor who worked on 11/23/25 was responsible for checking the freezer to ensure all items were labeled and dated. The Dietary Manager stated she also checked for unlabeled and undated food items each time she worked, and she had been out sick 11/24/25 and 11/25/25. An interview with the Administrator on 11/25/25 1:56 PM revealed she expected food to be labeled and dated when opened. 3. An observation of the reach-in freezer on 11/24/25 at 10:17 AM revealed an opened and undated box of turkey breakfast patties partially open to air sitting on a shelf. A telephone interview with the Dietary Manager on 11/25/25 at 12:47 PM revealed she expected staff to cover food, so it was not left open to air. An interview with the Administrator on 11/25/25 1:56 PM revealed she expected food to be covered and stored appropriately.</p>		