STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	C 08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIVENS HEALTH CENTER	600 BARRETT LANE ASHEVILLE, NC 28803

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E 000	Initial Comments An unannounced recertification survey was conducted from 08/22/22 through 08/26/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #YJWS11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 08/22/22 through 08/26/22. A total of 7 allegations were investigated and 1 was substantiated. Intakes NC00178133, NC00178142, NC00178256, and NC00183859. Event ID #YJWS11.	F 000		
F 656 SS=D	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	F 656		9/14/22

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

Electronically Signed | 09/14/2022

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 656	Continued From page 1 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 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 a care plan for hospice care and anticoagulation medication use for 1 of 5 residents (Resident #21) reviewed for unnecessary medications. Findings included: 1. Resident #21 was admitted to the facility 08/19/21 with diagnoses including atrial fibrillation (an irregular heartbeat) and heart failure. a. A review of Resident #21's Physician orders revealed an order for Eliquis (an anticoagulant medication) 2.5 milligrams (mg) dated 08/31/21. Review of the significant change Minimum Data Set (MDS) dated 06/17/22 revealed Resident #21	F 656	POC: F-656 During the survey, the survey team noted that Resident #21 did not have a specific care plan in place for either Hospice Services or Anticoagulant medication use. During the survey, a resident centered anticoagulant care plan was initiated for Resident # 21 on 8/26. In addition, during the survey, a resident centered Hospice Care plan was initiated for Resident # 21 on 8/26. Further, prior to the survey, a Four Seasons Hospice Care Plan was already in place for resident #21 and was initiated on 6/7/22. To ensure that no other residents were affected in a similar manner an audit of all	

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F 656	Continued From page 2 was moderately cognitively impaired and received an anticoagulant medication 7 out of 7 days during the lookback period. Review of Resident #21's care plan last updated 07/01/22 revealed there was no care plan for anticoagulation medication use. An interview with the Director of Nursing (DON) on 08/26/22 at 10:30 AM revealed she expected residents who received anticoagulant medication to have a care plan in place that reflected anticoagulation therapy. An interview with the Administrator on 08/26/22 at 10:41 AM revealed Resident #21's care plan should have been updated to reflect anticoagulation therapy according to Resident Assessment Instrument (RAI) guidelines. An interview with the MDS Coordinator on 08/26/22 at 10:47 AM revealed she did not routinely generate an anticoagulation care plan for every resident that received anticoagulant medication. b. Review of the hospice plan of care revealed Resident #21 began receiving hospice services 06/07/22. Review of the significant change Minimum Data Set (MDS) dated 06/17/22 revealed Resident #21 was moderately cognitively impaired and received hospice care. Review of Resident #21's care plan last updated 07/01/22 revealed there was no care plan to reflect she was receiving hospice services.	F 656	residents receiving anticoagulant medications was begun 8/29/22. These audits and updated care plans were completed as of 9/14/22. Likewise, an audit of all residents receiving Hospice services was begun 8/29/22. These audits and updated care plans were completed as of 9/14/22. On 8/29/22, the Administrator met with MDS Coordinator and had detailed discussions regarding the need for consistent care-planning of Hospice and anticoagulant use. This meeting provided the MDS coordinator instruction of the expectations going forward and outlined the plans of correction to ensure the expectations were met. Additional training and coaching will occur as indicated going forward. In order to prevent reoccurrence of this type of error in the future, in the 8/29/22 discussion, the Administrator instructed the MDS coordinator to initiate an Anticoagulant care plan immediately within a week of any new anticoagulant medication order. The Director of Nursing (DON) will monitor to ensure these are done and report her findings to the QAPI committee in the scheduled Risk management meetings. Likewise, in the 8/29/22 discussion, the Administrator instructed the MDS coordinator to initiate a Hospice care plan immediately within a week of any initiation of Hospice services. The Life Enrichment	

