(X6) DATE

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		NH0484	B. WING		C 02/20/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE	
		600 BAR	RETT LANE		
GIVENS F	IEALTH CENTER	ASHEVIL	LE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 050	Division of Health Ser within 24 hours of the	acility shall ensure that the vice Regulation is notified facility's becoming aware of the later than the care personnel of	L 050		3/15/19
	interview the facility far Health Service Regulation they became aware of abuse for 1 of 3 reside (Resident #1). The findings included Resident #1 was adm 07/16/18 with diagnost Disease, dementia, or deficit and others. Review of a facility por Prohibition Policy date "Reports of alleged in exploitation, involuntate misappropriation of reported to the Admin other appropriate propensory in the propensory	as, record review, and staff ailed to notify the Division of ation within 24 hours after f an allegation of resident ents sampled for abuse itted to the facility on see that included Alzheimer's agnitive communication slicy titled: Abuse/Neglect ed 11/20/17 read in part, cidents of abuse, neglect,		Plan of Correction for: Licensure Citation 10A-13D.2210(b) Facility shall ensure that the Division of Health Service Regulation is notified to 24 hours of the facility becoming award any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1). As soon as the DON and Administrate were informed of the allegation by the Nursing Assistant and Resident Care Coordinator, the accused employee we suspended from access to the facility the completion of the investigation. As soon as the DON and Administrator we informed of the allegation the incident reported to DHSR within 17 hours, and the Asheville Police Department on 26 within 90 minutes. Immediately follow the DON and Administrator being informed of the allegation, the resident involved assessed by an RN on 2/5/19. The resident was noted to have no visible injuries and behavior monitoring was	of within re of vas until s vere was d to 15/19 ing rmed

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/15/19 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 12 XLVX11

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		NH0484	B. WING		C 02/20/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	
GIVENS H	EALTH CENTER	600 BARRE	TT LANE		
OIV ENOT	EALITI GENTER	ASHEVILLE	E, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 050	Continued From page	1	L 050		
L 050	following the allegatio injury- no later than 24 allegation. " Review of an Initial AI 02/05/19 read in part, (DON) was notified by Coordinator (NCC) the witnessed NA #2 place manner to residents' #1 was verbally loud, over her mouth and to Review of an Investigation read in part, NA #1 stated that bed and NA #2 was assisting hed. NA #1 stated that bed and NA #2 was a she heard a slap and you do that and NA #2 Resident #1 was scraanother time she and Resident #1 to bed us began to scream and hand over Resident # waking up the other rethe facility investigation spoke with 3 nurses a with NA #2 during the interviews concluded been witnessed except that she feared retalial reporting the abuse. The part, NA #2 denied evitting, slapping, or she also denied placing a #1's mouth. The reporting the abuse. The part is mouth. The reporting a #1's mouth. The reporting a #1's mouth. The reporting the abuse. The part is mouth. The reporting a #1's mouth. The reporting the abuse. The part is mouth. The reporting a #1's mouth. The reporting the abuse. The part is mouth. The reporting the abuse. The part is mouth. The reporting a #1's mouth. The reporting the abuse. The part is mouth. The reporting the abuse.	legation Report dated the Director of Nursing the Nurse Care at Nursing Assistant (NA) #1 e her hand in a rapid arm, then when Resident NA #2 placed a gloved hand old her to "shush". ation Report dated 02/11/19 ated a couple of weeks ago her to place Resident #1 in t she was at the foot of the t the head of the bed and she asked NA #2 why did 2 replied "it was reflex and tching me." NA #1 stated at NA #2 were placing sing the lift and Resident #1 NA #2 placed a gloved 1's mouth to keep from esidents. The summary of on read in part, the facility and 6 NAs that had worked past 6 months. The that no abuse had ever of by NA #1. NA #1 stated dition from NA #2 for The corrective action read in ter laying hands on or macking any resident. NA #2 gloved hand over Resident tt indicated that the facility	L 050	begun with no indication of any chang the resident s behavior. Following the investigation, the employees who faile report in a timely manner were counse for their actions. To ensure no other residents were affected, a review of allegations of about and neglect from the previous 12 more indicated that each allegation was reported timely to Administration by fastaff and was reported to DHSR within hours as required. Additionally, in each case where reasonable suspicion of a crime existed, the Asheville police department was notified within 2 hours determining a reasonable suspicion of crime. To ensure all Staff members were retrained on proper reporting and protection of residents, On 2/7/19, Administrator David Moore personally informed each Dept. Director of the incident and reasserted our policy of immediate reporting of any allegations abuse, neglect or further suspicion of crime. On 2/7/19 and 2/8/19 Dept. managers from every department discussed with their employees the post and regulations on immediately report allegations of abuse and neglect to a supervisor. On 2/27/19 Admin David Moore informed all staff in writing, reminding them of their personal responsibility for prompt and immediar reporting of any allegation or suspicion.	e ed to eled use this cility in 24 ch is of fa a blicy ting te in of
	had substantiated the #2.	abuse and terminated NA		abuse in order to protect the residents from further abuse. Daily conversation continued through 3/1/19 with staff	

