PRINTED: 02/07/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
		345328	B. WING _	B. WING		12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 600 BARRETT LANE ASHEVILLE, NC 28803	ODE	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		EO	000		
F 561 SS=D	conducted on 12/18/2 facility was found in content of requirement CFR 483 Preparedness. Event Self-Determination CFR(s): 483.10(f)(1)-19/2 \$483.10(f) Self-determent of the resident has the promote and facilitate through support of resonat limited to the right (1) through (11) of this \$483.10(f)(1) The resonativities, schedules (waking times), health care services consiste assessments, and plate applicable provisions \$483.10(f)(2) The resonativity that are significated.	3.73, Emergency ID #VJXY11. (3)(8) mination. right to and the facility must a resident self-determination sident choice, including but at specified in paragraphs (f) as section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the	F 5	661		1/18/24
	community activities the facility.	ooth inside and outside the				
	religious, and commu interfere with the right facility.	ident has a right to ctivities, including social, inity activities that do not ts of other residents in the				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE		(X6) DATE

Electronically Signed 01/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345328	B. WING			12/21/2023
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, Z 600 BARRETT LANE ASHEVILLE, NC 28803	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE
F 561	staff interviews the faresident's choice to he residents (Resident # The finding included: Resident #10 was ad 11/02/22. A significant change assessment dated 10 Resident #10 had seconducted with Resident #10 had seconducted with Resident # and an observation with during the interview. Semi reclined position groomed with a light mustache. The family Resident was always facial hair and kept he neatly groomed for the She indicated if Resideard had been shaw disappointed. She compared with a light mustache indicated if Resideard had been shawd disappointed. She compared half of her huffamily member stated his room directing the but then she came to week to find that this his whole beard off. If member expressed the his beard for 30 plus member stated she are sident in the second process of the second proc	an, record review, family and acility failed to honor a ave a beard for 1 of 2 at 10) reviewed for choices. Imitted to the facility Minimum Data Set 10/28/23 indicated that were cognitive impairment. PM an interview was dent #10's family member were made of Resident #10 Resident #10 was sitting in a nasleeping. He was neatly growth of a gray beard and women were explained that the every particular about his is beard and mustache are past 30 years or more. Ident #10 understood that his red off, he would have been intinued to explain that a in to find that someone had sband's beard off. The dishe posted several signs in the staff not to shave his beard at the facility one day last time someone had shaved Resident #10's family the Resident had maintained years. The Resident's family inderessed her concern with	F 56	Disclaimer: The following provided by request, in a survey conducted, and of the facility admitting to, alleged deficient practice. 1. On 12/20/23 education NA#1 on the importance the residents right to material aspects of his or her life the director of nursing. 2. All male residents we affected by the reported On 01/16/24, the Director conducted interviews without or the representative of cognitive impairments to resident's shaving preferesidents report their shawere being honored by sinformation collected duwas provided to the MD the residents care plant the preferences. 3. The Director of Nursing the importance of follow preferences when perfored Education was completed Additionally, all new nurse continuing to be educated importance of adhering right to make choices also or her life in the facility.	follow-up to the does not represe or agreeing to, the e. In was provided to e of adhering to ake choices about in the facility by deficient practicor of Nursing the male resident with any resident with a identify the rences. All aving preferences aff. The ring the interview S nurse to updat to reflect these agreements or ing resident rming care. The red by 01/18/24 sing staff will be ed on the to the residents pout aspects of he	to to tt e. s n es vs e ff n
	Nurse Supervisor #1.			4.The Director of Nursin	g and/or designe	ee

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345328	B. WING			12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 561	made of Resident #10 the Resident's family different signs posted and bathroom of varic Resident #10's sidebic cheeks" and "stop shouseks, he is suppos goatee". An interview was con Supervisor #1 on 12/2 Supervisor acknowled family member came beard had been compupset at what she fous she assured the famil investigate the incide Director of Nursing. Interviews were cond Nursing (DON) on 12 12/21/23 at 10:10 AM she was informed of shaved off. The DON the family member ar Aide (NA) #1 who was the facility had shave multiple signs posted notice the signs until shave. The DON stat and shaved Resident be shaved. During an interview w 12/21/23 at 10:23 AM shaved Resident #10	23 an observation was 0's room accompanied by member. There were 3 I around the Resident's room ous directions: "do not shave urns", "stop shaving his aving Resident #10's ed to have a full beard, not a ducted with Nurse 20/22 at 11:50 AM. The dged that Resident #10's in to find that the Resident's oletely shaved off and was and. The Supervisor stated by member that she would nt and reported it to the ucted with the Director of all 20/23 at 12:53 PM and 1. The DON explained that Resident #10's beard being 1 stated she apologized to and informed her that Nurse as a fairly new nurse aide at d the Resident and despite around his room she did not after she had finished his ed the NA made a mistake 1:#10 thinking he needed to	F 56	will perform weekly audits for for weeks of all male residents to consider adherence to resident preference shaving. Audit results will be rethe monthly Quality Assurance Performance Improvement Con (QAPI) meetings by the Directo Nursing and/or designee where be reviewed and discussed. The Committee will assess and more action plan as needed to ensure continued compliance. 5.Completion Date 01/18/24	check for ces for ported at mmittee or of a they will e QAPI dify the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345328	B. WING _			12/	21/2023
	ROVIDER OR SUPPLIER			60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 BARRETT LANE SHEVILLE, NC 28803		
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F 578 SS=D	shaved for a few days shave him while she I was not aware that R supposed to be shave not notice the signs p went into his bathroor she had already shave she had worked with never paid attention to room. On 12/21/23 at 3:46 Fithe Administrator state with malicious intent, doing him a service. Request/Refuse/Dscr CFR(s): 483.10(c)(6)(f) Secondary formulate an advance services as the right the provision of medical services deemed medinappropriate. §483.10(g)(12) The farequirements specifies subpart I (Advance D (i) These requirements inform and provide wiresidents concerning medical or surgical trees.	looked like he had not been and thought she would had the time. She stated she esident #10 was not led. The NA stated she did osted in his room until she must to put the razor away, but led him. The NA explained Resident #10 before but had to the signs posted in his led the NA did not shave him but she thought she was led to refuse him to participate in or refuse him to participate in or refuse him editective. In this paragraph should be to fithe resident to receive led treatment or medical dically unnecessary or leadily must comply with the din 42 CFR part 489, irrectives). Its include provisions to critten information to all adult the right to accept or refuse		578			1/18/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345328	B. WING _		1:	2/21/2023
	ROVIDER OR SUPPLIER EALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578	facility's policies to i and applicable State (iii) Facilities are perentities to furnish the legally responsible for the requirements of this (iv) If an adult indivitime of admission and information or articular has executed an admay give advance of individual's resident with State law. (v) The facility is not provide this information or she is able to recomprovide this information to the information to the information to the information was accorded for 2 of 2 residirectives (Resident The findings included 1. Resident #47 was 06/03/22. A review of the code at the nursing station revealed a yellow get a record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed and the provided record of the code at the nursing station revealed a yellow get and the provided record of the code at the nursing station revealed and the provided record of the code at the nursing station revealed and the provided record r	written description of the mplement advance directives e law. rmitted to contract with other is information but are still for ensuring that the section are met. dual is incapacitated at the ind is unable to receive illate whether or not he or she wance directive, the facility directive information to the representative in accordance at relieved of its obligation to tion to the individual once he reive such information. The must be in place to provide the individual directly at the series and interviews the cure the code status curate throughout the medical idents reviewed for advanced to #47 and Resident #53). The status notebook maintained on on 12/19/23 at 11:05 AM olden rod code status of Do	F 5	Disclaimer: The following infor provided by request, in follow-to-survey conducted, and does not the facility admitting to, or agrealleged deficient practice. 1.The Code status for resident: #53 were verified and entered into all relevant locations within medical record on 12/20/2023. 2.Every Resident is identified a potentially being affected by the deficient practice. An audit was	up to the of represent reing to, the s # 47 and consistently in the se reported s performed	
	,	NR) dated 06/08/23. rterly Minimum Data Set		by the Health Informatics Direct Medical Records on 12/20/202 that no other residents had any	3 to ensure	

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AND DLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345328	B. WING			12	/21/2023
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		72172020
				600 E	BARRETT LANE		
GIVENS H	EALTH CENTER				EVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	Continued From page	e 5	F 5	78			
	assessment dated 09 cognition was severe			c	ndvances directive/code status locumented in the Medical Record. N other residents were identified.	0	
	A review of Resident	#47's medical record on					
	12/19/23 at 11:05 AM	l revealed an advanced		3	3.The Health Services Director		
	directive status of Ca	rdiopulmonary Resuscitation		r	e-educated the Director of Nursing,		
	(CPR).				nursing supervisors, Social Worker,		
					lealth Services Life Enrichment Direc		
		AM an interview was			Health Services Life Enrichment Assis		
		e #1 who explained the			Director, and Medical Records person	nel	
		s was maintained in their			on the documentation procedures for advanced directives and code status or		
		cord under their picture on The Nurse also stated their			01/18/2024. All new hires for staff that		
		maintained in the code			esponsible for the advanced	ale	
		h was kept at the nurses'			lirectives/code status documentation		
	station on the unit. Th	· · · · · · · · · · · · · · · · · · ·			procedures (Director of Nursing, nursi	na	
		e computer was the most			supervisors, Social Worker, Health	3	
		at was where the changes			Services Life Enrichment Director, He	alth	
	were made first befor	e the code status notebook.			Services Life Enrichment Assistant Director, and Medical Records person	nel)	
	An interview was con			l v	vill also be educated regarding this		
	•	20/23 at 11:43 AM. The		p	process during orientation. An addition	onal	
		that the advanced directives			hart audit of all resident□s code statu	ıs	
	_	the admission process and			vas completed on 1/10/2024. One		
		us was documented on the			liscrepancy (new admission) was		
	resident's face sheet			19	dentified and was immediately correc	ted.	
		DNR paperwork was placed			The Medical December Democrated and	d/	
		tebook at the nurses' station. d medical records was			I.The Medical Records Personnel and lesignee will perform weekly audits of		
	•	ng the code status directives			new admissions for four (4) weeks for		
	to make sure they ma	_			consistent documentation of the residence		
	to make suit they me	atoriou.			idvance directive/code status. Audit	5.11.5	
	During an interview w	vith the Director of Nursing			esults will be reported at the monthly		
	(DON) on 12/20/23 at	•			Quality Assurance Performance		
		g was responsible for putting			mprovement Committee (QAPI) meet	ings	
	•	atus in the code status			by the Medical Records Personnel and		
	notebook at the nurse	es' station and medical			lesignee where they will be reviewed		
	records was responsi	ible for making sure the			liscussed. The QAPI Committee will		
	code status was corre	ect in the electronic medical		a	ssess and modify the action plan as		

