STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213	(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
Lillington Health and Rehabilitation Center	**1995 East Cornelius Harnett Boulevard , Lillington, North Carolina, 27546**

(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
F0000	INITIAL COMMENTS The surveyor entered the facility to conduct a complaint investigation survey on 8/5/25 and exited on 8/8/25. Additional information was obtained on 8/11/25 and 8/13/25 and therefore the exit date was changed to 8/13/25. The following intakes were investigated: 2573562, 2576126, 2570074, and 2583514. One of ten allegations resulted in deficiencies.	F0000		08/20/2025
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or	F0627	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F627 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident number 5 is no longer in the facility. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice; The social work discharge planner reviewed all discharges on 8/27/25 that were scheduled for the next 7 days to ensure that the residents chosen home health agency has received the required documentation for the referral. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur. Both social work discharge planners were educated by the Regional social work and discharge planning specialist on 8/21/25 on honoring home health	09/05/2025

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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F0627 SS = D	Continued from page 1 her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge.	F0627	Continued from page 1 preferences and the referral process. The Director of Nursing will audit upcoming discharges for the next seven days weekly x8weeks to ensure that the residents chosen home health agency has received the required documentation for the referral. 4.How does the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. 5. Date of Compliance: 9/5/2025	

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F0627 SS = D	Continued from page 2 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable	F0627		

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F0627 SS = D	Continued from page 3 readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the	F0627		

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F0627 SS = D	Continued from page 4 data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff, resident, family, and home health agency staff members, the facility failed to have an effective discharge planning process that ensured a referral with all required documentation was submitted to the home health agency Resident # 5 selected resulting in a delay of planned services when the resident was discharged. This was for one (Resident # 5) of one resident reviewed for discharge services. The findings included: Resident # 5's hospital discharge summary, dated 7/25/25, revealed Resident # 5 had undergone a total left hip replacement surgery. Resident #5 was admitted to the facility on 7/25/25.	F0627		

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F0627 SS = D	Continued from page 5 Resident # 5's care plan, dated 7/28/25, noted Resident # 5 was expected to be at the facility for short term rehabilitation and return to the community setting. An intervention on the care plan noted upon discharge the resident was to be referred to community resources as indicated and per the resident or the resident's representative's preference. On 7/28/25 at 3:32 PM the Social Worker documented a discharge planning note which indicated the following information. The resident's family was involved in his care, and the resident planned to return home where he resided alone. Resident # 5's admission Minimum Data Set assessment, dated 7/31/25, revealed the resident was cognitively intact. On 8/5/25 (Tuesday) at 5:06 PM the Social Worker documented the following information. Resident # 5 was discharging home alone on 8/7/25 (Thursday). The family was aware and all equipment had been ordered. Home Health Agency # 2 was scheduled to begin services on 8/8/25 (Friday). On 8/7/25 (Thursday) at 5:02 PM the Social Worker documented the following information. The family had called and requested for the home health agency to be changed. They spoke to Home Health Agency # 1 and they would start care on 8/12/25 (which corresponded to the Tuesday following the resident's discharge the previous Thursday). According to the record, Resident # 5 was discharged home on 8/7/25 per order with home health services to be provided. Resident # 5's family member was interviewed on 8/7/25 at 3:53 PM and reported the following information. Other family members had utilized Home Health Agency # 1 in previous times and had been pleased. Therefore, Resident # 5 had wanted his home health services also provided by Home Health Agency # 1 when he was discharged. She (the family member) was helping Resident # 5 by making sure things were in place for him to go home. She (the family member) had spoken to the Social Worker on 8/4/25 (Monday) and requested that the home health referral be made to Home Health Agency # 1, and she thought this was to be set up for Resident # 5. On 8/6/25 she had left a message on the voice mail for the Social Worker to make sure everything was arranged and did not hear anything back. On the day of discharge, she learned that the referral had been sent to Home Health Agency # 2. She talked to the Social	F0627		

