STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asheboro Rehabilitation and Healthcare Center	**400 Vision Drive , Asheboro, North Carolina, 27203**

(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 and complaint investigation survey was conducted on 08/10/25 through 08/13/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D30E8-H1.	E0000		08/26/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/10/25 through 08/13/25. Event ID# 1D30E8-H1. The following intake was investigated 781568. 3 of 3 complaint allegations did not result in deficiency.	F0000		08/26/2025
F0584 SS = B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services	F0584	1.Facility failed to have a system in place to ensure clean linens were available for bathing. Resident #62 had no ill effects related to this incident. Resident #62s bathroom was cleaned on 8/13/2025. Resident #62's toilet seat was replaced on 8/13/2025. On 8/13/2025 the staff providing care, including housekeeping for Resident #62 were educated to make frequent checks on Resident #62s bathroom to ensure bathroom was clean, floor was free of urine and briefs were discarded appropriately. 2. All residents have the potential to be affected by this deficient practice; A whole house audit of all residents' bathrooms, sinks, floors, toilets, and base of toilets for cleanliness, dryness and bathroom floors free of debris, free urine odor was completed by housekeeping supervisor/designee on 8/15/25. 3. The Director of Nursing/Designee educated all staff, including agency staff, housekeeping and maintenance on 8/15/25, on the requirements of F584; specifically, ensuring resident bathroom sinks, floors, toilets, and base of toilets are clean, dry, and bathroom floor is free of debris, briefs are discarded properly, toilet	08/26/2025

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 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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F0584 SS = B	Continued from page 1 necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean toilet seat and an environment that was free of urine odor in residents' rooms. This deficient practice affected 1 of 4 residents reviewed for a safe, clean, comfortable, homelike environment (Resident #62). The findings included: An initial observation completed on 8/10/25 at 10:50 AM revealed Resident #62's bathroom had yellow staining on the left front of the toilet seat. In addition, the trash can in the bathroom had 2 soiled adult undergarments rolled up inside, and the resident's room and bathroom smelled strongly of urine. During subsequent observations on 8/11/25 at 1:18 PM and 8/12/25 at 2:40 PM Resident #62's room and bathroom continued to have strong urine odors, and the yellow staining on the toilet seat remained. Wetness was noted on the floor surrounding the front of the toilet and seeping towards the doorway during the observation on 8/12/25. Resident #62 resided in his room during all observations, and he did not have a roommate during the survey.	F0584	Continued from page 1 seats are without stains and without odors. This in-service will be added to the facility orientation process for all newly hired staff and agency staff and will be the responsibility of the Assistant Director of Nursing/Designee. 4. The Housekeeping Manager or designee will randomly audit 15-bathroom sinks, floors, toilets, and base of toilets for cleanliness, dryness, free of debris, briefs discarded appropriately, free of odor of urine and free of stains, weekly x 12 weeks. The Maintenance Director/Designee will randomly audit 10 bathrooms weekly for 12 weeks to ensure toilet seats are without stains. The Housekeeping Manager/Designee, and Maintenance Director/Designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance = 8/26/2025	

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F0584 SS = B	Continued from page 2 An interview and observation were conducted with the Housekeeping Director on 8/12/25 at 2:45 PM. He stated on the weekends the housekeeper scheduled for the hall Resident #62 resided on began cleaning rooms at the top of the hallway first then gradually worked down the hall completing each room. Based on his estimation of the time it took to clean a room; he stated housekeeping had probably not reached Resident #62's room during the time of the observation on 8/10/25 because the weekend staff didn't report for duty until 8:30 AM. He indicated stains did not typically come off toilet seats with cleaning products, and it was the responsibility of Maintenance to change the toilet seats out if there were stains. He indicated housekeeping staff had finished cleaning Resident #62's room on 8/12/25 at the time of the interview. The Housekeeping Director further stated he completed a walkthrough of each resident's room once housekeeping staff completed all rooms, but he had not conducted a walkthrough yet that day. The Housekeeping Director accompanied this surveyor to Resident #62's room on 8/12/25 and agreed with this surveyor that the room had a strong odor of urine upon entering. He acknowledged the yellow staining on the left front of the toilet seat and stated, "there appears to be urine on the bathroom floor around the toilet". He then indicated he would have housekeeping clean the resident's room immediately. The Maintenance Director was interviewed on 8/13/25 at 8:48 AM and stated he completed facility equipment checks daily, such as functioning doorways, magnetic locks, water temperatures, and the general appearance of the hallways. However, he stated specific items that needed repair in the resident's rooms were relayed to him by a work order. He indicated he had not received a work order regarding the toilet seat in Resident #62's bathroom notifying him the toilet seat needed to be replaced. A review of the work orders he had on file did not reveal a work order for replacement of the toilet seat. The Maintenance Director added a work order for the toilet seat to be removed in Resident #62's room during the interview and stated he would have the seat changed out. An observation completed on 8/13/25 at 9:00 AM revealed Resident #62's room was clean and no longer smelled of urine. On 8/13/25 at 1:15 PM the Administrator was	F0584		