Facility ID: 923490

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	(X3) DATE SURVEY COMPLETED
	345328	B. WING _		12/21/2023
NAME OF PROVIDER OR SUPP		1	STREET ADDRESS, CITY, STATE, ZIP COD 600 BARRETT LANE ASHEVILLE, NC 28803	•
PREFIX (EACH D	IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
responsible for On 12/20/23 at conducted with explained that orders pertain directives were health record were put in the were maintain Records staff sometimes the advanced directive staff sometimes the advanced directive state of the discreptive state stated regard record indicate forms in the codest. 2. Resident #104/01/23.	om page 6 tated medical records was or ensuring the two places matched. at 12:25 PM an interview was th Medical Records personnel who t she made sure the paperwork and aing to the residents' advance re signed and dated in the electronic and made sure the DNR forms e code status notebooks which ned at the nurses' desk. The Medical continued to explain that e doctors will change the residents' ective during their rounds and will estatus paperwork in the code status nking they were helping out and she was why there was a discrepancy in is advanced directive. erview with the Administrator on ancy in Resident #47's advanced as was because of human error. He less of what the electronic health ed the nurses knew to go by the ode status notebook at the nurses' 53 was admitted to the facility on e code status notebook maintained	F5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345328	B. WING _			12/21/2023
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	•	
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F 578	Continued From pag	ge 7	F 5	78		
	12/19/23 at 11:05 Af	t #53's medical record on M revealed an advanced ardiopulmonary Resuscitation				
	conducted with Nurs residents' code statu electronic medical re their profile screen. code status was also status notebook whi station on the unit. T medical record on the accurate because the	O AM an interview was see #1 who explained the us was maintained in their ecord under their picture on The Nurse also stated their or maintained in the code ch was kept at the nurses' The Nurse reported the use computer was the most part was where the changes one the code status notebook.				
	Supervisor explained were handled during the desired code staresident's face sheet notation such as the in the code status not The Supervisor states.	/20/23 at 11:43 AM. The d that the advanced directives g the admission process and itus was documented on the t in the computer and DNR paperwork was placed ptebook at the nurses' station. ed medical records was ting the code status directives				
	(DON) on 12/20/23 a explained that nursing the residents' code is notebook at the nursing records was responseded status was correcord. She stated in	with the Director of Nursing at 12:10 PM the DON ng was responsible for putting status in the code status ses' station and medical sible for making sure the rect in the electronic medical nedical records was ring the two places matched.				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED			
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F 578	Continued From pag	e 8	F 57	8		
F 582 SS=D	conducted with Mediexplained that she morders pertaining to the directives were signed health record and may were put in the code were maintained at the Records staff continus sometimes the doctor advanced directive doput the code status protebooks thinking the thought that was why Resident #53's advanced directive was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of record indicated the forms in the code status was stated regardless of records in the code status was stated regardless of records in the code status was stated regardless of records in the code status was stated regardless of records in the code status was stated regardless of recor	ors will change the residents' uring their rounds and will paperwork in the code status ney were helping out and she of there was a discrepancy in need directive. With the Administrator on the explained that the reason in Resident #53's advanced because of human error. He what the electronic health nurses knew to go by the attus notebook at the nurses' Coverage/Liability Notice (7)(18)(i)-(v)	F 58	2		1/18/24

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F 582	services; and (ii) Inform each Medic changes are made to specified in §483.10(g) section. §483.10(g)(18) The faresident before, or at periodically during the available in the facility services, including an covered under Medic facility's per diem rate (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible. (ii) Where changes alitems and services th facility must inform th 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or est deposit or charges all per diem rate, for the resided or reserved of facility, regardless of discharge notice requiv) The facility must resident representative the resident within 30 date of discharge from (v) The terms of an according to the second to the resident within 30 date of discharge from (v) The terms of an according to the second to the sec	caid-eligible resident when the items and services g)(17)(i)(A) and (B) of this acility must inform each the time of admission, and e resident's stay, of services and of charges for those by charges for services not are/ Medicaid or by the extrementation of the change as soon as is the made to charges for other at the facility offers, the eresident in writing at least ementation of the change. Or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually retained a bed in the any minimum stay or irrements. Fefund to the resident's days from the resident's	F	582			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 582	facility must not confl these regulations.	e 10 lict with the requirements of Γ is not met as evidenced	F 582			
	the facility failed to pi Facility Advanced Be prior to discharge fro	riew and interviews with staff rovide a Skilled Nursing eneficiary Notice (SNF-ABN) m Medicare Part A services eviewed for Beneficiary t #10).		Disclaimer: The following informat provided by request, in follow-up to survey conducted, and does not re the facility admitting to, or agreeing alleged deficient practice. 1.Resident # 10 expired on 12/22/2 therefore, no corrective action was possible. The Social Worker was	o the present g to, the	
	Review of the benefic Resident #10 reveale Non-Coverage (NOM Responsible Party (R NOMNC showed the be discharged from s 11/09/23 due to no fu was unable to provid provided to Resident	ed a Notice of Medicare INC) was signed by RP) on 11/06/23. The facility initiated Resident #10 skilled rehab therapy on urther progress. The facility e evidence a SNF-ABN was		re-educated by her supervisor Life Enrichment (LE) Director and the H Services Director on 12/19/2023 regarding proper notification of red of Medicare benefits. 2.Every resident with a reduction in Medicare services was identified a potentially being affected by the re deficient practice. On 12/19/2023, Social Worker and LE Director perf an audit to ensure no other resident affected similarly. Each resident ha initiation, reduction, or termination covered Medicare services since 0	dealth uction s ported the formed ats were aving an of	
	Resident #10 was dis A on 11/09/23 with re Resident #10 remain facility. During an interview of Administrator explain was responsible for p SNF-ABN forms. He	escharged from Medicare Part emaining benefit days. ed as a resident in the on 12/19/23 at 12:24 PM the ned the Social Worker (SW) providing the NOMNC and explained if Resident #10 or e the SNF-ABN form, it was		was verified by the LE Director to e proper and timely notice was provided one additional resident was identification and treceiving a Notice of non-Medicare Coverage (NOMNC) on 8/23/2023 not receive a final SNFABN. 3.Re-education was provided by the Health Services Director to the Soc Worker, Medical Records, Therapy director, Director of Nursing, and Medical Records.	ensure ded. ied as but did ee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345328	B. WING _			12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 600 BARRETT LANE ASHEVILLE, NC 28803	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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 582	at 12:35 PM. The SW responsible for provid ABN-SNF form. She of 5 to 7 days' notice who discharge, and she w For residents who rer Medicare Part A and I issued both the NOM The SW stated Resid get the ABN-SNF was	ducted with SW on 12/21/23 confirmed she was	F 5	Nurse on Medicare notifice 01/18/2024. This reeducate to denial notification police procedure for the Medical process. 4. The Life Enrichment Directory of the Social Worker is appropriate and timely accommodate and timely accommodate an audit for four residents having an initial termination of covered Medicare reduction of the conduct an audit for four residents having an initial termination of covered Medicare results of the recorded on an audit tool, be reported at the monthly Assurance Performance In Committee (QAPI) meeting Services Life Enrichment designee where they will discussed. The QAPI Corassess and modify the accommediate in the continuation of the services and modify the accommodate in the continuation of the services and modify the accommodate in the continuation of the services and modify the accommodate in the continuation of the services and modify the accommodate in the continuation of the services and modify the accommodate in the services and modify the services	ation was specific y and the re notifications rector and/or ekly, to ensure taking tion related to nefits. She will (4) weeks of all tion, reduction, or edicare services a timely notice is his will be. Audit results will y Quality improvement higs by the Health Director and/or be reviewed and mmittee will ction plan as led compliance.	
F 636 SS=B	CFR(s): 483.20(b)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	(2)(i)(iii) sessment fluct initially and periodically curate, standardized nent of each resident's	F 6	5.Completion date 01/18/	2024	1/18/24
	§483.20(b) Comprehe §483.20(b)(1) Reside	ensive Assessments ent Assessment Instrument.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345328	B. WING		12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 636	goals, life history ar resident assessmer by CMS. The assess the following: (i) Identification and (ii) Customary routin (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v (viii) Physical function (ix) Continence. (x) Disease diagnos (xi) Dental and nutri (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatme (xvi) Discharge plar (xvii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation assessment. The ainclude direct obserwith the resident, as licensed and nonlice members on all shift \$483.20(b)(2) Wher timeframes prescrib chapter, a facility massessment of a resident, as sessment of a resident assessment assessment of a resident assessment assessment of a resident assessment assessment assessment of a resident assessment	e a comprehensive sident's needs, strengths, and preferences, using the not instrument (RAI) specified esement must include at least demographic information ne. Ins. Vior patterns. Vior p	F 63	6	

