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TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 2/28/22 through 3/3/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #V44X11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 2/28/22 through 3/3/22. 12 of 12 complaint allegations was unsubstantiated Event ID #V44X11.	F 000		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview and record reviews, the facility failed to provide foot care and arrange podiatry services for 3 of 3 dependent residents with thick long curled toenails(Resident #19, Resident #20, and Resident #87) reviewed for foot care. The findings included: 1.Resident #19 was admitted to the facility on	F 687	Residents #19, #20 and #87 had foot care completed by nurse management on 3-3-22. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of current residents feet and need for toenail care was completed by nursing management on 3-5-22. Any resident in need of nail care or podiatry	3/31/22

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

Electronically Signed | 03/24/2022

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F 687	Continued From page 1 9/15/21. The diagnoses included diabetes. The annual Minimum Data Set dated 12/20/2021 indicated Resident #19 ' s cognition was intact. The MDS coded Resident #19 totally dependent on staff for all activities of daily living. Review of the care plan dated 12/14/21, identified the problem as Resident #19 required assistance with ADL Self Care Performance as evidence by status pos surgical site right plantar heel. The goal include Resident #19 would improve/maintain current level of function. The interventions included staff would adjust assistance to compensate for changing abilities and observe for decline in function. Review of the podiatry schedule from Sept 2021 through January 2022, revealed Resident #19 was not scheduled to be seen on 1/17/22, there was no consultation report or notation in Resident #19 ' s chart that he had been seen. Review of Resident #19 ' s skin assessments dated 1/25/22, 1/19/21, 2/18/22, 2/22/22, 2/11/22 and 2/28/22, there was no documentation of the condition of Resident 19#s toenails. Observation on 2/28/22 11:10 AM, Resident #19 reported difficulty walking due to heel surgery. Resident #19 stated he got around in the wheelchair. Resident #19 ' s feet were exposed, and the toenails were very long with thick skin between toes on both feet. The toenails were curled over each toe on both feet. Observation on 2/28/22 at 3:00 PM, Resident #19 was in his wheelchair sitting in front of room door. Resident #19 ' s right heel was wrapped in a dressing and his feet were exposed. Resident	F 687	referral was completed by direct care staff through 3-11-22. All direct care staff were re-educated by Nursing Management 3-25-2022 regarding providing foot care and referrals to podiatry for vascular or diabetic diagnosis. The DON/Unit Manager will complete 5 random foot care audits weekly for 12 weeks to assess for cleaning of feet, care of nails and skin condition. The results of the audits will be brought through the monthly QA&A meeting for 3 months for recommendations and need for further reviews	

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#19 ' s toenails on both feet had not been cut and cleaned.

An interview was conducted on 2/28/22 at 3:10 PM, Nurse #5 stated the Resident# 19 was being treated for a heel wound due to an abscess that was surgical removal a few weeks ago. Resident #19 was unable to apply measure to the foot currently. He was able to get around in wheelchair using the left foot. He received weekly skin checks and wound care management. The wound doctor checked the wound and determined if there was a need for a change in treatment.

Observation and interview were conducted on 3/2/20 at 9:08 AM, Resident #19 ' s was in his room lying in bed and both feet were exposed, and the condition of the toenails had not changed. Nurse #6 confirmed the condition of Resident #19 ' s toenails. Resident #19 stated he had not received podiatry services in the past 5 months, and no-one told him they would be making an appointment for him. Resident #19 stated he really wanted his toenails done. Nurse #6 stated all staff were responsible for checking the condition of a resident ' s feet and ensuring they were washed and clean. Any staff performing any care should have seen the condition of the resident's feet and reported it to nursing. Nurse #6 further stated the wound care nurse was also providing care for the resident's feet and should have also reported the condition of the feet. The nurse aides should report to nursing any resident who would need podiatry services. The information would be given to the social workers to set up an appointment. Nurse #6 confirmed the length of all the toenails and stated, "the resident should have been seen by

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podiatry several months ago."

Observation on 3/2/22 at 9:16 AM, the Director of Nursing (DON) observed Resident #19's feet and confirmed the condition of the resident's feet and stated he should have been placed on the podiatry list. The DON also stated all staff were responsible for cleaning and checking resident skin, toes during any form of care and report to nursing when a resident needed to be seen. The Director of Nursing (DON) stated the podiatrist was scheduled every 3 months and it was expected that any diabetic residents who needed podiatry service be added to the schedule. The Nurse Aides were responsible for reporting to nursing when diabetic resident's toenails were extremely, long/sharp and needed podiatry trim/cut. The DON added due to the complexity of diabetic footcare needs, podiatry was more appropriate to cut the toenails rather than nurses/nurse aide. The DON indicated there was no back up system in place for missed appointments or refusal of services. The DON further stated nursing could cut toenails in between appointment until and appointment could be obtained.

An interview was conducted on 3/2/22 at 9:22 AM, the Nurse Aide #4(NA) stated residents who were diabetic, the aides were not to cut the toenails. NA#4 further stated the aides should report the condition of the toenails if they toenails was getting to long or sharp the condition should be reported to the nursing staff so the resident could be scheduled for podiatrist. NA #4 stated she had worked with Resident #19 on a regular basis and the toenails had been in the current condition for several months. NA#4 state the condition of the toenails had been reported to

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nursing, but she was uncertain when the podiatry appointment had been schedule.