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F0584 SS = B	Continued from page 3 interviewed, and he stated housekeeping should clean the resident's room daily and ensure there are no strong odors in the resident's room.	F0584		
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 (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 staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of falls for 1 of 7 residents (Resident #97) reviewed for MDS accuracy. The findings included:	F0641	Resident #97, Minimum Data set, (MDS) was identified and corrected before transmission, to reflect correct resident number of falls during Minimum Data Set Assessment period, on 08/13/2025 by the Minimum Data Set (MDS)Nurse. All residents have the potential to be affected. A lookback audit of the resident Minimum Data Set (MDS) assessments completed in the last 30 days, was completed on 08/19/2025 by the Regional Clinical Reimbursement Manager for Identification of resident Minimum Data Set (MDS) correct coding of resident falls during Minimum Data Set (MDS) assessment period. The Regional Clinical Reimbursement Manager provided education for all Licensed Minimum Data Set (MDS) Nurses and Minimum Data Set (MDS) Coordinator on accurately coding on the Minimum Data Set (MDS) the number of falls during the assessment period. This education was completed on 8/19/2025 and will be added to the facility orientation program for all newly hired and agency Minimum Data Set (MDS) staff and will be the responsibility of the Regional Clinical Reimbursement Manager. The Regional Clinical Reimbursement Manager or Designee will audit 12 resident Minimum Data Set (MDS) assessments completed weekly for 12 weeks, to ensure correct coding of resident falls during Minimum Data Set (MDS) assessment period. The Minimum Data Set (MDS) Coordinator/Designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance = 8/20/2025	08/20/2025

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F0641 SS = D	Continued from page 4 Resident #97 was readmitted to the facility on 06/18/25 with diagnoses that included Dementia. A review of Resident #97's medical record revealed she had falls on 06/25/25 and 07/02/25 with no injuries. Resident #97 also had falls on 07/06/25 and 07/11/25 with minor injuries. A significant change Minimum Data Set (MDS) assessment, dated 07/29/25, indicated Resident #97's cognition was severely impaired and was coded for one fall with no injury since the last assessment (quarterly dated 06/24/25). An interview was conducted with the MDS Coordinator on 08/13/25 at 1:21 PM. The MDS Coordinator reviewed the MDS assessment dated 07/29/25 as well as Resident #97's medical record. The MDS Coordinator confirmed Resident #97 had 4 falls since the last assessment on 06/24/25 and should have been coded for 2 falls with no injuries and 2 falls with minor injuries. She stated it was an oversight. An interview was conducted with the Director of Nursing (DON) and the Administrator on 08/13/25 at 1:46 PM. The DON stated the MDS assessments should be coded accurately to reflect Resident 97's condition.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F0644	F644 Coordination of PASARR and Assessments. 1.Resident #66, Level II PASARR submitted on 8/12/2025 Resident #2, Level II PASARR submitted on 8/11/2025. 2. All residents with Level II PASRR Qualified conditions and those with a diagnosis of a Mental Disorder and/or Intellectual Disability have the potential to be affected. A whole house lookback audit of residents with Level II PASARR Qualified condition and those with a diagnosis of a Mental Disorder and/or Intellectual Disability, was completed by the Social Service Director/designee on 8/15/2025 for Identification of residents with Level II PASARR Qualified conditions, those with diagnosis of a Mental Disorder and/or Intellectual Disability and those with active and/or halted Level II PASARR Status. Any concerns were immediately corrected. 3. The Director of Nurse/Designee provided education on 8/15/2025 for the Social Services Director, regarding Social Services Director identification of Level II PASARR, residents with Level II PASRR Qualified condition and those with a diagnosis of a Mental	08/30/2025