PRINTED: 02/07/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345328	B. WING			12/	21/2023	
	ROVIDER OR SUPPLIER		•	60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 BARRETT LANE SHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii) Not less than once This REQUIREMENT by: Based on record revifacility failed to comp Minimum Data Set (North days of the Assessment pereviewed for resident Findings included: Resident #2 was adm 06/02/22. Review of Resident # revealed an annual North ARD of 08/10/23 was 09/08/23. During an interview of MDS Coordinator cor MDS assessment day not completed within	ction. The timeframes (3(b)) of this chapter do not (4) days after admission, as in which there is no the resident's physical or a purposes of this section, a return to the facility (4) absence for hospitalization (5) every 12 months. (6) is not met as evidenced (1) is not met as evidenced (1) assessment within 14 ent Reference Date (1) and referring to the last day (1) for 1 of 9 residents (1) assessments (Resident #2).	F	636	Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represe the facility admitting to, or agreeing to, alleged deficient practice. 1.Resident # 2 annual Minimum Data St (MDS) with an ARD of 8/10/23 was completed on 9/8/23, locked and transmitted to the CMS IQIES databas on 9/12/23. 2.Every resident was identified as potentially being affected by the reported deficient practice. On 01/12/24 the Hease Services Director audited all Minimum Data Set (MDS) schedules for completed for the most recent comprehensive assessments for all current residents. And of 01/18/2024, all current residents. And of 01/18/2024, all current residents with the lock date of 01/12/24 or prior have been completed. 3.On 01/18/24 the Interdisciplinary Team Members (MDS) nurse, Dining Services	e sent the Set e ed alth sion As s		

Facility ID: 923490

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345328	B. WING _			12/21/2023
	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE 600 BARRETT LANE ASHEVILLE, NC 28803	, ZIP CODE	
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F 636	assessments were r He explained the iss being late was ident Performance Improv process. The Admir breakdown was due Coordinator's worklo	ed he was aware MDS not being completed timely. ue with MDS assessments	F	Director, Dining Service Worker, and Health S Enrichment Assistant complete minimum da re-educated by Health on the Resident Asses (RAI) requirement to a comprehensive asses days of the assessme well as the completion federally required min (MDS) assessments. Interdisciplinary Team complete minimum da access to and will utili Scheduler in the elect software that shows th for all assessments. O is partnering with a Co Nurse Consultant to a need for additional MI with the timely complet assessments. 4.The Contracted Reg Consultant and/or des (5) Minimum Data Set four (4) weeks and the Data Sets (MDS) mor months to ensure the completed within the r frames. Audit results to on the audit tool titled (MDS) Completion. At reported at the month Performance Improve Committee meetings I and/or designee wher reviewed and discuss	ervices Life Director) that ata sets (MDS) were a Services Director sement Instrument complete all annual sements within 14 ent reference date as a schedule for all imum data set The a Members that ata sets (MDS) have ize the MDS cronic health record the completion date currently, the facility contracted Registered assess the current DS support to assist etion of MDS gistered Nurse signee will audit five ts (MDS) weekly for en five (5) Minimum anthly for two (2) assessments are required time will be documented Minimum Data Set udit Results will be ly Quality Assurance ement (QAPI) by the MDS Nurse re they will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER.		PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		345328	B. WING	·····	1	2/21/2023	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	·		
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F 636	Continued From page	e 15	F 63	Committee will assess and modaction plan as needed to ensure continued compliance. 5. Completion date 01/18/24	-		
F 637 SS=D	S483.20(b)(2)(ii) With determines, or should there has been a sign resident's physical or purpose of this section means a major declir resident's status that itself without further in implementing standal interventions, that had one area of the resider requires interdisciplinicare plan, or both.) This REQUIREMENT	hin 14 days after the facility d have determined, that	F 63			1/23/24	
	facility failed to comp Minimum Data Set (Nays after the facility change had occurred reviewed for hospice (Residents #28 and # Findings included: 1. Resident #28 was 06/27/22 with diagnor neurological condition	admitted to the facility on ses that included other		Disclaimer: The following inforr provided by request, in follow-u survey conducted, and does no the facility admitting to, or agree alleged deficient practice. 1.The MDS Nurse completed a Change in Status MDS assessr Resident #28 on 12/14/23. The MDS Nurse completed a S Change in Status MDS assessr Resident# 47 on 06/24 2. All Residents who were enrol hospice, had a change in hospice.	p to the it represent eing to, the Significant ment for ignificant ment for 4/23.		