Division of Health Service Regulation

STATE FORM 6899 XLVX11 If continuation sheet 2 of 12

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		NH0484	B. WING		02/20/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE	
00/500		600 BARR	ETT LANE		
GIVENS H	EALTH CENTER	ASHEVILL	E, NC 28803		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 050	Continued From page	e 2	L 050		
	An observation of Re	sident #1 was made on		members in huddles and shift meeting	ns on
		1. Resident #1 was sitting up		the importance of proper reporting.All	
		private dining feeding		newly hired staff members continue to	
		as alert and verbal but was		trained on reporting requirements on	
	unable to answer any	questions. Resident #1 was		first day of employment during their	
	_	while smiling at the staff		campus-wide orientation. New employ	/ees
	that was assisting he	r. No visible red marks or		in every department are trained on ab	use
	bruising were noted to	o either hand or forearm.		and neglect reporting during departme	
				orientation. Furthermore, all employee	es
		ducted with NA #1 on		are trained annually at a minimum on	
		I. NA #1 confirmed that on		abuse and neglect reporting requirem	ents
		#2 were working night shift		and procedures.	
		:#1's room putting her to she was at Resident #1's		To oncure ongoing compliance a OA	DI
		at Resident #1's head. NA #1		To ensure ongoing compliance, a QA plan was created 2/14/19. As of 2/22/	
		was removing Resident #1's		each Department Director has added	15,
	shoes she heard a ve	-		abuse and neglect reporting to their	
		t NA #2 and said, "what		scheduled departmental meetings for	the
	_	2 replied that she had		next 6 months, and will report this to t	
	slapped Resident #1	on the left forearm because		Monthly QAPI meeting until the Augus	st
		er on the chest. NA #1		QAPI meeting or until the QAPI team	
		A #2 to leave the room and		determines substantial compliance ha	ıs
		t #1 up with a blanket and		been achieved. Each subsequent	
		ed to NA #2 that she had put		allegation of abuse / neglect will be	
		NA #1 added that a couple		reviewed by the DON, Admin and LE	
	_	2/19 she and NA #2 were		Director to ensure proper reporting ar	
		er and were putting Resident echanical lift and while in the		protection of the resident occurred. At employees noted to be in violation of	-
		n to scream. NA #1 stated		policy, will be counseled. These revie	
		r gloved hand over Resident		will be reported to the QAPI subcomm	
		er from screaming and		until substantial compliance has been	
		lents. NA #1 confirmed that		achieved.	
		these events to the DON			
	because it was night	shift and the DON was not			
	_	ded that there was a nursing			
	supervisor in the facil	-			
	· ·	nted to report them directly			
		ated that on 01/31/19 she			
		e NCC and made her aware			
	of the slap that occur	red on 01/27/19 and the			