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F0644 SS = D	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, the facility failed to refer residents (Residents #2 and Resident #66) for a level II Preadmission Screening and Resident Review (PASRR) for newly diagnosed serious mental illness for 2 of 2 residents reviewed for PASRR. 1. Resident #2 was admitted to the facility on 10/25/24 with diagnoses that included bipolar type depression, dementia, anxiety disorder, and frontotemporal neurocognitive disorder. She was admitted with a level 1 PASRR as of 10/25/24 and no further screening was required unless a significant change occurred to suggest a diagnosis of mental illness. Record review revealed Resident #2 was diagnosed on 03/27/25 with schizoaffective disorder. There was no evidence that a referral for level II PASRR screening was completed. Resident #2's annual Minimum Data Set dated 04/10/25 indicated she was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. An interview was conducted on 08/11/25 at 3:34 PM with the Social Worker (SW). The SW verified she was responsible for ensuring residents with a newly evident diagnosis of a serious mental illness were referred for a level II PASRR evaluation. She explained a PASRR level II screening request should have been sent at the time Resident #2 was newly diagnosed with schizoaffective disorder on 03/27/25. She verified Resident #2 had not been referred for level II evaluation at any point after the new diagnosis through present day. The SW stated she reviewed the discharge summary when a resident went to the hospital and the physician, nurse practitioner, and/or psychiatry notes to check for new diagnosis. An interview was conducted on 08/13/2025 at 12:40 PM with the Administrator in conjunction with the Director of Nursing (DON). The Administrator stated he wasn't aware a level II PASRR needed to be requested if there was a new mental health diagnosis. The DON agreed. 2. Review of Resident #66's medical record revealed the resident was admitted to the facility on 11/10/23, and a PASRR level I was completed. According to a letter dated 2/2/24 the facility received from the State of North Carolina, a level II PASRR was halted on 2/2/24 due to the resident not	F0644	Continued from page 5 Disorder and/or Intellectual Disability and those with active and /or halted Level II PASARR Status. This education will be added to the facility orientation program for newly hired Social Service Staff and will be provided by the Administrator/Designee. 4.The Administrator/Designee will complete an audit of all residents with Level II PASARR Qualified condition and those with a diagnosis of a Mental Disorder and/or Intellectual Disability, and those with active and/or halted Level II PASARR status to include all new admissions, readmissions and those residents with changes in diagnosis of a Mental Disorder and/or Intellectual Disability, and those with a change in Level II PASARR status weekly for 12 weeks. The Administrator or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance = 8/30/2025	

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F0644 SS = D	Continued from page 6 meeting the criteria for a mental illness. The letter further explained no further level I screening was required unless a significant change occurred with the individual's mental status which suggested a psychiatric disorder that was not dementia. Resident #66 was diagnosed with unspecified psychosis not due to a substance or physiological condition on 5/2/24. A review of the active medication orders revealed Resident #66 was prescribed Seroquel extended release 24 hour (an antipsychotic medication) 50 milligrams for unspecified psychosis with behaviors with a start date of 6/3/25. There was no documentation regarding a new level II PASRR request in Resident #66's chart after the new mental health diagnosis or the addition of an antipsychotic medication. Review of Resident #66's comprehensive Minimum Data Set (MDS) dated 11/2/24 assessed the resident moderately cognitively impaired and revealed the resident had been evaluated by Level II PASRR and determined to have a serious mental illness. During an interview with the Social Worker (SW) on 8/12/25 at 2:25 PM she revealed a PASRR level II referral was supposed to have been completed when a resident had a significant change of condition or a newly added mental health diagnosis. It was further revealed by the SW she believed Resident #66 already had a level II determination after she received the PASRR letter from the State of North Carolina on 2/2/24. She stated she thought the letter "H" included with the resident's PASRR number meant the determination for a level II PASRR was completed and was indefinite without need to submit anything further for the resident. An interview was conducted with the Administrator with the Director of Nursing (DON) present on 8/13/25 at 12:40 PM. The Administrator stated he wasn't aware a level II PASRR needed to be requested if there was a secondary diagnosis of a mental health condition. He stated the facility should verify they were completing PASRRs correctly. The DON agreed the facility should make sure the PASRR was correct for each resident.	F0644		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F0690	1. Resident #47, Foley Catheter order to change monthly per the urologist was entered in Resident #47s individual electronic medication record on 8/13/2025	08/26/2025

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F0690 SS = D	Continued from page 7 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to follow a urology order to change the indwelling urinary catheter monthly for 1 of 2 residents reviewed for urinary catheters (Resident #47). The findings included: Resident #47 was admitted to the facility on 5/16/25 with diagnoses that included obstructive and reflux uropathy (condition where urine flow is blocked or reversed) and neuromuscular dysfunction of the bladder (a condition where the nerves controlling bladder function are damaged).	F0690	Continued from page 7 2. All residents with Foley Catheters have the potential to be affected. The Director of Nursing/ Designee completed an audit of all residents with Foley Catheters on 8/15/2025 to ensure accurate order transcription. No discrepancies were noted in audit process. 3. The Director of Nursing/Designee provided education for all licensed nurses, including licensed agency nurses on ensuring accurate transcription of Foley Catheter orders into the resident's individual electronic medical records. This education was completed on 8/15/2025 and will be added to the facility orientation program for all newly hired licensed nurses, including agency licensed nurses and will be the responsibility the Director of Nursing/Designee. 4. The Director of Nursing/designee will audit of all residents with Foley Catheters, including new admission/re-admissions and consultation orders to ensure accuracy of order transcription 5 times a week for 12 weeks. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance = 8/26/2025	