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F0627 SS = D	Continued from page 6 Worker who said they did not hear back from Home Health Agency # 1. She in turn called Home Health Agency # 1 and found they had not received any orders from the facility but were willing to accept him (Resident # 5) and provide services. She again let the facility know Resident # 5 wanted Home Health Agency # 1 and orders were sent to them on the day of discharge. The resident was safe and at home on the day of discharge but because the referral had not been sent in timely, Resident # 5 was having to wait on services until 8/12/25. The family member thought there should have been better communication. Resident # 5 was interviewed on 8/8/25 at 10:20 AM and reported the following information. He and his family member had talked to the Social Worker and conveyed that he wanted Home Health Agency # 1 to provide services when he went home. That had not been initially arranged and now he was having to wait until 8/12/25 for services to begin. In the interim, he was safe and had family to help until home health began. On 8/11/25 at 9:30 AM the Social Worker was interviewed and reported the following information. On 8/4/25 Resident # 5's family member did let her know that the resident preferred Home Health Agency # 1. She emailed the agency to see if they would accept the referral and did not hear back. She waited a few hours, emailed again, and did not hear back. She then made the referral to Home Health Agency # 2. She did not recall telling the resident or family about the change and she did not try to call Home Health Agency # 1 before switching the referral to another home health agency. A Scheduler at Home Health Agency # 1 was interviewed on 8/11/25 at 10:40 AM and reported the following information. They had a Healthcare Liaison who could take referrals, or the facility could call their general intake line and the information could be given to them. As the Scheduler she did not get any information related to Resident # 5 until 8/7/25 (the day of Resident # 5's discharge) and they let the facility know they could not be out until 8/12/25. Services were scheduled to begin on 8/12/25. The Scheduler was interviewed regarding if they could have started services by 8/8/25 (the day following discharge) if the facility had sent the referral information on 8/4/24 (Monday) when the family had requested services through them. The Scheduler reported that their home health agency could have done so. A Clinical Manager for Home Health Agency # 1 was interviewed on 8/11/25 at 10:50 AM and reported the services their company were to provide for Resident # 5	F0627		

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F0627 SS = D	Continued from page 7 included physical therapy, a nurse, and an aide. They did not receive the referral information until 8/7/25 and notified the facility it would be 8/12/25 before they could start, and the facility reported that was acceptable to the resident. Home Health Agency # 1's Healthcare Liaison was interviewed on 8/11/25 at 1:30 PM and reported the following information. The facility had been given instructions on how to submit information about a referral. They (Home Health Agency # 1) initially needed to have information where the resident resided, insurance information, and date of discharge. They (Home Health Agency # 1) can then let the facility know what date they can start services. They also need other items as well which included the order for services, the resident's hospital discharge summary if the resident had been hospitalized prior to the facility residency, and the last facility provider's note. She received an initial email on 8/4/25 at 10:55 AM and all the information was not sent. She thought that they were going to send the rest of the information and then she received an email just a few short hours later saying the resident was referred to another home health agency. She did not receive a call. At times she was busy, but she tried to quickly return emails and phone calls and if the facility was not able to reach her, then their home health agency had a main office that took referrals. The main office referral line information was on their website and easily accessible. Home Health Agency # 1's main office was contacted on 8/11/25 at 11:46 AM and the intake employee reported that the intake office answered the phone every day, and if the facility had not been able to reach the Healthcare Liaison, then they should have been called. On 8/11/25 the facility provided the email correspondence between their Social Worker and Home Health Agency # 1 for the date of 8/4/25. The correspondence was as follows. On 8/4/25 at 10:55 AM the Social Worker emailed Home Health Agency # 1's Healthcare Liaison and wrote, "I have [Resident # 5] that will be discharging home on Friday, he mentioned [Home Health Agency # 1]. I believe he has been a patient before, can you accept?" The email did not show any attachments or further information provided to Home Health Agency #1. Four hours later on 8/4/25 at 2:55 PM the Social Worker emailed Home Health Agency # 1's Healthcare Liaison, "I have found another company to accept, thank you."	F0627		

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F0627 SS = D	Continued from page 8 Interview with the Administrator on 8/11/25 at 1:23 PM revealed the Social Worker should have attempted to reach out again to Resident # 1's preferred home health agency when she did not hear back from the initial email on 8/4/25 and prior to making other arrangements.	F0627		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident and staff the facility failed to ensure an accurate accounting and administration of a controlled pain medication. This was for one (Resident # 5) of three residents whose controlled pain medication records were reviewed.	F0755	F755 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident number 5 is no longer in the facility. Nurse number 5 was educated by the Director of Nursing on 8/8/2025 on following the rights of medication administration and correct documentation on narcotic sheets. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing and Assistant Director of Nursing will audit all narcotic documentation sheets to ensure an accurate accounting of scheduled controlled pain medication. This will be completed by 9/1/25. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur. All nursing staff were educated on accurate documentation on the narcotic sheets on 8/22/25 by the staff development coordinator. The Director of Nursing and Assistant Director of Nursing will audit all narcotic documentation sheets to ensure an accurate accounting of scheduled controlled pain medication 2x per week for 8 weeks. 4.How does the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. 5. Date of Compliance: 9/5/2025	09/05/2025

