STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 2/3/25 through 2/6/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 734V11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 2/3/25 through 2/6/25. Event ID# 734V11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and physician interviews, the facility failed to ensure residents had pain patches removed at bedtime as ordered for 2 of 29 residents reviewed for medication errors (Residents #45 and #31). Findings included: 1. Resident #45 was admitted on 8/2/22 with multiple diagnoses including wedge compression fracture of the thoracic vertebrae numbers 11-12 (lower end of the middle section of the spine) and low back pain. The quarterly Minimum Data Set (MDS) dated 11/6/24 revealed Resident #45 was severely cognitively impaired and was documented as requiring pain management.	F 658	Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice. 1. Lidocaine patches were immediately removed by MA#1 for residents #31& #45. 2. An audit was completed by the DON on 02/07/25 for all current facility residents who were prescribed a medication patch. There were twelve (12) residents with orders for medication patches, but no others were found to have been affected by this deficient practice. 3. Education was completed by the	3/6/25

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

Electronically Signed | 02/28/2025

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 The physician order dated 1/23/25 read apply one Lidoderm (local anesthetic pain patch that contains lidocaine) 5% topical patch to T12 spine area every morning, remove Lidoderm patch each night at bedtime. A Medication Administration observation of Medication Aide (MA) #1 on 02/05/25 at 8:15 AM revealed a lidocaine patch was left in place on Resident #45's lower back dated 2/4/25. During an interview on 02/05/25 at 9:00 AM with MA #1, the MA verbalized that the overnight nurse must have forgotten to remove the pain patch from Resident #45's lower back at bedtime. In a phone interview on 02/06/25 at 7:30 AM, Nurse #1 confirmed she was the nurse for Resident #45 from 6:00pm on 2/4/25 to 6:00am on 2/5/25. Nurse #1 verbalized that, per physician order, pain patches are to be removed at bedtime. Nurse #1 stated that she got busy and forgot to remove the Lidocaine patch from Resident #45. During an interview on 02/06/25 at 11:04 AM with the facility's Physician, the Physician stated she expected staff to follow physician orders to remove a pain patch at bedtime. The Physician verbalized there was a low risk of skin irritation if the pain patch was left in place overnight. In an interview on 02/06/25 at 1:45 PM, the Director of Nursing (DON) stated that she expected nursing staff to follow physician orders. The DON also verbalized that the nurse should have removed the patch at bedtime from Resident #45 as ordered.	F 658	Director of Nursing (DON) to all current licensed nurses and medication aides related to the expectation that all medical provider orders are followed, specifically the need and expectation to follow orders on Lidocaine and other medication patches on 02/25/25. New nurses and medication aides will receive training during new hire orientation or before their next scheduled shift. 4. An observation audit will be conducted by the DON or designee three (3) times weekly on five (5) residents for four (4) weeks, five (5) residents weekly for four (4) weeks, and five (5) residents monthly for one (1) month to ensure proper medication patch application and removal. Audit results will be reported at the monthly Quality Assurance Performance Improvement Committee (QAPI) by the Director of Nursing or designee. The QAPI Committee will assess and modify the action plan as needed to ensure continued and ongoing compliance. 5. Completion date 03/06/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2	F 658		

During an interview on 02/06/25 at 2:00 PM with the Administrator, the Administrator stated that he would defer to the clinical team, but the expectation was for staff to document properly and to follow physician orders.

2. Resident #31 was admitted on 1/19/23 with multiple diagnoses including pain in the right shoulder.

The physician order dated 4/4/24 read to apply lidocaine (local anesthetic pain patch that contains lidocaine) 5% topical patch to the right shoulder every morning and remove the patch each night at bedtime.

The quarterly Minimum Data Set (MDS) dated 10/19/24 revealed Resident #31 had normal cognitive function and was documented as requiring pain management.

A Medication Administration observation of Medication Aide (MA) #1 on 02/05/25 at 08:45 AM revealed a lidocaine patch was left in place on Resident #31's right shoulder dated 2/4/25.