NAME OF PROVIDER OR SUPPLIER	45328	B. WING _		40/04/0000
NAME OF PROVIDER OR SUPPLIER		1		12/21/2023
			STREET ADDRESS, CITY, STATE, ZIP CODE	·
			600 BARRETT LANE	
GIVENS HEALTH CENTER			ASHEVILLE, NC 28803	
(X4) ID SUMMARY STATEMENT OF DEFINE (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 637 Continued From page 16		F 6	37	
record revealed a significant change assessment with an Assessment Re (ARD) of 11/09/23. The MDS assessigned as completed on 12/14/23 will days after the facility determined Rehad a significant change in status. During an interview on 12/19/23 at 4 MDS Coordinator revealed she was behind on completing MDS assessment MDS Coordinator confirmed Reside significant change MDS assessment 11/09/23 was late and not complete regulatory timeframe. During an interview on 12/19/23 at 8 Administrator revealed he was awar assessments were not being complete explained the issue with MDS as being late was identified 11/27/23 at Performance Improvement Plan (Pliprocess. The Administrator stated he breakdown was due to the increase Coordinator's workload as a result of changes to the Resident Assessment (RAI) guidelines. 2. Resident # 47 was admitted to the 06/03/22 with diagnoses that included disease. Review of Resident #47's medical rerevealed an order for Hospice service dementia and weight loss dated 06/08 Review of Resident #47's significant Minimum Data Set assessment for the same of the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of the resident #47's significant Minimum Data Set assessment for the process of t	ference Date sement was shich was 36 sident #28 :35 PM, the currently ments. The street that the sements are felt the sements are felt the sin MDS of the recent street that Instrument set facility on ad Alzheimer's second sees related to 08/23. change	F 6	providers, or discontinued hos services in 2023 and through were reviewed by the health s director on 01/12/24 to determ significant change in status as had been completed timely. O deceased resident (8/03/2023 identified during the audit. How to needing current information resident, no significant change assessment was completed. The interdisciplinary team (ME Dining Services Manager, Sociand Health Services Life Enric Assistant Director) reviewed a current residents to determine significant change in status had that may warrant a significant status assessment utilizing the guidelines (consistent patterns with either two or more areas two or more areas of improver baseline as indicated by compute resident's current status to recent CMS-required MDS on new residents were identified a significant change. 3. The MDS nurse was re-educed 1/18/24 regarding the Resider Assessment Instrument (RAI) schedule requirements for fed required minimum data set (Massessments, including significont status assessments. Current facility is working on assessing	ont/10/24 ervices sine if sessments ne) was wever, due on the e OS nurse, cial Worker, chment II other if a and occurred change in e RAI s of change of decline or ment) from carison of othe most 1/23/24. No as requiring cated on at completion erally DS) cant change ntly, the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345328	B. WING		12/21/2023
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION
F 638 SS=B	Data Set (MDS) Coo PM. The Coordinato significant change M within 14 days of the then acknowledged completed 2 days pa The Coordinator exp changes in the Resic (RAI) process and th required she was be assessments. An interview was coo Administrator on 12/ Administrator explain MDS assessments w time and stated he fo the increase in the M because of the recei guidelines. Qrtly Assessment at CFR(s): 483.20(c) §483.20(c) Quarterly A facility must asses quarterly review inst and approved by CM once every 3 months This REQUIREMEN by: Based on record rev facility failed to com Set (MDS) assessm Assessment Referer ARD and referring to	inducted with the Minimum ordinator on 12/21/23 at 12:20 or explained that the IDS had to be completed election of Hospice services the assessment was assed the 14-day timeframe. Idlained that due to the recent dent Assessment Instrument the number of assessments hind on multiple or multiple o	F 63	assessments. 4. The interdisciplinary team (MDS nu Dining Services Manager, Social Worl and Health Services Life Enrichment Assistant Director) or designees will review the current census weekly for 4 weeks to determine if a significant chain status assessments was needed, at so, completed timely and according to Resident Assessment Instruction. The results will be recorded on an audit too Audit Results will be reported at the monthly Quality Assurance Performan Improvement Committee meetings by MDS Nurse and/or designee where the will be reviewed and discussed. The Quality Assurance Committee will assurand modify the action plan as needed ensure continued compliance. 5. Completion 01/23/24	ker, I ange and if the esse ol. ce the ey ess to 1/18/24 is e sent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345328	B. WING		12	2/21/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803			
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F 638	#20, #28, #48, and # Findings included: 1. Resident #2 was a 06/02/22. Review of Resident # (EHR) on 12/19/23 at following: a. A quarterly MDS a 08/10/23 was marked b. A quarterly MDS a 11/10/23 with no date. During an interview of MDS Coordinator review in the properties of th	ents (Residents #2, #6, #16, 52). admitted to the facility on #2's Electronic Health Record t 3:55 PM revealed the assessment with an ARD of d as complete on 09/08/23. assessment with an ARD of e of completion. on 12/19/23 at 4:35 PM, the realed she was currently g MDS assessments. The colained Resident #2's sment dated 08/10/23 was ne MDS assessment dated been done. She confirmed ere not completed within the on 12/19/23 at 5:11 PM, the ed he was aware MDS ot being completed timely. ue with MDS assessments	F 63	,	with ARD 20/23 with ARD 17/23 t with ARD 20/23 t with ARD 15/23 t with ARD 26/23 t with ARD 17/23 as reported the Health inimum impletion f 01/18/24, te on or impleted arry Team services ger, Social fe were ices sment complete		
	(RAI) guidelines.	lent Assessment Instrument admitted to the facility on		frequently than once every three months and within fourteen (14) the assessment reference date. Interdisciplinary Team Members nurse, Dining Services Director,	days of The (MDS		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345328	B. WING _		12/21/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
				600 BARRETT LANE	
GIVENS H	EALTH CENTER			ASHEVILLE, NC 28803	
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F 638	(EHR) on 12/19/23 following: a. A quarterly MDS 08/10/23 was marked. A quarterly MDS 11/10/23 was marked. During an interview MDS Coordinator respectively MDS asset 11/10/23 were compared within the regulatory. During an interview Administrator reveat assessments were the explained the isobeing late was identificated being late was i	#6's Electronic Health Record at 4:00 PM revealed the assessment with an ARD of ed as complete on 09/02/23. assessment with an ARD of ed as complete on 12/17/23. on 12/19/23 at 4:35 PM, the evealed she was currently ng MDS assessments. The onfirmed Resident #6's essments dated 08/10/23 and oleted late and not completed	F	Services Manager, Social Life Enrichment Assistant complete minimum data access to and will utilizer. Scheduler in the electron software that shows the offer all assessments Curre is partnering with a Control Nurse Consultant to assess need for additional MDS with the timely completion assessments. 4. The Contracted Regist Consultant and/or design (5) Quarterly Minimum Dassessments weekly for and then five (5) Quarterly Sets (MDS) monthly for the ensure assessments are the required time frame. The reported at the month Assurance Performance (QAPI) Committee meeting Services Director and/or they will be reviewed and QAPI Committee will assess the action plan as needed continued compliance. 5. Completion date 01/18	I Worker, and Director) that Sets (MDS) have the MDS ic health record completion dates ently, the facility acted Registered ess the current support to assist in of MDS ered Nurse ee will audit five eata Sets (MDS) four (4) weeks by Minimum Data wo (2) months to completed within Audit results will by Quality Improvement engs by the Health designee where ediscussed. The ess and modify dit to ensure
		te of completion. on 12/19/23 at 4:35 PM, the evealed she was currently			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED			
		345328	B. WING		12/21/2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803			
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F 638	behind on completin MDS Coordinator con quarterly MDS assert not yet been done and During an interview Administrator reveal assessments were really the explained the issessments was idented to performance Improvements. The Admir breakdown was due Coordinator's worklooch anges to the Resi (RAI) guidelines. 4. Resident #20 wand 05/18/22. Review of Resident Record (EHR) on 12 quarterly MDS assert 11/09/23 that was mand 12/15/23. During an interview MDS Coordinator resident on completing MDS Coordinator con quarterly MDS assert completed late and regulatory timeframed During an interview Administrator reveal assessments were resident and resident to the performance of the perfo	g MDS assessments. The onfirmed Resident #16's assment dated 11/13/23 has and was late. on 12/19/23 at 5:11 PM, the ed he was aware MDS not being completed timely. The weight of the increase in the MDS and as a result of the recent dent Assessment Instrument as admitted to the facility on the increase in the MDS admitted to the facility on the increase in the MDS and as a result of the recent dent Assessment Instrument as admitted to the facility on the increase in the MDS assment with an ARD of arked as complete on the increase in the increase in the MDS assment with an ARD of arked as complete on the increase in the increase in the increase in the increase in the instrument in the increase in the increase in the increase in the instrument in the increase in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the increase in the instrument in the increase in the inc	F 63	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345328	B. WING		12/21/2023
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F 638	process. The Admir breakdown was due Coordinator's worklot changes to the Resident (RAI) guidelines. 5. Resident #28 was 06/27/22. Review of Resident Record (EHR) on 12 quarterly MDS assess 08/15/23 that was m 09/04/23. During an interview MDS Coordinator rebehind on completin MDS Coordinator concurred MDS assess completed late and regulatory timeframe. During an interview Administrator reveal assessments were respectively MDS assess completed late and regulatory timeframe. During an interview Administrator reveal assessments were respectively He explained the issue being late was identified performance Improvements. The Admir breakdown was due Coordinator's worklochanges to the Resid (RAI) guidelines.	rement Plan (PIP) was in histrator stated he felt the to the increase in the MDS and as a result of the recent dent Assessment Instrument as admitted to the facility on #28's Electronic Health #19/23 at 4:15 PM revealed a sement with an ARD of arked as complete on 12/19/23 at 4:35 PM, the vealed she was currently g MDS assessments. The infirmed Resident #28's sement dated 08/15/23 was not completed within the example of the was aware MDS and being completed timely, we with MDS assessments	F 63	8	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		(X3) DATE SURVEY COMPLETED		
		345328	B. WING		12/21/2023		
	A. BUILDING B. WING E OF PROVIDER OR SUPPLIER ENS HEALTH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803 B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803 B. WING FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BID PREFIX) REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803 B. WING FROM DEFICIENCY ASHED FROM DEFICIENCY ACTION SHOULD BID PREFIX FROM DEFICIENCY)		•				
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F 638	Review of Resident Record (EHR) on 1 the following: a. A quarterly MDS 08/22/23 was mark b. A quarterly MDS 11/22/23 with no da During an interview MDS Coordinator rebehind on completin MDS Coordinator equarterly MDS assecompleted late and 11/22/23 had not ye both assessments wregulatory timefram During an interview Administrator reveausessments were He explained the is being late was iden Performance Improprocess. The Admi breakdown was due Coordinator's workl changes to the Res (RAI) guidelines.	#48's Electronic Health 2/19/23 at 4:20 PM revealed assessment with an ARD of ed as complete on 09/06/23. assessment with an ARD of ite of completion. on 12/19/23 at 4:35 PM, the evealed she was currently ing MDS assessments. The explained Resident #48's assessment dated 08/22/23 was the MDS assessment dated at been done. She confirmed were not completed within the electron on 12/19/23 at 5:11 PM, the alled he was aware MDS into being completed timely, sue with MDS assessments tified 11/27/23 and a vement Plan (PIP) was in inistrator stated he felt the electron to the increase in the MDS and as a result of the recent	F 638	,			
	02/01/23. Review of Resident Record (EHR) on 1 the following: a. A quarterly MDS 08/10/23 was market	#52's Electronic Health 2/19/23 at 4:25 PM revealed s assessment with an ARD of ed as complete on 08/31/23.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345328	B. WING _			12/	21/2023
	ROVIDER OR SUPPLIER			60	TREET ADDRESS, CITY, STATE, ZIP CODE 10 BARRETT LANE SHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641 SS=D	During an interview of MDS Coordinator revibehind on completing MDS Coordinator corquarterly MDS assess 11/10/23 were complete within the regulatory of the explained the issubeing late was identiff Performance Improve process. The Administrator's workload changes to the Resid (RAI) guidelines. Accuracy of Assessment must resident's status. This REQUIREMENT by: Based on record revifacility failed to accurate the second record revisition of the resident's status. This REQUIREMENT by: Based on record revifacility failed to accurate the second record revifacility failed to accurate the second record revisition of the second record r	as complete on 12/17/23. In 12/19/23 at 4:35 PM, the ealed she was currently MDS assessments. The firmed Resident #52's sments dated 08/10/23 and eted late and not completed imeframe. In 12/19/23 at 5:11 PM, the did he was aware MDS of being completed timely. We with MDS assessments led 11/27/23 and a sment Plan (PIP) was in estrator stated he felt the of the increase in the MDS and as a result of the recent lent Assessment Instrument lents In 12/19/23 at 5:11 PM, the did he was aware MDS of the increase in the MDS are strator stated he felt the felt the of the increase in the MDS and as a result of the recent lent Assessment Instrument lents In 12/19/23 at 5:11 PM, the did not be increase in the MDS are strator stated he felt the of the increase in the MDS and as a result of the recent lent Assessment Instrument lents In 12/19/23 at 4:35 PM, the second increase in the MDS and a second in the increase in the MDS are strator stated he felt the of the increase in the MDS and as a result of the recent lent Assessment Instrument lents In 12/19/23 at 5:11 PM, the did not be increase in the MDS are strator stated to the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated he felt the of the increase in the MDS are strator stated		538	Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represe the facility admitting to, or agreeing to, alleged deficient practice. 1. On 01/17/24 The MDS Nurse modified Resident # 6 Annual MDS Assessment with an ARD of 5/10/23 to reflect the Legisland Resident # 1.	ent the	1/18/24