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F0755 SS = D	Continued from page 9 The findings include: Record review revealed Resident # 5 was admitted to the facility on 7/25/25 after being hospitalized for hip replacement surgery. Review of Resident # 5's admission Minimum Data Set assessment, dated 7/31/25, revealed the resident was cognitively intact. Review of physician orders revealed an order, dated 7/30/25, for Tramadol 50 mg (milligrams) two times a day for pain for 14 days. (Tramadol is a controlled pain medication and must be signed out of storage when removed with a notation of when the medication was removed and by whom.) Review of Resident # 5's August MAR (Medication Administration Record) revealed the resident's Tramadol was scheduled for 8:00 AM and 8:00 PM. According to the MAR Nurse # 1 placed a check mark by Resident # 5's 8:00 PM dose on 8/5/25 and the electronic MAR showed Nurse # 1 signed in the electronic record she did so at 9:49 PM. Review of Resident # 5's Controlled Drug receipt/ Record/ Disposition Form revealed Nurse # 5 had written she removed Tramadol on 8/5/25 at 9:00 PM and then she placed a line through the entry noting "mistake." According to this Controlled Drug receipt/Record/ Disposition Form there was no Tramadol removed on 8/5/25 from Resident # 5's supply. Resident # 5 was interviewed on 8/8/25 at 10:20 AM and reported on the evening of 8/5/25 he needed his pain medication, and it was very late before it was administered. Resident # 5 reported he received the pain medication around 11:00 PM on 8/5/25. Nurse # 5 was interviewed on 8/8/25 at 11:56 AM and reported that she had administered Resident # 5's Tramadol on 8/5/25 around 8:30 PM or 9:00 PM. Nurse # 1 was further interviewed regarding where she had obtained the Tramadol given that there had been no Tramadol signed out from Resident # 5's supply. Nurse # 1 reported the following information. She had inadvertently removed the Tramadol from Resident #6's supply. Resident # 6 was also on Tramadol and received it on an as needed basis. She discovered the error around 7:00 AM on 8/6/25 at the end of her night-time shift. At that point she signed on Resident # 6's Controlled Drug receipt/ Record/ Disposition Form that she had removed a Tramadol dose from Resident # 6's	F0755		

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(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
F0755 SS = D	Continued from page 10 supply but did not note she had signed it out for another resident. Nurse # 1 further reported when she administered the pain medication around 8:00 PM or 9:00 PM, Resident # 5 had not indicated he had needed anything for pain earlier than his scheduled dose. A review of Resident # 6's Tramadol Controlled Drug receipt/ Record/ Disposition Form revealed the form included Resident # 6's order at the top of the form. The order was for Tramadol 50 mg every eight hours as needed. Doses were signed out on 8/5/25 at 6:01 PM and again at 10:00 PM which indicated a span of 3 hours and 59 minutes between doses. There was no notation that this was an error or that the 10:00 PM dose was signed out for another resident. During the interview with Nurse # 1 on 8/8/25 at 11:56 AM, Nurse # 1 was interviewed regarding why she did not put 8:30 PM or 9:00 PM as the time on Resident # 6's Tramadol Controlled Drug receipt/ Record/ Disposition Form since this was the time she was reporting she had inadvertently made the mistake. Nurse # 1 reported the time between 6:01 PM (Resident # 6's last removed dose) and 8:30 PM would have been close in time so she put 10:00 PM instead. The DON (Director of Nursing) was interviewed on 8/8/25 at 12:20 PM and reported the following information. When an inadvertent mistake is made in controlled pain medications, then the nurse should call a supervisor and there should be two signatures noted on the Controlled Drug receipt/ Record/ Disposition Forms what had occurred so that the records were clear and accurate. The facility's Nurse Consultant was interviewed on 8/8/25 at 3:25 PM regarding the discrepancies regarding the differing times of administration being reported by Resident # 5 and Nurse # 1 when compared to the documentation on the MAR and the removal of the Tramadol from storage. According to the Nurse Consultant nurses should document the times controlled pain medications are administered and they should match the MAR and the Controlled Drug receipt/ Record/ Disposition Forms.	F0755		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	F812 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The dishwasher was repaired by an outside vendor on August 8, 2025.	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345213	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