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F 656	Continued From page 3 An interview with the Director of Nursing (DON) on 08/26/22 at 10:30 AM revealed Resident #21 should have a hospice care plan in place. An interview with the Administrator on 08/26/22 at 10:41 AM revealed he expected Resident #21 to have a care plan in place to reflect she was receiving hospice services. An interview with the MDS Coordinator on 08/26/22 at 10:47 AM revealed Resident #21 should have a hospice care plan in place. She explained the hospice care plan should have been initiated when Resident #21 began receiving hospice services and it was an oversight that the care plan was not developed.	F 656	Director (LE) will monitor to ensure these are done and report her findings to the QAPI committee in the scheduled Risk management meetings. Ongoing compliance will be monitored as noted in a Performance Improvement Plan (PIP) that was initiated 8/26/22. This PIP addresses Comprehensive Care planning and directs the DON and LE to report their Audits of Anticoagulant and Hospice Care Plans to the QAPI Committee for ongoing monitoring and oversight until 12/31/22 or until the QAPI Committee determines that ongoing, consistent compliance has been achieved. The completion date is 9/14/22.	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		9/14/22

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(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in

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F 886	Continued From page 5 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines by not testing residents and staff immediately in response to a staff member testing positive for COVID-19. The facility also failed to document COVID-19 test results in the residents' medical record for 3 of 3 residents reviewed (Resident #4, Resident #11, and Resident #25). These failures occurred during a COVID-19 pandemic. Findings included: 1. The CDC guidance related to "New Infection in Healthcare Personnel (HCP) or Residents" last updated 02/02/22, read in part, "Because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or nursing home resident should be evaluated as a potential outbreak. Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-Cov-2 infection, all HCP who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested as described in the testing section. If the facility does not have the expertise, resources, or ability to identify all close contacts they should instead investigate the outbreak at a facility-level or group-level: perform testing for all residents and HCP on the affected	F 886	POC: F886 During the survey, the facility was deemed by the survey team to be out of compliance with the expected timing of follow up testing when a new staff member covid case was noted. In addition, while the facility had records of resident testing results, the negative results were not in the individual resident's records. Givens Estates policy regarding Covid 19 testing is to follow the most recent CMS guidance. The Health Services Director (HSD) is responsible to ensure current CMS guidance is implemented consistently adhered to. On 8/25, the HSD reviewed the current CDC guidance with the survey team. Following the survey team's explanation of the guidance, the facility immediately revised their testing protocols to meet the current CMS / CDC guidance as required. This required testing will be widespread or contact traced as determined in conjunction with the Health Department and will be implemented immediately but not less than 24 hours following any newly determined positive test. In addition, on 8/24, the Health Information Specialist (HIS) facility uploaded the covid testing results for resident #1, #4, #25 in their	

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F 886	Continued From page 6 unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after exposure, if known) and, if negative, again 5 to 7 days later." The facility's resident and staff COVID-19 testing spreadsheet revealed Dietary Aide #1 tested positive for COVID-19 on 07/12/22. Further review revealed the following: Facility wide testing of all residents and staff was conducted on 07/14/22 to 07/15/22 with Dietary Aide #2 testing positive on 07/16/22 and Housekeeping Aide #1 testing positive on 07/17/22. No residents tested positive. Facility wide testing of all residents and staff was conducted on 07/18/22 to 07/19/22 with Housekeeping Aide #2 testing positive on 07/19/22. No residents tested positive. Facility wide testing of all residents and staff was conducted on 07/21/22 to 07/22/22 with the Environmental Services Team Leader #1 testing positive on 07/21/22 and Resident #44 testing positive on 07/22/22. Facility wide testing of all residents and staff was conducted on 07/25/22 and 07/26/22 with no new positive cases. Facility wide testing of all residents and staff was conducted on 07/28//22 and 07/29/22 with no new positive cases. During an interview on 08/23/22 at 4:04 PM, the Administrator explained due to the county transmission rate, they had been testing all non-vaccinated or up-to-date employees twice weekly on Tuesday and Fridays. If an employee tested positive and they identified no direct contact with residents, then they were informed by the Local Health Department they could wait until the next scheduled testing date to conduct	F 886	individual medical records. To ensure other residents were not affected in a similar manner, beginning immediately, The Director of Nursing (DON) and HSD will jointly evaluate the appropriate testing plan immediately following any newly determined positive test, and ensure testing begins immediately but not less than 24 hours following the positive result. Further, the HIS uploaded all Covid 19 testing results for all other resident into each resident's individual medical records. This occurred on 8/24 and 8/25/22. In order to prevent reoccurrence of this in the future, the HSD and DON will review the testing plans with the Givens Estates Covid 19 leadership team on a weekly basis to provide oversight and ensure adherence to the standard of immediately but not less than 24 hours following a newly determined positive test. The Admin Assistant will consistently upload resident Covid 19 testing results to the medical record in a timely manner. On 9/9/22 the HIS initiated training of the Admin Assistant to upload resident covid testing results into the medical record. The Health Information Specialist (HIS) will continue to ensure the Admin. assistant is adequately trained to upload resident test results and will review and document a random sample of 5 or more resident results weekly (as available) to ensure compliance. Ongoing compliance will be monitored as	