PRINTED: 02/07/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345328	B. WING _			12/21/2023
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZI 600 BARRETT LANE ASHEVILLE, NC 28803	IP CODE	
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F 641	letter dated 05/17/22 expiration date of 06 facility placement with nursing facility stay calendar days. Resident #6 was ad 05/18/22 with diagnorm dementia with agital dementia with agital The annual MDS as indicated Resident # considered by the sitt to have a serious m disability or other received by the facil Resident #6 had a 3 effective 05/17/22 w 06/16/22. During an interview MDS Coordinator experience of the provided by the facil Resident #6 had a 3 effective 05/17/22 w 06/16/22. During an interview MDS Coordinator expesident #6's PASE be a Level II PASE why his annual MDS did not accurately restatus. During an interview Administrator explait was behind on compand he felt the reason	I Determination Notification 2 for Resident #6 had an 3/16/22. It was noted nursing as appropriate for a limited lasting no more than 30 mitted to the facility on oses that included vascular cion and depression. sessment dated 05/10/23 66 was not currently tate Level II PASRR process ental illness and/or intellectual lated conditions. carolina Medicaid Uniform MUST) inquiry document ity on 12/18/23 revealed 30-day Levell II PASRR ith an expiration date of con 12/19/23 at 4:35 PM, the explained she did not realize are number was considered to a determination which was assessment dated 05/10/23 affect his Level II PASRR on 12/19/23 at 5:11 PM, the ned the MDS Coordinator oleting MDS assessments on Resident #6's MDS	F6	II PASRR. On 12/20/23, Modified Resident #18 A Assessment with an ARI include Hospice care. 2. Every resident with a Land/or currently receivin services has been identification potentially affected by the deficient practice. On 01 Worker developed a list who currently had a level who were currently on HMDS Nurse then review resident's most current to ensure those MDS ite accurately. Any required modifications to the MDS were to be completed by by 01/18/24. 3. On 01/18/24 the MDS re-educated by the Heal Director on the Resident Instrument (RAI) instruct Hospice care and PASR MDS assessment. 4. The Contracted Regist Consultant and/or design least two (2) MDS assess residents who are received and two (2) MDS assess residents with Level II Puthe current MDS assess accurately. This will be consulted to the property of the current MDS assess accurately. This will be consulted to the property of the current MDS assess accurately. This will be consulted to the property of the current MDS assess accurately. This will be consulted to the property of the current MDS assess accurately. This will be consulted to the property of the current MDS assess accurately. This will be consulted to the property of the current MDS assess accurately. This will be consulted to the property of the current MDS assess accurately. This will be consulted to the property of the pro	Annual MDS D of 10/20/23 to Level II PASRR g hospice ified as being he reported 1/18/24 the Social of all residents el II PASRR and dospice care. The ed those MDS assessment ems were coded d corrections or S assessments by the MDS Nurse Nurse was the Services t Assessment tions for coding the R sections of the tered Nurse hee will review at assments for ving Hospice care sments for ASRR's to ensure ement is coded done weekly for monthly for two	
	assessment did not	on Resident #6's MDS accurately reflect his Level II an oversight due to the MDS		four (4) weeks and then (2) months. The findings on an audit tool. Audit R	will be recorded	

Facility ID: 923490

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SUR\ COMPLETE	
		345328	B. WING		12/21/2	023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	,	
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F 641	completed. 2. Resident #18 wa 07/10/18 with diagnor hypertensive heart of disease with heart for Review of Resident initiated on 10/20/22 terminal prognosis for hospice services. The Hospice Recert revealed Resident # services effective 10. The annual MDS da Resident #18 was resident #18 was resident #18 coordinator correceiving hospice careceiving hospice care	to get MDS assessments s admitted to the facility on oses that included disease and chronic kidney ailure. #18's Hospice care planterevealed in part she had a for which she had elected diffication dated 10/18/23 and the facility of the	F 64	reported at the monthly Quality Ass Performance Improvement (QAPI) Committee meetings by the Health Services Director and/or designee of they will be reviewed and discussed QAPI Committee will assess and me the action plan as needed to ensure continued compliance. 5. Completion date 01/18/24.	n where d. The nodify	
F 644 SS=D	During an interview Administrator explai was behind on comp and he felt the reason assessment did not received hospice ca the MDS Coordinaton assessments comple	ARR and Assessments	F 64	4	1/18	8/24

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		E SURVEY MPLETED
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F 644	pre-admission scree (PASARR) program of this part to the ma avoid duplicative test includes: §483.20(e)(1)Incorpifrom the PASARR le PASARR evaluation assessment, care plicare. §483.20(e)(2) Referrall residents with new serious mental disor related condition for a significant change This REQUIREMEN by: Based on record refacility failed to requisered to the serious mental disor related condition for a significant change This REQUIREMEN by: Based on record refacility failed to requise screening and Residents	inate assessments with the ning and resident review under Medicaid in subpart C eximum extent practicable to ting and effort. Coordination corating the recommendations well II determination and the report into a resident's anning, and transitions of cring all level II residents and why evident or possible der, intellectual disability, or a level II resident review upon in status assessment. T is not met as evidenced wiew and staff interviews, the	F 6		up to the ot represent	
	dated 05/17/22 for R date of 06/16/22. It placement was appr	etermination Notification letter desident #6 had an expiration was noted nursing facility opriate for a limited nursing o more than 30 calendar		alleged deficient practice. 1.The Health Informatics Direct obtained a new Preadmission and Resident Review (PASRR resident # 6 which was complet 12/20/2023. 2.Every resident is identified a being affected by the reported practice. 01/11/2024 the Healt	Screening (t) for seted on seted seted seted seted seted seted sete sete	
		mitted to the facility on oses that included vascular		Informatics Director performed all current resident's PASRRs		

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) F 644 Continued From page 27 dementia with agitation and depression. The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY) F 644 accuracy. One (1) additional resident identified as having an expired thirty (30) PASRR. On 01/15/2024, the So Worker requested a PASRR for that resident from NC MUST. This reside received a level two (2) PASRR, and FL-2 has been completed and submit	STATEMENT C AND PLAN OF	(X3) DATE SURVEY COMPLETED
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 644 Continued From page 27 dementia with agitation and depression. The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE TAG (EACH CORRECTIVE ACTION SHOULD CROSS-		12/21/2023
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(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 644 Continued From page 27 dementia with agitation and depression. The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE ACTION SHOULD CROSS-REFERENCED TO THE APPR		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 644 Continued From page 27 dementia with agitation and depression. The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. PREFIX TAG PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION TO THE APPROPRIA	GIVENS H	
dementia with agitation and depression. accuracy. One (1) additional resident identified as having an expired thirty The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. accuracy. One (1) additional resident identified as having an expired thirty (30) PASRR. On 01/15/2024, the Solid Worker requested a PASRR for that resident from NC MUST. This resident from NC	PREFIX	
identified as having an expired thirty The annual MDS assessment dated 05/10/23 indicated Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. identified as having an expired thirty (30) PASRR. On 01/15/2024, the So Worker requested a PASRR for that resident from NC MUST. This reside received a level two (2) PASRR, and FL-2 has been completed and subm	F 644	
Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document provided by the facility on 12/18/23 revealed Resident #6 had a 30-day Levell II PASRR effective 05/17/22 with an expiration date of 06/16/22. Further review revealed no evidence a PASRR evaluation was requested or a new PASRR evaluation was requested or a new PASRR had been obtained. During an interview on 12/19/23 at 5:11 PM, the Administrator explained there was no one person responsible for submitting PASRR reevaluation requests as it was an Interdisciplinary Team effort. The Administrator stated he was not sure what happened or why a PASRR evaluation request was not requested prior to Resident #6's PASRR expiration date. The Administrator explained they realized it was an issue when reviewing Resident #6's PASRR information on 12/18/23 and a request for reevaluation was submitted. to NC MUST. 3. As a result of this audit, the Health Services Director and the Health Se Life Enrichment Director in and revised the PASRR protocol to 6 this deficiency does not re-occur. Th Interdisciplinary Team (MDS Nurse, Dining Services Director, Dining Ser Manager, Social Worker, and Life Enrichment Assistant Director) and the Health Services Life Enrichment Director and the Health Services Director and the Health Services Director cocur. Th Interdisciplinary Team (MDS Nurse, Dining Services Director, Dining Ser Manager, Social Worker, and Life Enrichment Assistant Director on 01/18/2024. 4.The Health Services Life Enrichment Director will review and monitor, we explained they realized it was an issue when reviewing Resident #6's PASRR information on 12/18/23 and a request for reevaluation was submitted.	F 644	ees d ces d ces d sure es or ol