During an interview on 02/05/25 at 09:00 AM with MA #1, MA #1 verbalized that the overnight nurse must have forgotten to remove the pain patch from Resident #31's right shoulder at bedtime.

In a phone interview on 02/06/25 at 07:30 AM With Nurse #1, Nurse #1 confirmed she was the nurse for Resident #31 from 6:00pm on 2/4/25 to 6:00am on 2/5/25. Nurse #1 verbalized that, per physician order, pain patches are to be removed at bedtime. Nurse #1 stated she got busy and forgot to remove the Lidocaine patch from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3 Resident #31 at bedtime. During an interview on 02/06/25 at 11:04 with the facility's Physician, the Physician stated she expected staff to follow physician orders to remove a pain patch at bedtime. The Physician verbalized there was a low risk of skin irritation if the pain patch was left in place overnight. In an interview on 02/06/25 at 1:45 PM with the Director of Nursing (DON), the DON stated she expected nursing staff to follow physician orders. The DON also verbalized that the nurse should have removed the patch at bedtime for Resident #31. During an interview on 02/06/25 at 2:00 PM with the Administrator, the Administrator stated that he would defer to the clinical team, but the expectation was for staff to document properly and to follow physician orders.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and physician interviews the facility failed to ensure a resident was provided supplemental	F 695	Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent	3/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 4 oxygen per physician's orders for 1 of 2 residents (Resident #43) reviewed for oxygen. findings included: Resident #43 was admitted to the facility on 4/17/24 with multiple diagnoses that included acute respiratory failure with hypoxia (an absence of enough oxygen to sustain bodily functions). The quarterly Minimum Data Set (MDS) dated 10/21/24 revealed Resident #43 was severely cognitively impaired and was documented as requiring supplemental oxygen. The physician's order dated 10/29/24 read to administer oxygen at 2 to 3 liters per minute via nasal canula. An observation of Resident #43 occurred on 02/04/25 at 9:00 AM. Resident #43 was observed in the sitting area on the 300 hall watching television. The resident's nasal canula was in place in the resident's nostrils and the tubing was connected to a portable oxygen tank secured to the back of Resident #43's wheelchair. While observing the gauge on the portable oxygen tank, the level of oxygen was in the red zone which showed the tank was almost empty. Another observation occurred on 02/04/25 at 9:30 AM. Resident #43 was observed in the sitting area of hall 300 and his portable oxygen tank gauge remained in the red zone. On 02/04/25 at 11:13 AM Resident #43 was observed sitting in the dining room adjacent to the front lobby of the facility. Resident #43's portable oxygen tank gauge was observed to be on empty.	F 695	the facility admitting to, or agreeing to, the alleged deficient practice. 1. Resident #43 was immediately provided with a full portable oxygen tank. Resident #43□s oxygen saturation levels were taken and were at 94%. 2. On 02/06/2025 an audit was completed by the Director of Nursing of all residents who use portable oxygen tanks and the tanks we were checked to ensure they were not empty. There were no additional tanks found to be empty at that time 3. Education on the importance of monitoring oxygen regulator levels on portable tanks will be provided to all nursing team members by the Director of Nursing by 03/06/25. All new hires will be educated on monitoring oxygen regulator levels on portable tanks in new hire orientation. 4. An observation audit will be conducted by the Director of Nursing or designee for all residents with portable oxygen three (3) times weekly for four (4) weeks, then two (2) times weekly four (4) weeks, then weekly for four (4) weeks to ensure residents with portable oxygen tanks are being monitored and changed when the oxygen regulator reading is low. These Audit results will be reported at the monthly Quality Assurance Performance Improvement (QAPI) Committee by the Director of Nursing or designee. The QAPI Committee will assess and modify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 5	F 695		

The resident was not observed to be in any respiratory distress at this time.

Further observation of Resident #43 occurred on 02/04/25 at 11:27 AM. The resident was observed in the dining room. The portable oxygen tank gauge continued to read empty. Resident #43 was not in any respiratory distress at this time.