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F0690 SS = D	Continued from page 8 A review of Resident #47's medical record indicated he was admitted from the hospital on 5/16/25 and had been utilizing a urinary catheter while at home. A review of Resident #47's physician orders included the following: · - An order dated 5/16/25 for indwelling catheter care- cleanse with soap and water every shift. · - An order dated 5/16/25 to monitor the urinary catheter output every shift. · - An order dated 5/20/25 to change the indwelling urinary catheter when occluded or leaking. · - An order dated 5/21/25 to anchor the urinary catheter tubing for safety. Check every shift for placement. A quarterly Minimum Data Set (MDS) assessment dated 6/30/25 indicated Resident #47 was cognitively intact and was coded for an indwelling urinary catheter being present. A review of Resident #47's Treatment Administration Records (TARs) from May 2025 through August 2025 indicated that the urinary catheter was changed on 6/23/25 and 7/10/25 due to leaking. Review of a urology progress note dated 7/22/25 indicated the nursing facility was to change the urinary catheter every month. A review of Resident #47's active physician orders did not include an order to change the urinary catheter monthly. Resident #47's August 2025 Medication Administration Record (MAR) and TAR were reviewed, and no entry was noted to change the urinary catheter every month which should have been scheduled for 8/22/25. On 8/12/25 at 3:00 PM, an interview occurred with Nurse #1. She had been the nurse assigned to Resident #47 on 7/22/25 when he returned from the urology appointment.	F0690		

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F0690 SS = D	Continued from page 9 Nurse #1 reviewed the urology progress note dated 7/22/25 and confirmed the provider had requested the nursing facility to change Resident #47's urinary catheter monthly. She stated that she had carried out all the other orders from the urology appointment on 7/22/25 but "didn't see" the order to change the urinary catheter monthly. Nurse #1 felt it was an oversight. Nurse #1 explained that the nurse assigned to residents that go out to appointments were responsible for transcribing any orders they returned with from the visit. In the past there was a unit manager that reviewed the specialist progress notes to ensure the orders were transcribed completely and accurate but at the time of Resident #47's appointment on 7/22/25 there was no unit manager. The Director of Nursing (DON) was interviewed on 8/13/25 at 11:45 AM and reported any resident that returned from a specialist appointment with new orders should be transcribed correctly and accurately.	F0690		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations, Registered Dietitian (RD) and staff interviews, the facility	F0693	1. Resident #11, and #88, used Tube Feeding Syringes were removed and new Tube Feeding syringe, plunger (separated from the barrel of the syringe), hung in room labeled with date, and resident name on 8/10/25. Residents # 11 and #88, Tube Feeding Pumps were cleaned on 08/12/25. Resident #3 Tube Feeding order was corrected with the Tube Feeding nutritional brand added to order on 8/12/2025. 2. All residents with Tube Feedings and Tube Feeding Pumps in use have the potential to be affected. A whole house 30-day lookback audit, of current residents receiving Tube Feeding and Tube Feeding pumps in use was completed by The Director of Nursing/designee on 8/15/2025 to ensure residents receiving Tube Feedings, Tube Feeding Pumps in use, proper storage of tube feeding syringe and plunger after use, cleanliness of tube feeding pumps and poles, and tube feeding orders were correct with the tube feeding nutritional brand entered in residents individual electronic medical records as per physician order. No other discrepancies noted. 3. The Director of Nursing/Designee educated all licensed nurses, including agency licensed nurses on ensuring residents receiving Tube Feedings, Tube Feeding Pumps in use, proper storage of tube feeding syringe and plunger after use, cleanliness of tube feeding pumps and poles, and tube feeding order accuracy including tube feeding nutritional brand	08/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