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN			(X3) DATE SURVE	ΞΥ
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F 644	Continued From page	ge 28	F 6-	Com actio cont	nmittee will assess and modify the on plan as needed to ensure inued compliance. ompletion Date 01/18/24	3	
F 645 SS=D	PASARR Screening CFR(s): 483.20(k)(1		F 64		omplotion Bate 61/16/21	1/18/	24
	. ,	ental disorder and individuals					
	or after January 1, 1 (i) Mental disorder a (i) of this section, ur authority has determindependent physic performed by a pers State mental health (A) That, because of condition of the indir	sing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) nless the State mental health nined, based on an al and mental evaluation son or entity other than the authority, prior to admission, of the physical and mental vidual, the individual requires a provided by a nursing facility;					
	and (B) If the individual is services, whether the specialized services (ii) Intellectual disables.	requires such level of ne individual requires					
	intellectual disability authority has determ (A) That, because of condition of the indi- the level of services and (B) If the individual is services, whether the	y or developmental disability nined prior to admission- if the physical and mental vidual, the individual requires a provided by a nursing facility; requires such level of the individual requires a for intellectual disability.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345328	B. WING		12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	12/2 // 2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475
F 645	Continued From pag	e 29	F 64	5	
	section- (i)The preadmission paragraph(k)(1) of the for determinations in to a nursing facility obeing admitted to the transferred for care in (ii) The State may chapreadmission screen paragraph (k)(1) of the anursing facility of (A) Who is admitted hospital after receiving hospital, (B) Who requires nurcondition for which the hospital, and (C) Whose attending before admission to the service of the service o	n a hospital. oose not to apply the ing program under nis section to the admission			
	section- (i) An individual is condisorder if the individual disorder defined in 4 (ii) An individual is contellectual disability intellectual disability or is a person with a described in 435.101 This REQUIREMENT by: Based on record rev	onsidered to have an if the individual has an as defined in §483.102(b)(3) related condition as 0 of this chapter. I is not met as evidenced riew and staff interviews, the		Disclaimer: The following information	
	facility failed to refer with mental health di	residents who were admitted sorders for a Level II		provided by request, in follow-up to the survey conducted, and does not represent	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				600 BARRETT LANE		
GIVENS H	EALTH CENTER			ASHEVILLE, NC 28803		
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F 645	Continued From page	∋ 30	F 64	45		
	(PASRR) evaluation a	for 1 of 2 residents reviewed		the facility admitting to, or agr alleged deficient practice. 1.Resident #57 was reviewed	-	
	The findings included	i:		MUST on 01/16/2024 and the Preadmission Screening and Review (PASRR) level was ol	accurate Resident	
		tion Notification letter dated esident #57 had a Level I ation date.		2.On 01/11/2024, the Health I Director completed a full audi all current residents and PAS	t/review of	
	08/01/23 with diagno	lisorder, major depressive		accuracy. Two (2) other resid identified as having inaccurat On 01/15/2024 the Social Worequested new PASRRs for the residents from NC MUST. The	e PASRRS. orker nose ese	
		mum Data Set (MDS) 3/05/23 revealed Resident o considered by the state		residents received a level two and the FL-2 □s are now beir and will be submitted to NC M	ng completed	
	illness or intellectual	ess to have a serious mental disability. Resident #57 cs on a routine basis during t period.		3.As a result of this audit, the Services Director and the Heat Life Enrichment Director have and revised the PASRR proto this deficiency does not reoccitize the protocol of	alth Services e reviewed col to ensure	
	MDS assessment dar part, Resident #57 ha disorder and received She was seen by the evaluation of mania a	g use Care Area ssociated with the admission ted 08/05/23 revealed in ad a diagnosis of bipolar d antipsychotic medications. Psychiatrist on 08/04/23 for and adjustments were made t was noted that a care plan		Interdisciplinary Team Member Nurse, Dining Services Direct Services Manager, Social Wo Life Enrichment Assistant Direct Health Services Life Enrichmer was educated on the revised Health Services Director on 0	ers (MDS ior, Dining orker, and ector) and ent Director protocol by	
	would be developed the effects. Review of a North Carlscreening Tool (NC N	for medication use and side are plan for medication use and side arolina Medicaid Uniform MUST) inquiry document by on 12/18/23 revealed		4.The Health Services Life Er Director will review and monit admissions, any resident with changes, and the list of PASF have an expiration date to en Social Worker is taking appro	or all new diagnosis RR□s that sure that the	

Facility ID: 923490

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345328	B. WING		12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, 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 COMPLETION
F 645	Continued From page	: 31	F 64	5	
F 656 SS=D	Resident #57 had a L 07/31/23. There were PASRR evaluation su 07/31/23. During an interview of Administrator explained submitting PASRR reconstruction interdisciplinary Team who should be responsively admitted with mental Level I PASRR determined the facility of information submitted assumption the hospit PASRR evaluation whow realized they couprocess for following when a resident was a mental health disorded Develop/Implement CCFR(s): 483.21(b)(1) The facility information submitted assumption the hospit PASRR evaluation whow realized they couprocess for following when a resident was a mental health disorded Develop/Implement CCFR(s): 483.21(b)(1) The facility information in the facility in the facility in the services and timeframedical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that a or maintain the resident resident resident resident resident reconditions and timeframedical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that a or maintain the resident residen	evel I PASRR effective e no requests for a Level II bmitted or completed since n 12/19/23 at 5:11 PM, the ed the current process for evaluation reviews was an a effort and he was not sure nsible for submitting PASRR quests when a resident was health disorders and had a nination. The Administrator usually went by the PASRR by the hospital with the tal had requested a Level II nen indicated. He stated he ald do better with their up on a resident's PASRR admitted to the facility with rs. comprehensive Care Plan (3) ensive Care Plans cility must develop and densive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ed in the comprehensive apprehensive care plan must	F 65	timely action related to PASRR s. SI will review weekly to ensure these PASRRs are at the proper level and/oresubmitted and that any 30-day PAS are resubmitted timely. These weekly audits will continue for at least sixty (days then randomly after. Audit Resulvill be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Health Services Life Enrichment Director and Social Worker where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. 5. Completion Date 01/18/24	or SRRS , 60) Ilts y at d/or ewed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345328	B. WING		12/21/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 656	(ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclu treatment under §48 (iii) Any specialized serenabilitative service provide as a result or recommendations. If findings of the PASA rationale in the resid (iv) In consultation wiresident's representa (A) The resident's godesired outcomes. (B) The resident's profuture discharge. Fawhether the resident community was asselocal contact agencia entities, for this purp (C) Discharge plans plan, as appropriate, requirements set for section. §483.21(b)(3) The section graph in the section of the section o	24, §483.25 or §483.40; and would otherwise be required 8.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized is the nursing facility will f PASARR a fa facility disagrees with the RR, it must indicate its ent's medical record. The resident and the ative(s)-bals for admission and reference and potential for cilities must document be seed and any referrals to resident and the resident and the resident and the resident and the resident of the resident of the resident and train to the resident and any referrals to resident and any referrals to resident and the resident of the resident and the resident and the revices provided or arranged lined by the comprehensive any entered and trauma-informed. The resident's individual care upled residents whose closed	F 656	Disclaimer: The following information provided by request, in follow-up to the survey conducted, and does not repre the facility admitting to, or agreeing to alleged deficient practice. 1.Resident #65 expired on 9/26/2023	e sent

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	· ,	TE SURVEY MPLETED
		345328	B. WING		1	2/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
GIVENS H	IEALTH CENTER			ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	08/15/23 with diagno (severe and sudden cracks or breaks but S2/S3 (referring to a L4-5 (referring to lum chronic L5 compress in the bones that male. The admission Minim 08/21/23 revealed Recognition. She require and locomotion off the assistance with all of (ADL). She received pain medication and out of 10 (numerical being the worst poss day-to-day function. The ADL Care Area A associated with the a 08/21/23 revealed in assistance with all AL She admitted with a land fractures of the severtebrae and additions tenosis, hypertensic disease, macular deghistory of falling. She for strength and mob poor pain control and independently with trees.	Imitted to the facility on ses that included acute onset) nondisplaced (bone maintains proper alignment) sacrum fracture), severed (bar fracture), and severe, ion (type of fracture or break ke up the spine) fracture. Inum Data Set (MDS) dated esident #65 had intact red supervision with eating e unit and extensive staff ther activities of daily living scheduled and as needed reported a pain level of 09 pain rating scale with 10 lible pain) that affected Assessment (CAA) admission MDS dated part, Resident #65 required DL due to limited mobility. Furinary tract infection (UTI), for acrum and fifth lumbar and diagnoses of spinal on, gastrointestinal reflux generation, weakness, and e was working with therapy ility, however, limited due to I was able to eat any set-up. It was noted a eveloped for staff assistance	F 68	therefore no correction was 2.Every resident is identified being affected by the report practice. Care plans were re 01/16/2024 by the Health In Director for all residents to comprehensive care plan had developed. All resident's car currently up to date. 3.The Interdisciplinary Team Dining Services Director, Di Manager, Social Worker, an Enrichment Assistant Direct re-educated by a Health Seron 01/18/24 on the important developing a care plan and plans to reflect the resident's condition/problem and care 4.The Contracted Registere Consultant will monitor at lecare plans weekly for two (2 monthly for 2 months to detecare plan was developed wiregulatory timeframe. The awill be recorded on an audit Care Plans. Audit Results wat the monthly Quality Assult Performance Improvement of designee where they will and discussed. The Quality Committee will assess and a action plan as needed to en	d as potentially ed deficient eviewed on formatics determine if a ad been are plans are In (MDS nurse, ning Services and Life for) were rvices Director nice of updating care is current regimen. In (MDS nurse, ning Services and Life for) were rvices Director nice of updating care is current regimen. In (MDS nurse, ning Services for the condition of the formation of the format	
	08/21/23 revealed in assistance with all AI She admitted with a land fractures of the servertebrae and additions tenosis, hypertension disease, macular deghistory of falling. She for strength and mobeor pain control and independently with tracare plan would be deand improved self-car.	part, Resident #65 required DL due to limited mobility. urinary tract infection (UTI), sacrum and fifth lumbar anal diagnoses of spinal an, gastrointestinal reflux generation, weakness, and was working with therapy ility, however, limited due to I was able to eat ay set-up. It was noted a eveloped for staff assistance		care plans weekly for two (2 monthly for 2 months to detecare plan was developed wiregulatory timeframe. The awill be recorded on an audit Care Plans. Audit Results wat the monthly Quality Assur Performance Improvement of meetings by the Health Servor designee where they will and discussed. The Quality Committee will assess and it	2) weeks, then ermine if the ithin the audit results tool titled vill be reported rance Committee vices Director be reviewed Assurance modify the essure	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345328	B. WING		1	2/21/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 600 BARRETT LANE ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	and preferred to lay find which was interfering and mobility. It was redeveloped for assess interventions to improse the fall CAA associated 08/21/23 reveal had a fall prior to adnadmission, and a carrifor risk of fall with injurand limited mobility. Review of Resident # plan on 12/20/23 reveal care plan initiated on care plan initiated on care plan initiated on other care plans development of the facil normally completed of for residents. The MIR Resident #65's care protected for a time to learn the facilibeen the reason Resident plan was not development.	icult time with pain control lat in bed to relieve pain with therapy for strength noted a care plan would be ment of pain and possible ove pain relief. Ited with the admission MDS alled in part, Resident #65 hission, none since the plan would be developed any due to weakness, pain, In 12/21/23 and a nutritional 109/01/23. There were noteloped. In 12/21/23 at 12:50 PM, the offirmed she was the MDS are of Resident #65's ity and was the one who comprehensive care plans DS Coordinator reviewed plan and stated she would comprehensive or complete. In explained she had only year and it took her some thy's system which may have ident #65's comprehensive weloped. In 12/21/23 at 12:58 PM, the the there would be developed. In 12/21/23 at 12:58 PM, the the there would be developed.	F 65	56			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345328	B. WING		12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	
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F 695 F 695 SS=D	Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respiratracheostomy care The facility must enneeds respiratory care and tracheal scare, consistent wit practice, the comproduce plan, the resid and 483.65 of this straightful This REQUIREMENT by: Based on observative resident and staff in post cautionary and the use of oxygen for respiratory care 48). The findings included 1. Resident #3 was 01/25/23 with diagrical resident and staff.	tory care, including and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced tions, record reviews and atterviews the facility failed to I safety signs that indicated or 2 of 2 residents reviewed (Resident #3 and Resident #	F 695	Disclaimer: The following information provided by request, in follow-up to the survey conducted, and does not reprete the facility admitting to, or agreeing to alleged deficient practice. 1. During the Survey, the nursing floor staff placed red warning signs indicatioxygen use on the room door of Residual Resident #48. 2. Every resident using oxygen is idental potentially being affected by the	e sent , the ng dent
	05/11/23 revealed of via nasal cannula to above 90%. An interview and ob #3 on 12/18/23 at 1 Resident lying in be with oxygen being of	nt #3's physician orders dated oxygen at 2-5 liters per minute or maintain oxygen saturation oservation made with Resident 0:44 AM revealed the ed wearing a nasal cannula delivered at 3 liters per minute, ined she wore oxygen all the		reported deficient practice. An observation audit was performed by the Director of Nursing on 12/26/2023 to ensure that residents on oxygen had red warning signs posted on the room doors indicate the use of oxygen. All were properly in place. 3. The Health Services Consultant performed an observation audit on 01/12/2024 to follow up and ensure the all residents that are on oxygen had residents.	f all ating n