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F0812 SS = F	Continued from page 11 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews with staff, an employee at the local public health department and a commercial equipment service provider, the facility failed to ensure their kitchen dishwashing machine had the cleaning and sanitation chemical agents connected correctly into the dishwashing machine and also failed to ensure water leaks from the dishwashing machine were repaired to prevent water leaking multiple feet throughout the kitchen floor on multiple days. During the time the dishwasher was not functioning correctly, the facility continued to use the machine to wash reusable meal trays. This was for one of one dishwashing machines utilized by the facility to provide clean dishes for all halls of the facility. The findings included: On 8/5/25 at 12:45 PM an initial observation of the kitchen was made. At that time there was water on the floor spanning approximately 15 feet from the dishwasher. The Certified Dietary Manager (CDM) was interviewed at this time and reported the following information. They were currently using the dishwasher only to wash reusable trays (used to hold the disposable plates and utensils they were currently using to serve residents' meals). The facility had experienced problems with the dishwasher for several weeks. The dishwasher had two motors that lifted a mechanism to drain the contents of the dishwasher after each cycle. One of the motors was broken and on order.	F0812	Continued from page 11 2.How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the same deficient practice. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur. The dietary manager was educated on 8/8/25 that the dishwasher must be checked atleast twice daily to ensure proper connection of the cleaning and sanitation chemicals and ensure that there are no water leaks. The dietary manager will inspect the dishwasher at least twice daily for 8weeks to ensure the chemicals are connected correctly and that the dishwasher is free of leaks. The dietary manager was educated 8/29/25 by the administrator that if the dishwasher is malfunctioning or there are leaks, he needs to call the maintenance director and the administrator and not use the dishwasher until it has been repaired. In this event the facility will use the three compartment sink and or disposal dishware. The maintenance director was educated on 8/29/25 by the administrator to call a vendor to repair the dishwasher immediately if it is malfunctioning. 4.How does the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 9/5/2025	

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F0812 SS = F	Continued from page 12 Therefore, when the dishwasher emptied, water would overflow onto the floor from the drain that did not work, and the staff would have to mop up the water. During a second observation of the kitchen on 8/6/25 at 10:40 AM the floor was observed to be wet again from the dishwasher. The wet area spanned approximately 15 feet away from the dishwasher. The CDM, who began facility employment on 6/23/25, was interviewed again and reported the following information. Since being employed at the facility, he thought the dishwasher was under a rental agreement, which he also thought entailed the rental company performing monthly service and maintenance checks. Since he had begun, the dishwasher had leaked numerous places. There were two areas at the top that had been squirting water towards the walls. A welder eventually came and welded the holes. Part of the feed line had also separated from the dishwasher and was leaking. Therefore, it had been hard to tell how long the current problem with the motor being broken and causing water leakage had been occurring because there had been so many problems with the machine leaking. He (the CDM) thought at the current time it was only leaking during the rinse cycle because he noticed the problem when the machine showed it was going into the rinse cycle, and therefore he thought the water on the floor was only rinse water. The CDM further reported the following. The local health department had performed an inspection on 7/1/25 and reported that the machine was not sanitizing and the facility was instructed to use single service items for food service to residents. Since 7/1/25 he had used single service items except for reusable trays because of the malfunctioning dish washer. The local health department had instructed them to use the three compartment sink for sanitation if needed. They had tried using the three compartment sink for the reusable trays but found that the trays did not air dry quickly enough to be available for the next meal delivery time. He was not able to order single service trays because he worked for a contracting company which required him to get supplies from a specific supply company. That supply company did not have single service trays. Therefore, since it had been identified by the local health department that the dishwashing machine was not sanitizing, he would manually open the machine and insert the sanitizer. When the machine leaked then the kitchen staff would mop the floor. According to the CDM, a service provider came in on 7/18/25 and identified that the lines from the soap, rinse, and sanitizing agents were not correctly fed into the machine which had led to the machine not sanitizing the trays. The chemical agents usually lasted for about 1 ½ to 2 weeks before they needed to be changed. He did not	F0812		