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F0693 SS = D	Continued from page 10 failed to ensure the enteral tube feed (a method of supplying nutrition through a feeding tube that goes directly into the stomach or small intestine) formula was specified in the active physician's order for Resident #3. This failure had been ongoing since June 2025. In addition, the facility failed to store a plastic enteral feeding syringe with the plunger separated from the barrel of the syringe for Resident #11 and Resident #88 which had the potential for bacterial growth and contamination. The deficient practice affected 3 of 4 residents reviewed for enteral feeding management (Resident #3, Resident #11 and Resident #88). The findings included: 1. Resident #3 was admitted to the facility on 10/18/24. Her diagnoses included a history of a stroke and diabetes type 2. A review of Resident #3's physician orders included the following: - - An order dated 1/18/25 through 6/18/25 for Glucerna 1.5 calories via a pump at 55 milliliters (ml) per hour from 8:00 PM to 12:00 noon. - - The order dated 6/18/25 read "two times a day for Nutritional Support. Administer 55 ml per hour via pump continuously for 12 hours or until total nutrient is delivered. On at 8:00 PM and off at 8:00 AM." This order did not indicate which type of formula to provide to Resident #3. A quarterly Minimum Data Set (MDS) assessment dated 7/24/25 indicated Resident #3 had moderately impaired cognition and received 51% or more of her total calories and more than 501 ml of fluids per day by enteral feedings. A review of the June 2025, July 2025 and August 2025 Medication Administration Records (MARs) read "two times a day for Nutritional Support. Administer 55 ml per hour via pump continuously for 12 hours or until total nutrient is delivered. On at 8:00 PM and off at 8:00 AM." An interview occurred with Nurse #1 on 8/12/25 at 3:00 PM. She had been assigned to care for Resident #3 on	F0693	Continued from page 10 entered in order as per physician order. This education was completed on 8/15/2025 and will be added to the facility orientation program for all newly hired licensed nurses, including new agency licensed nurses and will be the responsibility of the Director of Nursing/Designee. The Director of Nursing/Designee educated the Regional Dietitian on ensuring orders include the tube feeding nutritional brand in the order. This education was completed on 8/15/2025 and will be added to the facility orientation program for any newly hired Regional Dietitian employees and will be the responsibility of the Director of Nursing/Designee. 4. The Director of Nursing/Designee will complete an audit, of residents receiving Tube Feedings, Tube Feeding Pumps in use, proper storage of tube feeding syringe and plunger after use, cleanliness of tube feeding pumps and poles, 5 times a week for12 weeks. The Director of Nursing/Designee will audit all residents, including new admissions/re-admission with tube feeding orders to ensure accuracy and to include tube feeding nutritional brand entered in order as per physician order weekly for 12 weeks. The Director of Nursing/Designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance = 8/26/2025	

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F0693 SS = D	Continued from page 11 the 3:00 PM to 11:00 PM shift on 7/22/25, 7/29/25 and 7/31/25. Nurse #1 stated that she always provided Glucerna 1.5 formula for Resident #3 when she was assigned to her on the 3:00 PM to 11:00 PM shift. Nurse #1 reviewed the current active orders and verified the order dated 6/18/25 did not contain which enteral feeding formula to provide to Resident #3. Nurse #1 stated she didn't realize the current order didn't specify which enteral feeding formula to provide, just that she knew Resident #3 had received Glucerna 1.5 in the past. A phone interview occurred with the Registered Dietitian on 8/12/25 at 3:37 PM. She was able to review Resident #3's current physician orders and confirmed the order she wrote on 6/18/25 did not include which tube feed formula to provide to Resident #3. The Registered Dietitian explained that on 6/18/25 she adjusted Resident #3's infusion time for the enteral tube feed and felt it was an oversight not to have specified which tube feed formula to use. A phone interview was conducted with Nurse #6 on 8/12/25 at 6:19 PM. Nurse #6 had been assigned to Resident #3 on the 3:00 PM to 11:00 PM shift on 8/11/25 and stated that she had always provided Resident #3 Glucerna 1.5 for her tube feed. Nurse #6 further stated that she was unaware the current order didn't specify which enteral formula to use. A phone interview occurred with Nurse #7 on 8/13/25 at 8:58 AM. She had been assigned to Resident #3 on the 3:00 PM to 11:00 PM shift on 8/6/25. Nurse #7 stated she noticed the current order didn't specify which formula to use but she knew Resident #3 "had been on Glucerna 1.5 at one point and was a diabetic". A phone interview was completed with Nurse #10 on 8/13/25 at 11:40 AM who was assigned to care for Resident #3 on the 3:00 PM to 11:00 PM shift on 8/4/25. She recalled providing Glucerna 1.5 to Resident #3 at the time of her tube feeding and stated that she didn't notice the current order did not specify which formula to use, just that she knew Resident #3 "had used Glucerna 1.5 before". The Director of Nursing was interviewed on 8/13/25 at 11:45 AM and stated that she would expect the tube feeding orders to specify which formula to provide.	F0693		