On 02/04/25 11:33 AM Medication Aide (MA) #1 was interviewed. The MA explained when a resident was on a portable oxygen tank, she would check the tank "periodically" to ensure the tank would not become empty. She further explained that any staff member could assist a resident with their portable oxygen tanks. MA #1 stated Nursing Assistant (NA) #1 had applied the portable oxygen tank to Resident #43 prior to taking him to the sitting area this morning. She also stated she had not checked Resident #43's portable oxygen tank today (02/04/25).

NA #1 was interviewed on 02/04/25 at 11:40 AM. The NA stated she normally checked residents' portable oxygen tanks every 30 minutes if the tank was already low. NA #1 explained if a resident was off the hall for reasons, such as activities, staff usually would come to let her know that the tank was low. The NA stated she had not checked Resident #43's portable oxygen tank since he left the hall for activities and lunch.

On 02/06/25 at 11:04 AM the Physician was interviewed. The Physician stated that she expected portable oxygen tanks to be checked hourly while in use. She also stated she was not sure what the facility protocol was regarding who should check portable oxygen tanks.

the action plan as needed to ensure continued and ongoing compliance.

5. Completion date 03/06/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 6 The Director of Nursing (DON) was interviewed on 02/06/25 at 1:45 PM. The DON stated activities staff, NAs and other dining room staff were expected to check portable oxygen tanks and report to nursing staff if tanks were low. She further stated that not everyone had been trained to monitor portable oxygen tanks. During an interview with the Administrator on 02/06/25 at 2:00 PM the Administrator stated he would defer the issue to the clinical team, but he expected all staff members to monitor and ensure resident's safety.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 812	Disclaimer: The following information is	3/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 7	F 812		

facility failed to ensure 5 of 36 dishes ready for use on the tray line were free from dried scattered crumb like particles, provide expiration dates for 4 of 4 frozen boxes of pureed foods, label and date one stainless steel container of gravy and four cookie sheets of bacon that was located in 1 of 5 reach in coolers, and ensure 1 of 4 dietary staff restrained hair during food preparation. These practices had the potential to affect food served to residents.

Findings included:

1. During the initial tour of the kitchen on 02/03/2025 at 11:12 AM the following areas of concern were observed. Two white scoop bowls with a yellow/orange substance on the bottom and side of each bowl and three divided plates with yellow/orange dried scattered crumb like particles. The dishes were observed on the tray line, ready to be used.

On 2/5/25 at 11:05 AM Dietary Assistant #2 was interviewed. She explained she was one of three people who checked the dishes for cleanliness. Dietary Assistant #2 revealed the person who pulled the dishes out of the dishwasher should be checking for cleanliness, the dishes should be checked again when moved to storage and a third time when moved to the tray line. She stated if dirty dishes were found on the tray line, then one of the three steps were not completed.

The interview on 2/3/25 at 11:15 AM with Dietary Manager #1 indicated the procedure for assuring dishes are clean before using was a three-step process. The first check occurred when dishes were removed from the dishwasher, the second check occurred when the dishes were put into

provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice.

1. A. On 02/03/25 identified plates, scoop bowls, and divided plates were immediately removed from service by the Dining Services Director. Identified scoop bowls were discarded, and the divided plates were cleaned/sanitized and inspected prior to usage.

B. On 02/03/25 unlabeled bacon and the container of gravy were discarded by the Dining Services Director. Unlabeled Frozen Purees were also discarded by the Dining Services Director. An inspection was completed on 02/03/25 by the Dining Services Director to ensure no further items were improperly labeled. No additional items were identified. On 02/06/25 the Dining Services Director contacted the manufacturer of frozen purees for clarification on specific expiration dates for products on hand. They provided written information certifying that products were safe to use for at least 32 months postdate of manufacture excluding Puree Bacon and Country style pork which has a shelf life of 24 months postdate of manufacture. All products were within the appropriate time frame. This information was provided to the survey team on 02/06/25.