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F0812 SS = F	Continued from page 13 know when the chemical agents had last been changed prior to the error of the crossed lines being detected on 7/18/25. Therefore, he could not say how many days the trays had been going through the machine and out to residents without being sanitized. He did know that there had been multiple days of problems with the machine leaking water. A local Health Department Employee was interviewed on 8/6/25 at 9:23 AM and reported the following information. An inspection occurred on 7/1/25 by a colleague from the health department. The facility's dishwashing machine was not sanitizing on 7/1/25 at that visit. At that time the facility was directed to not use the dishwasher, use single service items for food service, and the three-compartment sink was to be used if needed for sanitation. She returned on 7/17/25 and the dishwasher was still broken and not sanitizing when checked. There was no evidence that the facility was using disposable meal service items at that time. There was also water on the floor. The CDM had reported to her that they were waiting for the health department's report to fix the dishwashing machine. She did not understand why the facility needed the report to fix the dishwashing machine. Since 7/17/25 the health department had received information from the facility that a service provider had found that the hoses were not tied into the cleaning agents correctly on 7/18/25 and that issue had been repaired but the facility had also submitted to the health department that the dishwashing machine needed further repairs. On 8/8/25 at 8:52 AM the commercial service provider, who was at the facility on 7/18/25, was interviewed and reported the following information. Their role was to supply the chemical agents but they were not under contract to repair or maintain the machine. When he arrived on 7/18/25 he checked the chemical agents and the lines from the chemical agents that fed into the machine were crossed. The detergent line was feeding into where the sanitizer should have been fed into the machine, and the detergent was feeding into where the sanitizer should have been feeding into the machine. The machine had water coming out of the backside also and the motor to the drain was making a loud chatter. The drain line making the chatter seemed to be locking up and therefore it would not drain correctly. This service provider was interviewed regarding whether it would always be rinse water that was not draining since the CDM noticed that the water would overflow the drain when the machine turned to the rinse cycle. The service provider reported that it could be either dirty water or rinse water. This was because once the wash cycle was completed, the machine then would show as being in	F0812		

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F0812 SS = F	Continued from page 14 the rinse cycle, but it would be emptying dirty water before beginning the rinse cycle. The malfunctioning motor could hang up at anytime during the process. The Administrator and the CDM were interviewed together on 8/8/25 at 11:00 AM and reported the following. When the health department employee arrived on 7/1/25 it was her understanding that they would give her a written report of the problem and provide some education. She thought education would be a good idea. They wanted to cooperate and were waiting on the actual report from the health department to have the machine fixed. In the interim, excluding the reusable trays, they were using disposable single use food service items to serve food to residents. Review of a facility invoice revealed the dishwasher holes, which had been identified as leaking water on the floor when the CDM was hired in June 2025, were repaired on 7/23/25 by a welding company. During an interview on 8/8/25 at 8:19 AM with the Health Department Employee, who visited the facility on 7/17/25, the Health Department employee reported the following. Dirty water overflowing from the dishwasher was a sanitation issue. The health department also considered overflowing rinse water onto the floor as a sanitation issue because the water could attract pests into the kitchen. The dishwasher should not be used if it was leaking water on the floor and/or was not sanitizing.	F0812		
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews with staff, an employee at the local public health department and a commercial equipment service provider, the facility failed to ensure a mechanical dishwashing machine was operating correctly to prevent water leaking multiple feet throughout the kitchen floor on multiple days. This was for one of one dishwashing machines utilized by the facility to service dishes and trays for the entire facility. The findings included: On 8/5/25 at 12:45 PM an initial observation of the	F0908	F908 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The dishwasher was repaired by an outside vendor on August 8, 2025. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the same deficient practice. 3.The measures that will be put into place of systemic changes made to ensure the deficient practice will not recur. The dietary manager was educated on 8/8/25 that the dishwasher must be checked at least twice daily to	09/05/2025