Division of Health Service Regulation

STATE FORM 6899 XLVX11 If continuation sheet 3 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		NH0484	B. WING		C 02/20/2019	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 02/20/2010	
TVAME OF T	NOVIDER OR GOLT EIER		RETT LANE	KIE, ZII GOBE		
GIVENS H	EALTH CENTER		LE, NC 28803			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	ΓE
L 050	Continued From page	e 3	L 050			
	stated she would also DON. NA #1 stated the she had been reeduced had to immediately resupervisor, or facility wait several days befoccurred. She added reported when NA #2 01/27/19 to the nursing duty. An interview was con 02/19/19 at 12:27 PM 01/31/19 NA #1 had of messenger on social needed to talk to her. called NA #1 and was shift that she had worstapped Resident #1 recall which hand. The not want to get anyoch had an obligation to resupervisor.	oreport it to the DON and of attempt to speak to the nat since the investigation sated and learned that she eport any abuse to the nurse, management and could not fore telling someone what that she should have a slapped Resident #1 on any supervisor that was on the NCC on the NCC stated that on contacted her via private media and stated that she informed that on the last ricked with NA #2, NA #2 had on the hand but could not the NCC stated that NA #1 did the in trouble but felt like she eport it. The NCC stated that				
	issue to the DON or A	he needed to report the Administrator. The NCC ent a text message to the				
	DON on 01/31/19 that to her. She added that days and was unable 02/05/19 and that wa incident that NA #1 hours of the issue. She added should have followed	at stated she needed to talk at she was off work for a few to speak to the DON until s when she reported the ad shared with her on stated she assumed that NA with the DON and report that as a manager she up and ensured that the				
	_	reported to the DON and/or ately after she found out on				
	An interview was con	ducted with NA #2 on				

Division of Health Service Regulation

STATE FORM 6899 XLVX11 If continuation sheet 4 of 12

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED
						0
		NH0484	B. WING		02	C 2 /20/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ON/ENG H	EALTH CENTED	600 BARF	RETT LANE			
GIVENS H	EALTH CENTER	ASHEVILI	_E, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 050	Continued From page 02/19/19 at 4:50 PM.	e 4 NA #2 confirmed that she	L 050			
	had been terminated	from her employment at the				
	facility on 02/07/19 fo	r an allegation of abuse. NA				
		s never slapped or hit any				
		sident #1 and she never				
		over Resident #1's mouth aming. NA #2 stated the				
	•	ue and she would never hit				
		e added that she had abuse				
		and had been taught that if				
	she witnessed or hea	rd any abuse she should				
	report it immediately t staff.	to the facility management				
	An interview was con-	ducted with the DON on				
	02/19/19 at 1:27 PM.	The DON stated that on				
	02/05/19 the NCC car	me into her office and asked				
	•	#1. She stated she replied				
	"NO" and the NCC sta					
	II	A #2 had slapped Resident				
	to Resident #1. The D	nile they were providing care				
		the conversation and they				
		hone. During the phone				
		N stated that NA #1 reported				
		ed Resident #1 and placed a				
	-	mouth to keep her from				
	_	I stated that they arranged				
		the facility the next day to ent, but they went ahead and				
	_ ~	to the Division of Health				
		otified the police department				
	_	gation. The DON reported				
	_	cheduled to work again until				
		e she was interviewed and				
	· ·	oyment. The DON was				
		#1 had told the NCC on				
		e allegation and stated that				
	•	C to immediately notify				

Division of Health Service Regulation

STATE FORM 6899 XLVX11 If continuation sheet 5 of 12

Division of Health Service Regulation

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		NH0484	B. WING		02/2) 10/2019
	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA TT LANE , NC 28803	TE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 050	stated that she would have reported the issinstead of waiting a fethe NCC. An interview was condadministrator on 02/1 Administrator stated to called into the DON's aware that NA #1 repslapped Resident #1. that the DON immedia went and filed the initistate regulatory agenday NA #1 came to the statement and the factivided up the investig the information had be they had enough information with the stated that he expected incident immediately a expected the NCC to	expect that NA #1 would use at the time it occurred aw days before reporting it to ducted with the 9/19 at 3:28 PM. The hat on 02/05/19 he was office and verbally made orted that NA #2 had The Administrator stated ately called NA #1 and he had 24-hour report with the cy. He added that the next e facility to give her dility management team gration to complete it. Once seen collected they believed remation to speak to NA #2 ken to NA #2 decided to ation and terminate her facility. The Administrator and the also immediately report the came aware on 01/31/19	L 050			
L 051	allegations of any act (1), shall document al	acility shall investigate listed in G.S. 131E-256(a) I information pertaining to d shall take the necessary er incidents while the	L 051			3/15/19