C. On 02/06/25, DA#1 was instructed to put on a beard net. DA#1 was educated on the importance of wearing proper beard restraints when working around food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 8 storage and then a third time when dishes were moved to the tray line for use. The interview with the Administrator on 2/6/25 at 2:19 PM indicated he expected the facility to follow the policies and procedures of providing clean dishes to the residents. 2. During a continued initial tour of the kitchen on 02/03/2025 at 11:20 AM, the following items were noted in a reach in cooler: one stainless steel container with gravy with no date; four sheet pans of bacon covered with parchment paper with no date; one open box containing twenty-three packages of frozen pureed green beans with no use by dates marked; one open box containing twenty-four packages of frozen pureed seasoned peas with no used by dates marked; one closed box and one open box for a total of thirty-nine packages of pureed corn on the cob with no use by date marked. Interview with Dietary Assistant #1 on 2/6/25 at 10:20 AM indicated he thought pureed frozen foods were good for six months after the printed packaged on date. He reported that if food had been in the cooler for six months, he threw it away. An interview with Dietary Manager #1 on 02/02/2025 at 11:25 AM indicated the bacon and gravy were part of the daily prep for breakfast and everyone, "just knows" that it was prepared the day before. Dietary Manager #1 revealed he did not know how long after the printed "packaged on" date the frozen pureed food was good. He was observed to ask the person who ordered the food and Dietary Manager #1 reported he wasn't sure but thought it was one year.	F 812	2. No residents were affected by the alleged deficient practice however all residents who consume food could have potentially been affected by the reported deficient practice. 3. All Dining Services Team members were educated by Dining Services Leadership (Dining Services Director and Dining Services Manager) on the importance of proper sanitation/cleanliness of all items prior to usage. All Dining Services Team members will be educated by Dining Services Leadership (Dining Services Director and Dining Services Manager) on the importance of proper labeling/dating when storing food items. A review and revision of the hair restraint policy was conducted by Dining Services Leadership in conjunction with the Health Services Director. Dining Services Team members will be educated by Dining Services Leadership (Dining Services Director and Dining Services Manager) on the importance of proper use of Hair restraints (hair and beard restraints. This will be completed by 03/06/25. All new hires will be educated on procedures during new hire orientation. 4. A. Dining Services Director or designee will inspect, dishes for cleanliness, and proper dishwashing procedures five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for three (3) months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 9 Documentation provided by Dietary Manager #1 revealed pureed frozen foods were considered usable for 32 months after the packaged-on date printed on the containers. During an interview with the Administrator on 2/6/25 at 2:19 PM he indicated he expected the facility to follow the policies and procedures of dating food containers. 3. On 2/5/25 at 11:10 AM during the process of checking food temperatures on the steam table, Dietary Aide #1 was observed leaning over the food to assess temperatures. Dietary Aide #1 was observed with facial hair approximately an inch long. He was not wearing a hair restraint on his face. An interview with the Dietary Manager #1 on 2/5/25 11:12 AM indicated that all employees were expected to wear appropriate hair covering when preparing food. During an interview with Dietary Aide #1 on 2/6/25 at 10:20 AM, he indicated kitchen staff were always supposed to have a hair restraint on head and face if they have a beard when working around food. He reported he thought his hair was about three inches long and was observed to sit just above the top of his shoulders. He reported his beard was about a quarter to one inch long and was observed to not hang off his chin. An interview with the Administrator on 2/6/25 at 2:19 PM indicated he expected staff to follow the policies and procedures for wearing hair restraints.	F 812	B. The Dining Services Director or designee will check refrigerators/coolers five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for three (3) months to ensure proper product label and dating has occurred. C. The Dining Services Director or designee will observe for appropriate usage of hair/beard nets area five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks and then monthly for three (3) months Audit results will be reported at the monthly Quality Assurance Performance Improvement Committee (QAPI) meetings by the Dining Services Director and/or designee where they will be reviewed and discussed. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance. 5. Completion date 03/06/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 10	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		3/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 11 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and physician interviews, the facility failed to ensure accurate documentation in the medical record for 2 of 29 residents (Residents #45 and #31) reviewed for accurate medical records. Findings included: 1. Resident #45 was admitted on 8/2/22.	F 842	Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice. 1. One on one education was provided to Nurse #1 over the phone concerning the deficient practice and the expectation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 12 The physician's order dated 1/23/25 read apply one Lidoderm (local anesthetic pain patch that contains lidocaine) 5% topical patch to T12 spine area every morning, remove Lidoderm patch each night at bedtime. A review of Resident #45's Medication Administration Record (MAR) for the month of February 2025 revealed Nurse #1 had documented the removal of the Lidocaine pain patch from Resident #45's lower back at 8:00 PM on 02/04/25. A medication pass observation of Medication Aide (MA) #1 on 02/05/25 at 8:15 AM revealed a lidocaine patch was left in place on Resident #45's lower back dated 2/4/25. During an interview on 02/05/25 at 09:00 AM with MA #1, the MA verbalized that the overnight nurse must have forgotten to remove the pain patch from Resident #45's lower back at bedtime. In a phone interview on 02/06/25 at 07:30 AM, Nurse #1 confirmed she was the nurse for Resident #45 from 6:00 PM on 2/4/25 to 6:00 AM on 2/5/25. Nurse #1 stated that she had documented the task as completed in the electronic medical record of Resident #45 but then "got busy" and forgot to remove the Lidocaine patch from Resident #45. In an interview on 02/06/25 at 1:45 PM, the Director of Nursing (DON) stated that the nurse should not have documented that the pain patch was removed until after the task was completed. During an interview on 02/06/25 at 2:00 PM with	F 842	that she follows MD orders and documents accurately and timely. 2. The Director of Nursing audited the medical records of all residents with medication patches to ensure the removal and documentation of these medication patches were accurate. No other residents were identified with errors. 3. Education provided to all Nurses and Medication Aides concerning the importance of proper documentation on the Medication Administration Record was completed by the Director of Nursing with a completion date of 02/27/25. New nurses and medication aides will receive training during new hire orientation related to proper and timely documentation on the Medication Administration Record. 4. An audit will be conducted by the Director of Nursing or designee three (3) times weekly on five (5) residents for four (4) weeks, five (5) residents weekly for four (4) weeks, and two (2) residents monthly for one (1) month to ensure medication patch removal is completed and documentation is accurate. Results of these audits will be reported at the monthly Quality Assurance Improvement (QAPI) Committee by the Director of Nursing or designee. The QAPI Committee will assess and modify the action plan as needed to ensure continued and ongoing compliance. 5. Completion date 03/06/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 13	F 842		

