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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Givens Health Center	**600 Barrett Lane , Asheville, North Carolina, 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
E0000	Initial Comments An unannounced recertification survey was conducted on 03/16/26 through 03/18/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F39C7-H1.	E0000		04/04/2026
F0000	INITIAL COMMENTS A recertification survey was conducted from 03/16/26 through 03/18/26. Event ID# 1F39C7-H1	F0000		04/04/2026
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F0640		03/18/2026

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 reverse for further 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.

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

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F0640 SS = A	Continued from page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for discharge MDS assessments (Resident #47). The findings included: Resident #47 was admitted to the facility on 10/09/25. A review of nursing documentation dated 11/07/25 revealed Resident #47 had been discharged home. A review of Resident #47's Electronic Medical Record (EMR) revealed no discharge MDS assessment had been completed. An interview was conducted with the MDS Coordinator on 03/17/26 at 11:24 AM. She stated she received information about resident discharges during the facility's morning meetings and emails from therapy and	F0640		

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F0640 SS = A	Continued from page 2 writes them on a paper schedule she used to track discharges. The MDS Coordinator explained she tried to complete discharge MDS assessments within 5 days of discharge. She stated Resident #47 was not on her paper discharge schedule and not completing the discharge MDS assessment had been an oversight. An interview with the Director of Nursing (DON) on 03/17/26 at 11:49 AM revealed each resident who was discharged was discussed in the facility's clinical morning meetings. She stated the MDS Nurse attended the clinical morning meeting either in person or virtually and should have completed a discharge MDS for Resident #47. During an interview with the Administrator on 03/17/26 at 11:54 AM he indicated Resident #47's discharge MDS should have been completed within the required timeframe.	F0640		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F0641	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. The Minimum Data Set (MDS) Nurse modified Resident # 4 Annual MDS Assessment with an Assessment Reference Date (ARD) of 10/15/2025 to accurately reflect 2 or more falls without injury on 03/18/2026 Every resident who sustained a fall has been identified as being potentially affected by the reported deficient practice. On 04/03/2026 the Director of Nursing and Health Services Director developed a list of current residents who sustained a fall within their ARD period over the last six (6) months. The MDS Nurse then reviewed the most current MDS assessment to ensure those MDS items were coded accurately. Any required corrections or modifications to the MDS assessments were to be completed by the MDS Nurse by 04/15/2026 On 04/02/2026 the MDS Nurse was re-educated by Health Services Director and Director of Nursing on the Resident Assessment Instrument (RAI) instructions for coding J1700-J1900 Falls sections of the MDS assessment. All future nurses who may be responsible for completing section J of the MDS will be educated on coding J1700-J1900 falls sections. The Director of Nursing and/or designee will review at least three (3) MDS assessments for residents who sustained falls to ensure the current MDS assessment is coded accurately. This will be done weekly for four (4)	04/15/2026

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F0641 SS = D	Continued from page 3 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the fall history on the Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for accidents (Resident #4). Findings included: Resident #4 was admitted to the facility on 02/19/2025 with diagnoses including Alzheimer's disease, heart failure, and dementia. Review of the nurse's progress note dated 08/22/2025, a fall event record dated 09/06/2025, and the nurse's progress note dated 09/26/2025 revealed Resident #4 had three unwitnessed falls in her room where she was found sitting on floor. The notes and fall record revealed after each fall the nurse assessed Resident #4 and Resident #4 had no injury. The annual Minimum Data Set (MDS) assessment dated 10/15/2025 indicated Resident #4 had no falls since the prior assessment. During an interview of 03/18/2026 at 2:29 PM, the MDS Coordinator confirmed she completed Resident #4's fall history on the annual MDS dated 10/15/2025. She explained she reviewed the resident's fall event history when completing the assessment and coded any falls that occurred after the prior MDS. The MDS Coordinator confirmed the prior MDS was completed on 07/16/2025 and any falls from 07/17/2025 through 10/15/2025 should have been coded on Resident #4's annual MDS. She reviewed the nurse's progress notes and fall event history and stated the annual MDS dated 10/15/2025 should have been coded to reflect 2 or more falls without injury and she would modify Resident #4's assessment. During an interview on 03/18/2026 at 2:59 PM, the Director of Nursing (DON) stated MDS assessments should be accurate and correctly coded. The DON indicated she expected the annual MDS dated 10/15/2025 reflected Resident #4 had two or more falls without injury.	F0641	Continued from page 3 weeks and then monthly for two (2) months. The findings will be recorded on an audit tool. Audit Results will be reported at the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings by the Health 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. Completion date 04/15/2026	

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F0641 SS = D	Continued from page 4 During an interview on 03/18/2026 at 3:02 PM, the Administrator stated MDS assessments should be accurate and correctly coded, and the annual MDS dated 10/15/2025 should have been coded to reflect Resident #4 had fallen since the prior assessment.	F0641		