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F0693 SS = D	Continued from page 12 A phone interview occurred with Nurse #12 on 8/13/25 at 1:56 PM. She had been assigned to care for Resident #3 from 7:00 PM to 7:00 AM on 8/2/25, 8/3/25, 8/9/25 and 8/10/25. She recalled providing Glucerna 1.5 for Resident #3's tube feed and had not noticed the current order did not include which tube feed formula to provide to Resident #3. 2. Resident #11 was admitted to the facility on 11/3/19 with diagnoses that included dysphagia (difficulty swallowing), esophageal obstruction, and severe protein-calorie malnutrition. A review of Resident #11's physician orders included the following: - - An order dated 4/2/24 for the feeding tube to be flushed with 15 milliliters (ml) of water before and after each medication administration. - -An order dated 4/3/24 for tube feed formula 1.5 calories from 9:00 PM to 9:00 AM running at 85 ml per hour for 12 hours. An annual Minimum Data Set (MDS) assessment dated 7/1/25 indicated Resident #11 had moderately impaired cognition and received 51% or more of her total calories and more than 501 ml of fluids per day by enteral feedings. During an observation of Resident #11 on 8/10/25 at 10:50 AM, the plastic syringe used to provide medications and flush the feeding tube was noted in a plastic bag hanging from the feeding pump pole with the plunger in the barrel of the syringe. Droplets of a clear liquid were noted in the tip of the syringe. Nurse #2 was interviewed on 8/10/25 at 10:57 AM and explained that she had provided Resident #11 with her medications and water flush via the feeding tube that morning. She stated that she was not aware the plunger should be removed from the barrel of the syringe and stored separately. The Director of Nursing was interviewed on 8/13/25 at 11:45 AM and stated the plunger for the enteral feeding	F0693		

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F0693 SS = D	Continued from page 13 syringe should be removed from the barrel and stored separately due to the potential for bacterial growth in the syringe tip. 3. Resident #88 was admitted to the facility on 9/17/19 with diagnoses that included traumatic brain injury and dysphagia. A review of Resident #88's physician orders included the following: - - An order dated 1/19/25 for nothing by mouth (NPO) status. - - An order dated 1/20/25 to flush feeding tube with 30 milliliters of water before and after each medication administration. An annual Minimum Data Set (MDS) assessment dated 5/7/25 indicated Resident #88 had severely impaired cognitive skills for daily decision-making and received 51% or more of her total calories and more than 501 ml of fluids per day by enteral feedings. During an observation of Resident #88 on 8/10/25 at 2:49 PM, the plastic syringe used to provide medications and flush the feeding tube was noted in a plastic bag hanging from the feeding pump pole with the plunger in the barrel of the syringe. Droplets of a clear liquid were noted in the tip of the syringe. Nurse #2 was interviewed on 8/10/25 at 2:51 PM and explained that she had provided Resident #88 with her medications and water flush via the feeding tube that morning. She stated that she was not aware the plunger should be removed from the barrel of the syringe and stored separately. The Director of Nursing was interviewed on 8/13/25 at 11:45 AM and stated the plunger for the enteral feeding syringe should be removed from the barrel and stored separately due to the potential for bacterial growth in the syringe tip.	F0693		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F0695	1. Resident #12's Oxygen canisters were properly placed in oxygen carrier and removed from resident room on 8/10/25. Resident #88's Oxygen rate was corrected and administered at the prescribed rate on 8/10/2025	08/26/2025

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F0695 SS = D	Continued from page 14 § 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 record reviews, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate (Resident #88) and failed to secure two oxygen cylinders stored in a resident's room (Resident #12) for 2 of 3 residents reviewed for respiratory care (Resident #88 and #12). The findings included: Resident #88 was admitted to the facility on 9/17/19. Her diagnoses included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). An annual Minimum Data Set (MDS) assessment dated 5/7/25 indicated Resident #88 had impaired memory and severely impaired decision-making skills. She was coded with the use of oxygen. A review of Resident #88's active physician orders included an order dated 5/27/25 for oxygen at 2 liters via nasal cannula as needed for shortness of breath. On 8/10/25 at 2:49 PM, Resident #88 was observed lying in bed with her eyes closed and oxygen flowing via a nasal cannula. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally at eye level. Resident #88 was observed lying in bed on 8/11/25 at 2:03 PM with oxygen flowing via a nasal cannula. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally at eye level. An observation was made with Nurse #1 of Resident #88's oxygen concentrator on 8/12/25 at 3:00 PM, who stated the oxygen regulator on the concentrator was set at 1.5	F0695	Continued from page 14 2. All residents with oxygen have the potential to be affected. A whole house audit of residents with oxygen in use was completed by The Director of Nursing/ Designee on 8/15/2025 of all residents receiving oxygen to ensure oxygen rate was accurate based on physician orders and oxygen canisters were secured properly in oxygen carrier when not in use. No other concerns were identified. 3. The Director of Nursing/Designee provided education for all staff on ensuring oxygen canisters are secured properly when not in use. This education was completed on 8/15/2025 and will be added to the facility orientation program for newly hired staff, including agency staff and will be the responsibility of the Director of Nursing/Designee. The Director of Nursing/Designee provided education for all licensed nurses, including licensed agency nurses on ensuring residents with oxygen have the accurate rate per physician orders. This education was completed on 8/15/2025 and will be added to the facility orientation program for newly hired licensed nurses, including agency licensed nurses and will be the responsibility of the Director of Nursing/Designee. 4.The Director of Nursing/Designee will audit 5 residents with oxygen weekly for 12 weeks to ensure the oxygen rate is accurate per physician orders. The Director of Nursing/Designee will randomly audit 5 residents with oxygen weekly for 12 weeks to ensure oxygen cannisters are properly secured in oxygen carriers. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance: 8/26/2025	