the Administrator, the Administrator stated that he would defer to the clinical team, but the expectation was for staff to document accurately.

2. Resident #31 was admitted on 1/19/23.

The physician order dated 4/4/24 read to apply lidocaine (local anesthetic pain patch that contains lidocaine) 5% topical patch to the right shoulder every morning and remove the patch each night at bedtime.

A review of Resident #31's Medication Administration Record (MAR) for February 2025 revealed Nurse #1 had documented the removal of the pain patch from Resident #31's right shoulder at 08:00 PM on 02/04/25.

A medication pass observation of Medication Aide (MA) #1 on 02/05/25 at 08:45 AM revealed a lidocaine patch was left in place on Resident #31's right shoulder dated 2/4/25.

During an interview on 02/05/25 at 09:00 AM with MA #1, MA #1 verbalized that the overnight nurse must have forgotten to remove the pain patch from Resident #31's right shoulder at bedtime.

In a phone interview on 02/06/25 at 07:30 AM With Nurse #1, Nurse #1 confirmed she was the nurse for Resident #31 from 6:00pm on 2/4/25 to 6:00am on 2/5/25. Nurse #1 stated she had documented the task as completed in the electronic medical record of Resident #31 but then "got busy" and forgot to remove the Lidocaine patch from Resident #31 at bedtime.