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F0908 SS = D	Continued from page 15 kitchen was made. At that time there was water on the floor spanning approximately 15 feet from the dishwasher. The Certified Dietary Manager (CDM) was interviewed at this time and reported the following information. They were currently using the dishwasher only to wash reusable trays (used to hold the disposable plates and utensils they were currently using to serve residents' meals). The facility had experienced mechanical problems with the dishwasher for several weeks. The dishwasher had two motors that lifted a mechanism to drain the contents of the dishwasher after each cycle. One of the motors was broken and on order. Therefore, when the dishwasher emptied, water would overflow onto the floor from the drain that did not work, and the staff would have to mop up the water. During a second observation of the kitchen on 8/6/25 at 10:40 AM the floor was observed to be wet again from the dishwasher. The wet area spanned approximately 15 feet away from the dishwasher. The CDM, who began facility employment on 6/23/25, was interviewed again and reported the following information. Since being employed at the facility, he thought the dishwasher was under a rental agreement, which he also thought entailed the rental company performing monthly service and maintenance checks. Since he had begun, the dishwasher had leaked numerous places. There were two areas at the top that had been squirting water towards the walls. A welder eventually came and welded the holes. Part of the feed line had also separated from the dishwasher and was leaking. Therefore, it had been hard to tell how long the current problem with the motor being broken and causing water leakage had been occurring because there had been so many problems with the machine leaking. He did know that there had been multiple days of problems with the machine leaking water. A local Health Department Employee was interviewed on 8/6/25 at 9:23 AM and reported the following information. An inspection occurred on 7/1/25 by a colleague from the health department. The facility's dishwashing machine was not sanitizing on 7/1/25 at that visit. At that time the facility was directed to not use the dishwasher, use single service items for food service, and the three-compartment sink was to be used if needed for sanitation. She returned on 7/17/25 and the dishwasher was still broken and not sanitizing when checked. There was also water on the floor. The CDM had reported to her that they were waiting for the health department's report to fix the dishwashing machine. She did not understand why the facility needed the report to fix the dishwashing machine. Since	F0908	Continued from page 15 ensure that there are no water leaks. The dietary manager will inspect the dishwasher at east twice daily for 8weeks to ensure the chemicals are connected correctly and that the dishwasher is free of leaks. The dietary manager was educated 8/29/25 by the administrator that if the dishwasher is malfunctioning or there are leaks, he needs to call the maintenance director and the administrator and not use the dishwasher until it has been repaired. In this event the facility will use the three compartment sink and or disposal dishware. The maintenance director was educated on 8/29/25 by the administrator to call a vendor to repair the dishwasher immediately if it is malfunctioning. 4.How does the facility plans to monitor its performance to make sure that solutions are sustained? All findings will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) monthly. Results of audits will be reviewed at QAPI meeting x3 meetings for analysis of patterns, trends or need for further systemic changes. Date of Compliance: 9/5/2025	

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F0908 SS = D	Continued from page 16 7/17/25 the health department had received information from the facility that a service provider had found that the hoses were not tied into the cleaning agents correctly on 7/18/25 and that issue had been repaired but the facility had also submitted to the health department that the dishwashing machine needed further repairs. On 8/8/25 at 8:52 AM the commercial service provider, who was at the facility on 7/18/25, was interviewed and reported the following information. The facility owned the machine, and it was not rented. They (the service provider) did not do any routine service for machines that were not under contract with them. Also, their company did not do repairs for the facility. Their role was to supply the chemical agents for the machine. When he arrived on 7/18/25 he checked the chemical agents. He also observed while there that the machine had water coming out of the backside also and the motor to the drain was making a loud chatter. The drain line making the chatter seemed to be locking up and therefore it would not drain correctly. The Administrator and the CDM were interviewed together on 8/8/25 at 11:00 AM and reported the following. The Administrator reported it had not been conveyed to her that the dishwashing machine was not rented and rather was owned by the facility. That week (the week of the survey) she had learned at one time the machine had been rented and during a corporate buyout the previous year, the dishwashing machine had somehow become the property of the facility. When the health department employee arrived on 7/1/25 it was her understanding that they would give her a written report of the problem and provide some education. She thought education would be a good idea and they wanted to cooperate and were waiting on the actual report from the health department to have the machine fixed. In the interim, excluding the reusable trays, they were using disposable single use food service items to serve food to residents. The CDM was interviewed again about dates when the dishwashing machine had been leaking and repaired and reported that when he arrived in June it was spurting water and needed to be welded and the feed line was broken and leaking at some point as well. He further reported that the service provider for the chemical agents who discovered the lines were crossed on 7/18/25 was the person who ordered the motor part for the malfunctioning drain. The CDM was interviewed regarding whether he was aware of the date the motor was ordered and who was supposed to actually replace the broken motor when it arrived. The CDM was not sure who the repair person was intended to be when the part was ordered.	F0908		

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F0908 SS = D	Continued from page 17 Review of a facility invoice revealed the dishwasher holes, which had been identified as needing repaired when the CDM was hired in June 2025, were repaired on 7/23/25 by a welding company.	F0908		