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F0695 SS = D	Continued from page 15 liters when viewed horizontally at eye level. Nurse #1 verified Resident #88 was ordered to receive 2 liters of oxygen and adjusted the rate. Nurse #1 stated that oxygen rates were checked when she provided medications throughout the day but was unable to state why she didn't notice Resident #88 was not receiving the ordered rate of oxygen. During an interview with the Director of Nursing on 8/13/25 at 11:45 AM, she indicated it was her expectation for oxygen to be delivered at the ordered rate. 2. Resident #12 was admitted to the facility on 5/9/23. A review of Resident #12's physician orders revealed an order dated 5/30/25 for supplemental oxygen at 2 liters per minute continuous for hypoxia. A review of Resident #12's quarterly Minimum Data Set (MDS) dated 6/12/25 revealed his cognition was severely impaired and he had supplemental oxygen. MDS revealed that Resident #12 required continuous oxygen while he was a resident. On 8/10/25 at 2:15pm an observation was made of Resident #12 laying in his bed wearing continuous oxygen via nasal cannula delivered at 2 liters per minute. Also observed were two free-standing unsecured oxygen E cylinders stored upright in the room between the wall and a cabinet on the left as you enter Resident #12's room. On 8/10/25 at 2:45pm the Director of Nursing (DON) was notified by the surveyor of the unsecured oxygen tanks in Resident #12's room. During an observation at 4:30pm on 8/10/25 the oxygen tanks were observed to have been removed from Resident #12's room. During an interview with Nurse Aide (NA) #1 on 8/12/25 at 1:22pm the NA explained full oxygen tanks were stored in one locked room with upright holders on the floor and empty tanks were stored in a different locked room with upright holders on the floor. NA #1 reported oxygen tanks were not stored in a resident's room unless the tank were in a holder on the back of the resident's wheelchair. On 8/12/25 at 1:27pm an interview was conducted with Nurse #3 who explained the oxygen cylinder tanks should	F0695		

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F0695 SS = D	Continued from page 16 be stored in the oxygen storage room in holders. The Nurse stated she did not notice the oxygen cylinders stored in Resident #12's room earlier this week. During an interview with the DON, in the presence of the Administrator, on 8/13/25 at 11:15am. The DON explained the oxygen cylinders should be stored in the transport caddy or in the oxygen storage room and should not be left in a resident's room unsecured.	F0695		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing	F0732	1. Nurse Staffing Information was posted on 8/10/25. 2. All residents have the potential to be affected. Audit was completed by The Director of nursing/Designee on 8/15/2025 for Identification of and posting of Nurse Staffing Information. No issues identified. 3. The Director of Nursing/Designee provided education to the scheduler, backup scheduler and licensed nurses on ensuring nurse staffing information is posted daily. This education was completed on 8/15/2025. This education will be added to the facility orientation program for newly hired schedulers, backup schedulers and licensed nurses and will be the responsibility of the Director of Nursing/Designee. 4. The Director of Nursing/Designee will audit nurse staff postings 7 times a week for 12 weeks to ensure nursing staff information is posted per regulation. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance = 8/26/2025	08/26/2025