In an interview on 02/06/25 at 1:45 PM with the Director of Nursing (DON), the DON stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 14 the nurse should not have documented that the pain patch was removed until after the task was completed During an interview on 02/06/25 at 2:00 PM with the Administrator, the Administrator stated that he would defer to the clinical team, but the expectation was for staff to document accurately.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		3/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff	F 880	Disclaimer: The following information is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 and physician interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a urinary catheter for when Nursing Assistant (NA) #1 emptied the resident's urinary catheter bag without wearing a gown for 1 of 2 staff (NA #1) observed for infection control practices. Findings included: The facility's policy titled "Enhanced Barrier Precautions" revised on 6/2024 states EBP refers to an infection control intervention designed to reduce transmission of multi-drug organisms that employs targeted gown, and gloves use during high contact resident care activities. Observation of Resident #43's door on 02/02/25 at 12:15 PM revealed signage for Enhanced Barrier Precautions. The signage indicated that staff who are performing direct care to Resident #43 required a gown and gloves to be worn. Further observation revealed a caddy outside of Resident #43's door that contained Personal Protective Equipment (PPE) such as gowns and gloves. An observation was made of Resident #43 on 02/03/25 at 12:34 PM. Resident #43's call light had been activated. Nursing Assistant (NA) #1 was observed entering Resident #43's room and Resident #43 explaining he needed his catheter bag emptied. NA #1 was observed emptying resident's urine catheter leg bag without wearing a gown. An interview was conducted with NA #1 on 02/03/25 at 12:45 PM. The NA was asked for	F 880	provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to, the alleged deficient practice. 1. During the survey, NA#1 was educated on Enhanced Barrier Precautions by the Director of Nursing. 2. An audit conducted by the Director of Nursing on 02/06/25 of residents on enhanced barrier precautions identified any resident on enhanced barrier precautions as potentially affected by the alleged deficient practice. 3. Education provided to all staff members Nursing and Therapy Services in relation to the requirements of Enhanced Barrier precautions provided by the Director of Nursing with a completion date of 03/06/25. All new hires will be educated on precautions during new hire orientation. 4. Staff will be quizzed on posted Precautions during routine clinical rounds by the Director of Nursing or designee. At least four (4) staff members will be quizzed three (3) times per week for four (4) weeks and then then three (3) staff members two (2) times per week for four (4) weeks and then random/PRN quizzing of staff members monthly for two (2) months. Resident Care Coordinators or designees will report results from routine clinical rounds to observe staff's adherence to posted precautions three (3) times weekly for four (4) weeks, then once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345328	A. BUILDING _____ B. WING _____	02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 examples of why a resident would be on EBP. NA #1 stated EBP was usually implemented for residents with a catheter and for other reasons but could not recall any other reasons. The NA remembered having one meeting about EBP. NA #1 could not recall having any other education regarding EBP. The NA stated she was aware Resident #43 was on EBP and that she should have been wearing a gown and gloves to empty the resident's catheter. NA #1 stated she "just forgot". The physician was interviewed on 2/06/25 at 11:04 AM. The physician stated she expected staff to follow EBP protocol when giving direct care to residents with a catheter. The physician stated there was a lower risk to the residents if a gown was worn for emptying a catheter. An interview was conducted with the Director of Nursing (DON) on 02/06/25 at 1:45 PM. The DON confirmed that staff should be wearing a gown and gloves when giving direct care to residents such as changing the resident in bed, emptying a catheter, or helping a resident to the bathroom. The DON could not state why NA #1 had not worn a gown while providing direct care to Resident #43. The Administrator was interviewed on 02/06/25 at 2:00 PM. The Administrator stated that staff were educated regarding EBP annually and during the annual skills fair. The Administrator stated staff were expected to wear all PPE as needed.	F 880	weekly for four (4) weeks. Audit results will be reported at the monthly Quality Assurance Performance Improvement (QAPI) Committee by the Director of Nursing or designee. The QAPI Committee will assess and modify the action plan as needed to ensure continued ongoing compliance. 5. Completion date 03/06/25	