Division of Health Service Regulation

STATE FORM 6899 XLVX11 If continuation sheet 6 of 12

Division of	<u>of Health Service Regu</u>	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		NH0484	B. WING		C
		NHU484] 5:		02/20/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE	
		600 BARR	ETT LANE		
GIVENS H	EALTH CENTER		E, NC 28803		
			12,140 20003		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
1.054	0 : 15	0	1.054		
L 051	Continued From page	2 6	L 051		
	This Rule is not met	as evidenced by:			
		n, record review, and staff		Plan of Correction for:	
		ailed to take the necessary		Licensure Citation 10A-13D.2210 (c)	Δ
		er resident abuse while the		facility shall investigate allegations of	
		rocess for 1 of 3 residents		act listed in G.S. 131E256(a)(1), shall	,
	sampled for abuse (R			document all information pertaining to	I
	Sampled for abuse (IN	resident #1).		such investigation, and shall take the	
	The findings included				
	The findings included	•		necessary steps to prevent further	
	Resident #1 was adm	sitted to the facility on		incidents while the investigation is in	
		ses that included Alzheimer's		progress.	
	_			In order to ensure the resident was	
	deficit and others.	ognitive communication			
	delicit and others.			protected from further harm, as soon a the DON and Administrator were infor	
	Davious of a facility no	oliov titlad: Abusa/Naglast			
		blicy titled: Abuse/Neglect ed 11/20/17 read in part,		of the allegation by the Nursing assist	ant
	•	•		and Resident Care Coordinator, the	
		egation of abuse/neglect, the		accused employee was suspended fro	
	Health Care Administ	•		access to the facility until the complete	
		ent/residents is/are protected		of the investigation. Immediately follow	
		ther abuse/neglect during		the DON and Administrator being info	
	the investigative proc			of the allegation, the resident involved	was
	•	oval of employee from the		assessed by an RN on 2/5/19. The	
		esidents by reassignment to		resident was noted to have no visible	
		sion or termination as the		injuries and behavior monitoring was	
	_	nt. If reassigned to another		begun with no indication of any chang	I
	_	employee will be strictly		the resident s behavior. Following the	I
		ct supervisor for appropriate		results of the investigation the accuse	u
	_	y assigned unit. The direct		employee was terminated from	
	•	nsure there is no further		employment.	
	contact between the	•		To amount no other second	
	accused until the inve	estigation is complete."		To ensure no other residents were	
				affected: Facility leadership began	
	_	sistant (NA) #1's time care		investigating the accusation immediat	•
		gh 02/23/19 revealed that		and interviewed 3 nurses and 6 CNAs	who
		ut on 01/27/19, 01/28/19,		had worked with the accused. None	
	01/31/19, 02/01/19, 0	2/02/19, 02/03/19, 02/04/19		expressed any knowledge of any abuse	se of

Division of Health Service Regulation

STATE FORM 6899 XLVX11 If continuation sheet 7 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING.	BUILDING:	
		NH0484	B. WING		C 02/20/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	
GIVENS H	EALTH CENTER	600 BARRI ASHEVILLI	ETT LANE E, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
L 051	Continued From page	? 7	L 051		
L 051	and on her last day of Review of an Initial Al 02/05/19 read in part, (DON) was notified by Coordinator (NCC) the place her hand in a raarm, then when Resid NA #2 placed a glove told her to "shush". Review of an Investige read in part, NA #1 st NA #2 was assisting hed. NA #1 stated that bed and NA #2 was a she heard a slap and you do that and NA #1. Resident #1 was scraanother time she and Resident #1 to bed us began to scream and hand over Resident # waking up the other reconcluded that no about witnessed except by I read in part, NA #2 door hitting, slapping, or #2 also denied placin Resident #1's mouth. the facility had substaterminated NA #2. An observation of Resolve 19/19/19 at 11:52 AM	legation Report dated the Director of Nursing y the Nurse Care at NA #1 witnessed NA #2 apid manner to residents' dent #1 was verbally loud, d hand over her mouth and ation Report dated 02/11/19 ated a couple of weeks ago ner to place Resident #1 in at she was at the foot of the t the head of the bed and she asked NA #2 why did 2 replied "it was reflex and ttching me." NA #1 stated at NA #2 were placing sing the lift and Resident #1 NA #2 placed a gloved th's mouth to keep from esidents. The investigation use had ever been NA #1 The corrective action enied ever laying hands on r smacking any resident. NA	L 051	a resident by the accused or any other employee. Facility leadership also interviewed 6 interviewable residents who had been been cared for by the accused employ in the past. None of these expressed being abused by the accused, or by a staff member, and none stated any knowledge of any abuse by the accusor any other employee. A review of all allegations of abuse or neglect in the 12 months prior to this occurrence demonstrated that the factonsistently removed each identified accused employee from resident cared during the investigations thereby protecting all Residents. In order to prevent re-occurrence, Poliwere reviewed and are appropriate, stating When there is an allegation of abuse/neglect, the Health Care Administrator or Designee will ensure the resident/residents is/are protected from any potential further abuse/negled during the investigative process. This be accomplished by removal of emplofrom the care of the resident/residents. The direct supervisor will also ensure there is no further contact between the complainant and the accused until the investigation is complete. On 2/7/19, Administrator David Moore reasserted personally to each department manage the facility policy of immediate reporting any allegations of abuse or neglect as	that lect will exyee s& lect der ng of
	herself lunch. She wa unable to answer any	is alert and verbal but was questions. Resident #1 was		as need to remove the accused emplo from patient care during investigation	oyee of
		while smiling at the staff No visible red marks or		any allegation. On 2/7/19 and 2/8/19 I managers from every department	Dept.