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345328	B. WING _	B. WING		12/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CIVENS II	EALTH CENTER			60	00 BARRETT LANE		
GIVENS II	EALINCENIER			Α	SHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	_	2/18/23 at 10:44 AM and	F 6	695	warning signs indicating the use of oxy on the room door. All signs were prope	rly	
	warning sign posted	revealed there was no on the outside of Resident			in place. Effective 01/15/2024 the Direction of Nursing re-educated all facility licens	sed	
	#3's door to indicate of				nursing staff on the need to place the r warning signs indicating oxygen use of		
		AM an interview was e #1 who explained the			the resident⊡s room door and that the nurse applying the oxygen equipment i	ic	
		he oxygen should post the			also responsible for hanging the warning		
	oxygen in use signs on the resident's door.				sign on the door. All new licensed nurs	sing	
	An interview conductor	ed with Nurse Supervisor #1			during Nursing Orientation.		
	on 12/20/23 at 11:33	AM. The Supervisor					
	before the resident w	ygen set up was prepared as admitted to the facility			4.An observation of signs will be conducted during routine clinical round	s	
	which included the re signs posted on the d	d no smoking oxygen in use loorframes.			by the Director of Nursing, and the Nursing Administrative Assistant will all perform a visual weekly audit to ensure		
	An interview conducted with the Director of Nursing (DON) on 12/20/23 at 12:01 PM revealed the oxygen in use signs should be posted on the doorframe of all rooms that had oxygen in use in them. The DON stated the nurses should be checking the doors for the oxygen signs when they made rounds.				that each resident receiving oxygen ha the red warning sign indicating oxygen use on the room door. These weekly visual audits will be performed for thirty-days (30) days. Audit Results wil reported at the monthly Quality Assura Performance Improvement Committee meetings by the Director of Nursing or	l be nce	
	12/21/23 at 3:26 PM that he had already b oxygen signs were no doors of the residents indicated his expecta responsible for postin on the residents' door 2. Resident #48 was	with the Administrator on the Administrator explained een made aware that the of posted on some of the swho received oxygen. He tion was that nursing be go the oxygen in use signs resthat receive oxygen. admitted to the facility on 48's diagnoses included			designee. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. 5. Completion date 01/18/24		
		obstructive pulmonary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345328	B. WING		12/21/2023	
NAME OF PROVIDER OR SUPPLIER GIVENS HEALTH CENTER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 BARRETT LANE ASHEVILLE, NC 28803	1 121/1010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 695	Continued From pa	nge 37	F 695			
	Resident #48 receir rate of 2 liters per r continuous oxygen	e physician orders included ved continuous oxygen at a ninute (LPM) as needed and at 2 LPM twice daily when by for hypoxia (low levels of 's tissues).				
	AM, Resident #48 v wheelchair wearing at 2 liters per minut posted on the outsi	ion made on 12/19/23 at 9:24 was sitting in his room in his oxygen via nasal cannula set te. There was no warning sign de of the entry door to indicate in the room of Resident #48.				
	Nurse #1 explained assigned nurse for the person who init	on 12/20/23 at 11:25 AM she occasionally was the Resident #48. She revealed iates oxygen should post the s on the resident's door.				
	Nurse Supervisor # oxygen included to	on 12/20/23 at 11:33 AM t1 explained the setup for post the red no smoking on the doorframe entering the				
	Nursing (DON) on the warning signs s doorframe of all roo DON stated the nur	cted with the Director of 12/20/23 at 12:01 PM revealed should be posted on the oms with oxygen in use. The rses should be checking the gns when they make rounds.				
	Administrator reveal warning signs oxyg some of the doors	on 12/21/23 at 3:26 PM the aled he was made aware the len in use were not posted on of the residents who received led his expectation was that				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345328	B. WING			12/	21/2023
	ROVIDER OR SUPPLIER			600	REET ADDRESS, CITY, STATE, ZIP CODE 0 BARRETT LANE SHEVILLE, NC 28803		
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F 695		e 38 e for posting the oxygen in dents' doors that receive	F	695			
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(c)(d)(F	367			1/18/24
	monitoring. A facility must establis policies and procedur collections systems, a adverse event monitor procedures must include following: §483.75(c)(1) Facility	sh and implement written sh and implement written ses for feedback, data and monitoring, including bring. The policies and sude, at a minimum, the maintenance of effective d use of feedback and input					
	from direct care staff, resident representativ information will be use	other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and					
	systems to identify, coinformation from all donot limited to the facil §483.70(e) and include	maintenance of effective ollect, and use data and epartments, including but ity assessment required at ling how such information up and monitor performance					
	and evaluation of per	ology and frequency for such					
		adverse event monitoring, s by which the facility will					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345328	B. WING		12/21/2023	
NAME OF PROVIDER OR SUPPLIER GIVENS HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	1 12/2 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 867	analyze and use data adverse events in the facility will use the day prevent adverse events and track performance implementing those and track performance implements are resulting to the facility will use determine underlying impacting larger systemic has been determined in the determined in the facility will be designed to elevel to prevent qual safety problems; and (iii) How the facility wor its performance in ensure that improve \$483.75(e) Program \$483.75(e) Program \$483.75(e) (1) The facility wor in the facility wore	fy, report, track, investigate, a and information relating to e facility, including how the ata to develop activities to ents. systematic analysis and acility must take actions be improvement and, after actions, measure its success, and its entire actions, measure its success, ace to ensure that ealized and sustained. acility will develop and addressing: a systematic approach to grauses of problems tems; a systematic approach to grauses of problems tems; allow of care, quality of life, or devill monitor the effectiveness in provement activities to ments are sustained. activities. activities. activities that focus on the, or problem-prone areas; and affect health eafety, resident autonomy,	F 86	7		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345328	B. WING		12/21/2023	
	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803		'	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 867	activities must track resident events, an implement preventi that include feedba facility. §483.75(e)(3) As primprovement activities distinct performance number and freque conducted by the facility and complexity of the available resources assessment required Improvement project annually a project the problem-prone area collection and analy (c) and (d) of this second (d) of this second (e) of this second (e) of this section. The contraction is section in the contraction is section. The contraction is section in the contraction is section in the contraction is section. The contraction is section in the contraction is section. The contraction is section in the contraction is section. The contraction is section in the contraction is section in the contraction is section. The contraction is section in the contraction is section in the contraction is section. The contraction is section in the contraction is section. The contraction is section in the contraction is section in the contraction is section in the contraction is section. The contraction is section in the contraction is section in the contraction is section. The contraction is section in the contraction is section in the contraction is section.	ormance improvement or medical errors and adverse alyze their causes, and ve actions and mechanisms ck and learning throughout the art of their performance ties, the facility must conduct the improvement projects. The incy of improvement projects acility must reflect the scope the facility's services and so, as reflected in the facility and at §483.70(e). The course of the hold of the data are proportion of the QAPI and are paragraphs (a) through the data are gimen reviews, and act on the including are the QAPI program and data are gimen reviews, and act on the control of the QAPI and analyze data, including are the QAPI program and data are gimen reviews, and act on the control of the QAPI program and data are gimen reviews, and act on the control of the QAPI and analyze data, including are the QAPI program and data are gimen reviews, and act on the control of the QAPI program and data are gimen reviews, and act on the control of the QAPI program and data are gimen reviews, and act on the control of the QAPI program and data are gimen reviews, and act on the control of the QAPI program and data are gimen reviews, and act on the control of the QAPI program and data are gimen reviews, and act on the control of the QAPI program and data are gimen reviews.	F 867			