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F0732 SS = C	Continued from page 17 data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure nurse staffing data was posted daily for 1 of 4 days of the survey conducted 8/10/25 through 8/13/25 (8/10/25). Findings included: During the initial tour of the facility on 8/10/25 at 10:00 AM, the posting of the daily staffing data was dated 8/8/25. An interview was conducted with Nurse Aide #3 on 8/10/25 at 3:40 PM who stated she was filling in for the scheduler who was currently on vacation. She indicated the scheduler did not work on the weekends, and it was up to the nursing staff to post the daily schedule on the weekends. On 8/10/25 Nurse #4 entered the facility from her reported break at 10:00 AM and stated, “I am an agency nurse, and this is my first day working. I don’t know anything, and I can’t help you.” The Director of Nursing was interviewed on 8/10/25 at 3:36 PM who stated the scheduler was responsible for posting daily staffing when she worked, but the hall nurse was responsible for the daily posting on the weekend. The Administrator was interviewed on 8/13/25 at 12:50 PM who stated the facility’s scheduler went on vacation Friday, but he expected the facility to accurately post the daily schedule.	F0732		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	1. Nurse #1 was provided education on proper hand hygiene between medication administration, in between donning and doffing gloves, after administration of eye	08/26/2025

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F0880 SS = D	Continued from page 18 §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 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	F0880	Continued from page 18 drop medication administration. Hand hygiene competency completed on 8/13/25. 2. All residents have the potential to be affected. On 8/15/2025 The Director of Nursing/Designee completed a whole house audit/hand hygiene during medication administration competency check off for all licensed nurses, including licensed agency nurses for accuracy of hand hygiene with donning and doffing of gloves while administering eye drop medication. 3. The Director of Nursing/Designee provided education for all licensed nurses, including agency nurses on ensuring hand hygiene is performed during medication administration, including eye drop medication administration, including performing hand hygiene between each resident and donning and doffing of gloves. This education was completed on 8/15/2025 and will be added to the facility orientation program for newly hired licensed nurses, including new agency nurses and will be the responsibility of the Director of Nursing/Designee. 4. The Director of Nursing designee will audit 3 nurses weekly for 12 weeks for proper hand hygiene when administering medications, between each resident, donning and doffing gloves, including eye medication administration. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Date of compliance = 8/26/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345277	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 19 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 observation, record review and Nurse Practitioner (NP) and staff interviews, the facility failed to implement their policies and procedures for hand hygiene when Nurse #1 failed to perform hand hygiene between residents during 2 of 3 medication administration observations and failed to perform hand hygiene before donning gloves and after glove removal during administration of eye drops. This deficient practice was for 1 of 5 staff members observed for infection control practices (Nurse #1). A review of the facility policy titled Medication Administration (not dated): Preparation instructions stated in part: Perform hand hygiene before preparing and administering medications. A review of the facility policy for administering eye drops (not dated) stated in part: perform hand hygiene, apply gloves, administer eye drops, remove gloves, and perform hand hygiene. A continuous observation was started on 08/13/25 at 8:11 AM and ended at 8:26 AM of Nurse #1 preparing and administering Resident #60 and Resident #48's medications. Nurse #1 was observed at the medication cart collecting the needed supplies and medications for Resident #60, surveyor accompanied Nurse #1 into the room, and Nurse #1 sat the medication cup on the bed side table. Resident #60 picked up the cup of medications and took them sitting the cup back on the	F0880		

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F0880 SS = D	Continued from page 20 bed side table. Nurse #1 picked up the empty medication cup and the water cup and exited the room. Nurse #1 did not perform hand hygiene at any time before preparing or administering Resident #60's medications. Nurse #1 went back to the medication cart and immediately started preparing Resident #48's medications without performing hand hygiene. At 8:20 AM an observation was made of Nurse #1 collecting the needed supplies and medications for Resident #48. Once in the room, Nurse #1 set down the cup of water and the medication cup, put on disposable gloves and proceeded with handing Resident #48 the medication cup and water. Nurse #1 was then observed administering eye drops to Resident #48. Nurse #1 removed her gloves and threw them away before proceeding to the medication cart in the hallway. Nurse #1 did not perform hand hygiene at any time during the continuous observation of preparing or administering medications to Resident #48. In an interview with Nurse #1 on 08/13/25 at 8:27 AM she stated she was aware she should have performed hand hygiene between residents and before donning gloves and after removing her gloves when administering eye drops. She further revealed she did not perform hand hygiene because she was nervous, and she forgot to do so. An interview was conducted on 08/13/25 at 10:44 AM with the NP. She stated staff should wash hands or use hand sanitizing gel between residents during medication administration. They should also wash their hands prior to and after eye drop administration to prevent cross contamination of bacteria. An interview was conducted on 08/13/25 at 1:43 PM with the Director of Nursing (DON) in conjunction with the Infection Preventionist (IP). The DON stated nurses were to perform hand hygiene between each resident when care was provided including medication administration. She also stated nurses were to wash hands prior to and after eye drops are administered. She indicated Nurse #1 should have performed hand hygiene between residents and prior to and after the administration of eye drops. The IP Nurse agreed with the DON.	F0880		