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

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

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 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. 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. (continued on next page)

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.

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

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

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	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 interviewed, and he stated housekeeping should clean the resident’s room daily and ensure there are no strong odors in the resident’s room.

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	345277	A. Building B. Wing	08/13/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:Resident #97 was readmitted to the facility on [DATE] 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 [DATE] 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.

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	345277	A. Building B. Wing	08/13/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE], 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 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. (continued on next page)

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	345277	A. Building B. Wing	08/13/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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.

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	345277	A. Building B. Wing	08/13/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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). 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 [DATE] 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. 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.

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, Registered Dietitian (RD) and staff interviews, the facility 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 [DATE]. 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 [DATE] 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 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. 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 [DATE] 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 [DATE] 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

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

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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** 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 [DATE]. Her diagnoses included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). An annual Minimum Data Set (MDS) assessment dated [DATE] 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 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 [DATE]. 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 [DATE] 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. (continued on next page)

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	345277	A. Building B. Wing	08/13/2025

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

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	345277	A. Building B. Wing	08/13/2025

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 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.

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	345277	A. Building B. Wing	08/13/2025

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 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.