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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 867 Continued From page 41		F 8	67			
	Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following the annual recertification and complaint surveys conducted on 04/09/21 and 08/26/22. This was for a repeat deficiency for failure to provide beneficiary notice originally cited on 04/09/21 and subsequently recited on the annual recertification survey conducted on 12/21/23. The repeat deficiency for failure to develop and implement a comprehensive care plan was originally cited during the recertification and complaint survey conducted on 08/26/22 and subsequently recited on the annual recertification survey conducted on 12/21/23. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings included:			Disclaimer: The following inf provided by request, in follow survey conducted, and does the facility admitting to, or ag alleged deficient practice. 1.On 1/15/2024 the Health S Director contacted the Qualit Improvement Organization (C State Quality Monitoring by a facility Quality Improvement state Quality Improvement S Director reviewed the survey the repeat deficiencies F582 and developed monitoring to cited deficiency as part of the correction developed with Director developed with Director, Admiss Coordinator, Social Worker, Informatics Director, Health S Consultant and Contracted F Nurse Consultant.	ervices y QIO) with the email to enlist support. ervices findings for and F656 ols for each e plan of rector of Services Life ions Health Services	
	staff the facility failed Facility Advanced Bo prior to discharge fro for 1 of 3 residents r Notification (Resider During the recertifica conducted on 04/09/ provide the Centers	ord review and interviews with d to provide a Skilled Nursing eneficiary Notice (SNF-ABN) om Medicare Part A services eviewed for Beneficiary at #10). ation and complaint survey '21, the facility failed to for Medicare and Medicaid sing Facility Advanced		3.On 01/18/24 the Health Se Director held a meeting with leadership consisting of Director Nursing, Resident Care Coor Social Worker, Administrative Health Services Life Enrichm Health Services Life Enrichm Director, Assistant Dining Services Ma Minimum Data Set (MDS) Nu Environmental Services Supplementary of Directors o	Departmental ctor of rdinator, e Assistant, ent Director, ent Assistant ervices nager	
	Beneficiary Notice (f	orm CMS-10055 SNF ABN) discharge from Medicare Part 2 of 3 residents reviewed for		Nursing Administrative Assist Services Admissions Coordir Medical Records Personnel	tant, Health nator, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345328	B. WING		.	12/21/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 867	resident's individual of sampled residents who reviewed (Resident # During the recertifical conducted on 08/26/2 develop a care plan of anticoagulation media residents reviewed for During an interview of Administrator reveals held to review quality trends and audits we as needed. He stated and the MDS Coordin requirements played deficiencies. He explicate the software the facility submission of MDS and not completed timesident's care plan. SNF-ABN forms those included in the review Medicare Non-Covertimely. Influenza and Pneum CFR(s): 483.80(d)(1)	rd review and staff failed to develop a plan that addressed a pare needs for 1 of 3 pose closed records were 65). Ition and complaint survey 22 the facility failed to por hospice care and pation use for 1 of 5 r unnecessary medications. In 12/21/23 at 5:15 PM the d monthly meetings were measures and identify the completed and modified If the change in leadership pator and the new MDS a role in the repeat of ained there were issues with the used that caused the ssessments to be rejected mely that could impact the For the issuance of the the were overlooked and not the to ensure the Notice of age (NOMNC) was issued occoccal Immunizations (2)	F 88	survey findings and plans of correfor the areas of concern. 4.On 01/18/2024 the Health Servi Director implemented the followin continued monitoring measures: hoc quality assurance discussion occur weekly to discuss monitorin and to make process revisions if corrective measures are not effect b) the monitoring results will also reported to the Quality Assurance Process Improvement Committee monthly for no less than 3 months QAPI Committee will then determ continued monitoring is needed a modifications to the action plan an needed to ensure continued composition of the Scholar Committee and Process Improvement Committee and Process Improvement Committee agenda the new cited deficiencies and modification date 01/18/24	ices g a) Ad will ng results stive and be and e (QAPI) s. The ine if nd/or if re pliance. or revised ss to reflect	1/18/24
	§483.80(d) Influenza immunizations §483.80(d)(1) Influen policies and procedur	za. The facility must develop				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345328	B. WING			12/	21/2023
	ROVIDER OR SUPPLIER		•	6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 BARRETT LANE ISHEVILLE, NC 28803	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883	each resident or the receives education repotential side effects (ii) Each resident is communization Octobe annually, unless the contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv) The resident's medocumentation that in following: (A) That the resident was provided educated and potential side effirmmunization; and (B) That the resident immunization or did resident or the resident immunization or did resident or the resident immunization or did resident or the resident immunization or did resident in the resident or the resident immunization or did resident in the resident or the resident immunization or did resident immunization or did resident in the resident immunization or did resident in the resident immunization or did resident immuniz	e influenza immunization, resident's representative egarding the benefits and of the immunization; offered an influenza er 1 through March 31 immunization is medically er resident has already been as time period; or eresident's representative or refuse immunization; and dical record includes andicates, at a minimum, the	F	883			
	must develop policies that- (i) Before offering the immunization, each representative receive benefits and potential immunization; (ii) Each resident is communization, unless medically contrained already been immunication the resident or the second contrained to the second contrained c	esident or the resident's es education regarding the I side effects of the offered a pneumococcal the immunization is ated or the resident has zed; he resident's representative or refuse immunization; and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345328	B. WING			12/21/2023	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	21/2023		
ON/ENG H	IFALTU OFNITED			6	00 BARRETT LANE		
GIVENS H	EALTH CENTER			Δ	SHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	following: (A) That the resident was provided educati and potential side effirmmunization; and (B) That the resident pneumococcal immulate pneumococcal im	or resident's representative on regarding the benefits ects of pneumococcal either received the nization or did not receive munization due to medical fusal. The is not met as evidenced eiew and interviews with the facility failed to offer and the iza vaccine for 1 of 5 or immunizations (Resident).	F	8883	Disclaimer: The following information i provided by request, in follow-up to the survey conducted, and does not repres the facility admitting to, or agreeing to, alleged deficient practice. 1.On 12/21/23 consent for flu vaccine voltained from resident #5 and vaccine was administered by licensed nurse. 2.All residents were potentially affected the reported deficient practice. The Director of Nursing completed an audit	eent the vas	
	previous immunization Coordinator and will refer to the history. Prior to	ns and the Medical Records notify the DON or designee immunization, the resident ntative will be provided			Flu vaccination status on 01/18/2024. I the audit, The Director of Nursing found one (1) cognitively impaired resident without a consent for the Flu vaccine. (n d	
	and potential side efformmunization. Receip	ation regarding the benefits ects of the influenza ot of education and refusal of ocumented in the medical			01/18/2024 consent was received from the resident's representative and the vaccine was administered.		
	record. All residents waccine beginning in unless medically conwas already immuniz provided in the facility	will be offered an influenza October of each year, traindicated or the resident			3.The Director of Nursing and the Heal Informatics Director developed a prototo encourage and allow cognitively inta residents to make decisions regarding vaccinations. Re-education was completed by the Director of Nursing to	col ct	

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		345328 B. WING		NG		12/21/2023	
	ROVIDER OR SUPPLIER	,	•	STREET ADDRESS, CITY, STATE, ZIP COE 600 BARRETT LANE ASHEVILLE, NC 28803			
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F 883	record: site of admini administration; manu the vaccine; expiration person administering. Resident #5 was admo1/25/23 with diagnofailure with hypoxia (Interest of the medical revealed she was list Party (RP). Review of the immunication Resident #5 signed of covid-19 booster vaction 07/06/23. There will will be documentation to supeducation for the influction for the inf	stration; date of facturer and lot number of an date; and name of the the vaccine." Initted to the facility on ses including respiratory ow oxygen levels). It records for Resident #5 ed as her own Responsible Izations record revealed consent to receive the cine and it was administered was no consent or declination opport the facility provided uenza vaccine for 2023. In Minimum Data Set dated esident #5 cognition was not offered. In 12/21/23 at 3:46 PM the DON) revealed she was the st, and it was joint effort to munizations were offered to ned the process was for the ordinator to obtain consent the assigned nurse to be and document it was given dication Administration lee lot number and expiration	F 88	nursing supervisors on the revaccination procedure completed of 1/18/2024. Nursing Supervisities designee will be responsible flu consents for all residents. 4. The Director of Nursing will audit all new admissions were weeks during the annual Fluensure all new admits have mannual Fluvaccine, consents and Fluvaccine is given upout the resident and/or resident representative. Audit Results reported at the monthly Quali Performance Improvement Comeetings by the Director of Nodesignee. The QAPI Commit assess and modify the action needed to ensure continued for the supervision of	eted on sors or for obtaining I continue to ekly x 4 season to eceived the sare signed, in request of will be ity Assurance committee lursing or tee will in plan as compliance.		

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		345328	B. WING		12/21/2023
	NAME OF PROVIDER OR SUPPLIER GIVENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	,
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F 883	education, either ga influenza vaccine or DON explained Res asked to sign conse the influenza vaccin annual vaccinations stating Resident #5 herself. The DON coable to make her ow when the family mer the influenza vaccin Resident #5 and it was Resident #5 receive prior to admission and interview was coph with Resident #5 facility did not offer Itoday (12/21/23). Reprovided education being immunized and and did receive the During an interview Administrator stated forms for immunizations.	unable to provide flow Resident #5 received we consent, or declined the n admission to the facility. The ident #5's family member was int for Resident #5 to receive when the facility started the in October 2023 but refused was able to sign for consent confirmed Resident #5 was with healthcare decisions and mber did not sign consent for we there was no follow up with was missed. The DON stated do the pneumococcal vaccine and was up to date. Inducted on 12/21/23 at 4:54 So Resident #5 revealed the mer the influenza vaccine until wesident #5 revealed she was with the discussed the benefits of do n 12/21/23 at 5:06 PM the consent and declination ions should be followed up on the DON who was also the	F 88	3	