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F 886	Continued From page 7 facility-wide testing of residents and staff. The Administrator stated an outbreak started on 07/12/22 when Dietary Aide #1 developed symptoms of congestion and a runny nose and tested positive for COVID-19. He explained Dietary Aide #1 worked in the kitchen as a dishwasher and assisted with meal tray preparation during resident meal service but had no close contact with residents, wore Personal Protective Equipment (PPE) consistently and remained socially distanced. He added based on the guidance they received from the Local Health Department, they were ok to wait until the next scheduled testing date on 07/15/22 to test other residents and staff. During follow-up interviews on 08/25/22 at 3:33 PM and 08/26/22 at 8:45 AM, the Administrator confirmed they did not perform COVID testing on the dietary staff members who had worked with Dietary Aide #1 on 07/12/22 as part of their contact tracing. The Administrator stated the CDC guidance for New Infection in Healthcare Personnel (HCP) or Residents last updated 02/02/22, indicated "when performing an outbreak to a known case, facilities should always refer to the recommendation of the jurisdictions public health authority." He explained they had followed the guidance they received from the Local Health Department and restated they were informed they could wait until the next scheduled testing date on 07/15/22 to test other residents and staff. The Administrator added he felt they had met the regulation requirements for testing based on their interpretation and guidance received from the Local Health Department. 2. The facility's resident and staff COVID-19 testing spreadsheet provided by the Administrator	F 886	noted in two Performance Improvement Plans (PIP) that were initiated 8/26/22: The First PIP addresses timely initiation of testing in response to a newly identified case. The HSD will report compliance with testing scheduling to the QAPI Committee for ongoing monitoring and oversight until 12/14/22 or until the QAPI Committee determines that ongoing, consistent compliance has been achieved. The Second PIP relates to resident testing results. The HIS will continue to report the weekly audit results to the QAPI Committee for ongoing monitoring and oversight until 11/14/22 or until the QAPI Committee determines that ongoing, consistent compliance has been achieved. The completion date is 9/14/22.	

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revealed in response to a staff member testing positive for COVID-19 on 07/12/22, all residents and staff were tested on the following dates: 07/14/22 to 07/15/22, 07/18/22 to 07/19/22, 07/21/22 to 07/22/22, 07/25/22 to 07/26/22, 07/28/22 to 07/29/22.

a. Resident #4 was admitted to the facility on 05/24/22 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #4's medical record revealed no COVID test results for the month of July 2022.

b. Resident #11 was admitted to the facility on 06/02/22 with diagnoses that included hypertensive heart disease. Review of Resident #11's medical record revealed no COVID test results for the month of July 2022.

c. Resident #25 was admitted to the facility on 02/22/22 with diagnoses that included cardiorespiratory conditions. Review of Resident #25's medical record revealed no COVID test results for the month of July 2022.

During interviews on 08/26/22 at 8:45 AM and 10:49 AM, the Administrator confirmed residents' COVID-19 negative rapid test results were not currently documented in their medical record. He explained positive test results were documented in the resident's medical record and negative test results were documented on the facility's COVID-19 testing spreadsheet/log. The Administrator stated he had no explanation as to why they did not document the negative test results in the resident's medical record but he would have staff work on getting the information entered.