Division of Health Service Regulation

STATE FORM 6899 XLVX11 If continuation sheet 8 of 12

Division of Health Service Regulation

Division o	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		C
		NH0484	B. WING		02/20/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE	
		600 BARR	ETT LANE		
GIVENS H	EALTH CENTER		E, NC 28803		
	OLIMANA DV OT		Ť	PROVIDEDIO DI ANI OF CORRECTION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
1.054	0 " 15	_	1.054		
L 051	Continued From page	e 8	L 051		
	bruising were noted to	o either hand or forearm.		discussed with their employees the po	olicy
				and regulations on immediately report	ring
	An interview was con	ducted with NA #1 on		allegations of abuse and neglect to a	
	02/20/19 at 11:45 AM	I. NA #1 confirmed that on		supervisor. On 2/27/19 Admin David	
	01/27/19 she and NA	#2 were working night shift		Moore informed all staff in writing,	
		#1's room putting her to		reminding them of their responsibility	for
		she was at Resident #1's		prompt and immediate reporting of an	
		at Resident #1's head. NA #1		allegation or suspicion of abuse in ord	
		was removing Resident #1's		protect the residents from further abuse	
	shoes she heard a ve			Daily conversations continued through	
		t NA #2 and said, "what		3/1/19 with staff members in huddles	
	_	2 replied that she had		shift meetings on the importance of pi	
		on the left forearm because		reporting. All newly hired staff member	-
		er on the chest. NA #1		continue to be trained on reporting	15
		A #2 to leave the room and			
				requirements on their first day of	
		t #1 up with a blanket and		employment during their campus-wide	<i>;</i>
		ed to NA #2 that she had put		orientation. New employees in every	
		NA #1 added that a couple		department are trained on abuse and	
		2/19 she and NA #2 were		neglect reporting during departmental	
		er and were putting Resident		orientation. Furthermore, all employee	S
		echanical lift and while in the		are trained annually at a minimum on	
	_	n to scream. NA #1 stated		abuse and neglect reporting requirem	ents
		r gloved hand over Resident		and procedures.	
		er from screaming and			DI.
	J 1	lents. NA #1 confirmed that		To ensure ongoing compliance: A QA	
	T =	these events to the DON		plan was created 2/14/19. As of 2/22	⁷ 19,
	_	shift and the DON was not		each Department Director has added	
		stated that on 01/31/19 she		abuse and neglect reporting to their	
		e Nurse Care Coordinator		scheduled departmental meetings for	
		of the slap that occurred on		next 6 months, and and will report this	
	01/27/19.			the Monthly QAPI meeting until the Au	ıgust
				QAPI meeting or until the QAPI team	
		ducted with the NCC on		determines substantial compliance ha	iS
		The NCC stated that on		been achieved. Each subsequent	
	01/31/19 NA #1 had o	contacted her via private		allegation of abuse / neglect will be	
	messenger on social	media and stated that she		reviewed by the DON, Admin and LE	
	needed to talk to her.	The NCC stated that she		Director to ensure proper reporting an	d
	called NA #1 and was	s informed that on the last		protection of the resident occurred. A	ıy
	shift that she had wor	ked with NA #2, NA #2 had		employees noted to be in violation of	this

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slapped Resident #1 on the hand but could not

