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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51797 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 [DATE] 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 [DATE] revealed Resident #45 was severely cognitively impaired and was documented as requiring pain management. 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. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 [DATE] 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 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51797 Based on observation, record review, and staff and physician interviews the facility failed to ensure a resident was provided supplemental 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 [DATE] 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 [DATE] 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. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51385 Based on observations and staff interviews, the 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 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51797 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 [DATE]. 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 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 [DATE]. 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51797 Based on record review, observation, and staff 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 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.