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policy, will be counseled disciplined.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED	
		NH0484	B. WING		C 02/20/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE. ZIP CODE		
			ETT LANE	,		
GIVENS H	EALTH CENTER		E, NC 28803			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	V (X5)	\neg
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
L 051	Continued From page	9	L 051			
L 051	recall which hand. The NA #1 that she needed DON or Administrator off work for a few day to the DON until 02/0 reported the incident her on 01/31/19. The that NA #1 would get report the issue. She she should have follo abuse allegation was Administrator immedi 01/31/19. An interview was con 02/19/19 at 4:50 PM. had been terminated facility on 02/07/19 fo She also confirmed the facility on the followin 01/31/19, 02/01/19, 0 and on her last day on NA #2 also confirmed suspended from emphas she been moved routinely cared for Rewas scheduled off who 02/04/19 and was not 02/07/19. NA #2 statistically stated the allegwould never hit or slated.	e NCC stated that she told ed to report the issue to the c. She added that she was and was unable to speak 5/19 and that was when she that NA #1 had shared with NCC stated she assumed in touch with the DON and added that as a manager wed up and ensured that the reported to the DON and/or ately after she found out on ducted with NA #2 on NA #2 confirmed that she from her employment at the ran allegation of abuse. The interpolation of abuse and she had worked at the g days: 01/27/19, 01/28/19, 2/02/19, 02/03/19, 02/04/19 of employment on 02/07/19. It that she had not been loyment at the facility nor to a different unit and esident #1, she stated she ten she clocked out on a scheduled to return until ted that she has never sident including Resident #1	L 051	These reviews will be reported to the QAPI subcommittee until substantial compliance has been achieved.		
	been taught that if sh abuse she should rep facility management s	e witnessed or heard any port it immediately to the staff.				
	An interview was con	ducted with the DON on				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SU	ID\/EV
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLE	
			A. BUILDING: _	A. BUILDING:		
					C	
		NH0484	B. WING		02/20	/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER			I E, ZIP CODE		
GIVENS H	EALTH CENTER		RETT LANE			
		ASHEVILI	E, NC 28803			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	ESCIDENTIF TING IN CINIATION)	TAG	DEFICIENCY)	MAIL	57.1.2
			+			
L 051	Continued From page	e 10	L 051			
	02/19/19 at 1·27 PM	The DON stated that on				
		me into her office and asked				
		#1. She stated she replied				
	"NO" and the NCC sta	•				
		IA #2 had slapped Resident				
	•	nile they were providing care				
	to Resident #1. The D					
		the conversation and they				
		phone. During the phone				
		N stated that NA #1 reported				
		ed Resident #1 and placed a				
		mouth to keep her from				
	_	I stated that they arranged				
	_	the facility the next day to				
		ent. The DON reported that				
	_	uled to work again until				
		e she was interviewed and				
		oyment. The DON was				
		#1 had told the NCC on				
		e allegation and stated that				
		C to immediately notify				
	•	strator, so the investigation				
	could have begun imr					
	removed from duty to	protect Resident #1 and the				
	other residents. The	DON also stated that she				
	would expect that NA	#1 would have reported the				
		curred instead of waiting a				
	few days before repo	rting it to the NCC again so				
		cility could have been				
	protected from any fu	rther potential abuse.				
	An interview was con-	ducted with the				
	Administrator on 02/1	9/19 at 3:28 PM. The				
	Administrator stated t	hat on 02/05/19 he was				
	called into the DON's	office and verbally made				
	aware that NA #1 rep	-				
	-	Once the information had				
	_ · · · · · · · · · · · · · · · · · · ·	elieved they had enough				
	1	to NA #2 and once we had				
		ided to substantiate the				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		NH0484	B. WING		02/2	0/2019
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 02/2	0/2019
	IEALTH CENTER	600 BARRE	ETT LANE			
OIVEITO I	I		E, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
L 051	facility. The Administr NA #1 to report the in occurred, and he also immediately report the aware on 01/31/19 in:	ate her employment with the ator stated that he expected cident immediately after it expected the NCC to e incident when she became	L 051			

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

PRINTED: 03/13/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) I	DATE SURVEY COMPLETED
		345328	B. WING			C 02/20/2019
NAME OF PROVIDER OR SUPPLIER GIVENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 000	INITIAL COMMENTS No federal deficiencie		FO	DEFICIENCY)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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.

Facility ID: 923490