An interview was conducted on 3/2/22 at 9:57 AM, the Social Work Director (SWD) stated the podiatrist visits the facility every three months and any diabetic resident would be added to the schedule when nursing reported a resident needed podiatry services. The SWD confirmed Resident #19 had not been on the podiatry list in the last 5 months. She further stated nursing was provided with a clinic form to be completed when any resident needed to be scheduled for outside services. She added there was no system in place if a resident missed the scheduled day for podiatry services due to other appointments. SWD further stated she was currently working on a schedule now for podiatry services to include new residents as of 3/2/22. Nursing was responsible for letting the social work department know when outside/clinic services were needed.

An interview was conducted on 3/2/22 on 11:20 AM, The Administrator stated nurse aides and nursing was responsible for ensuring residents skin/toenails etc. were being checked and cleaned during personal care. Nurse aides should report to nursing any resident that needed podiatry services. Nurse Aides could cut resident toenails that were not diabetic and should be cleaning and checking between toes to ensure thorough cleaning. The wound care nurse should also be checking resident ' s feet when performing wound care of affected area and documenting on the wound care list the resident needed podiatry services. The Administrator added the feet should be checked for all residents when skin assessments were being completed and the condition of the resident ' s

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feet/toenails should be reflected on the assessment. Nursing should be notifying the social workers to let them know when a resident needed to be seen by any outside service by completing the clinic form. The Administrator stated there was no direct system in place to ensure residents who missed appointments would receive a follow-up appointment. In addition, the Administrator added nursing should be cutting resident toenails in between appointments until the resident could be scheduled, if they were unable report to nurse practitioner.

A follow-up interview was conducted on 3/2/22 at 2:05 PM, the Administrator stated the skin/wound assessment should include staff observation of the entire body and the condition of a resident ' s toenails would be included in that assessment. Staff were responsible for observing the condition of the resident ' s feet and providing foot care during care or referring the resident to podiatry services. The Administrator reviewed the wound skin assessment form for Resident #19 dated 1/25/22 through 3/1/22. The wound/skin assessment form which documents the skin condition section V4 documents a visual evaluation from head to toe was done. There was no documentation indicated the condition of Resident #19 ' s toenails.

2. Resident #20 was admitted to the facility on 8/1/17. The diagnoses included end stage renal disease, polyneuropathy, and diabetes. The quarterly Minimum Data Set (MDS) dated 12/21/2021, indicated Resident #20 ' s cognition was intact. The MDS coded Resident #20 totally dependent on staff for all activities of daily living.

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Review of the care plan dated 12/30/21, identified the problem as Resident #20 had diabetes. The goal included Resident #20 would be free from any signs and symptoms of hyperglycemia. The intervention included staff would check all of body for breaks in skin and treat promptly as ordered by doctor. If infection is present, consult doctor regarding any changes in diabetic medications. 2. Resident #20 had ADL Self Care Performance Deficit related to impaired mobility, muscle weakness, pain. The goal included Resident #20 would have all needs met. The interventions included staff would adjust assistance to compensate for changing abilities. Observe/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Staff would observe resident for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. Resident #20 would wear off loading boot while in bed as resident allows. Staff would provide weekly skin checks every Thursday.

Review of the podiatry schedule from Sept 2021 through January 2022, revealed Resident #20 was not scheduled to be seen on 1/17/22, there was no consultation report or notation in Resident#20 ' s chart indicating she had been seen.

Observation on 2/28/22 at 10:00 AM, Resident #20 was in bed and her feet were exposed from under the blanket. On both feet the big toenail had extremely thick brown growth, about 1 1.2 to 2 inches beyond the fatty part of the toe, the other 4 digits were very long thick with brown matter, yellowing of the toenail bed.

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Observed on 3/1/22 at 10:45 AM, Resident #20 was in bed with feet exposed, the toenails on both feet were very long about 1 1/2 inches in length, very thick, long with sharp edges and toenails growing into the sides of the next toe. The bottoms and back of feet had very thick scaly dry skin and brown dirty particles between the toes. The nailbeds were yellow. Resident #20 stated her toenails hurt and staff would wash the top of her feet and not the bottom or between the toes. She further stated they did hurt but with a patient staff "I would appreciate the toenails to be cut. "I don ' t like covers over my toes because of the pressure on my toenails/feet. This was one reason she did not like to wear shoes or socks."

Observation on 3/1/22 at 12:45 PM, Resident #20 was in bed eating lunch and her feet were exposed. The toenails were not cut and remained in the same condition. Resident #20 stated staff have not offered her podiatry services or attempted to cut her toenails. She further stated, "they see they need to be cut down, they get caught in the blanket sometimes and they hurt and when I have mentioned it to a nurse or an aide, they constantly stated they would get someone in to look at them and no-one has been in here yet to check them." Resident #20 further stated I know staff see my toenails need to be cut and they just wash around it sometimes. There were times they don't even wash my feet."

Observed Resident #20 on 3/1/22 at 3:10 PM, Resident #20 ' s toenails had not been cleaned or cut.
Observed 3/2/22 at 8:33 AM, Resident #20 was in bed eating breakfast, the feet were exposed and there was no change in condition of the feet. Nurse Aide #3(NA) observed Resident #20 ' s

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feet and Resident #20 explained to NA#3 that she would like her feet to be thoroughly washed top/bottom and wanted her toenails cut. NA#3 stated that she does not cut toenails in the resident's current condition. The nurse or the podiatrist would be the one to cut diabetic resident's toenails. NA#3 confirmed the condition of the toenails. NA#3 stated aides would let nursing know when the resident's toenails were getting extremely long and needed to be cut. NA#3 reported nursing had been informed about Resident #20 ' s feet and condition of the toenails several months ago. NA#3 stated was not aware if the resident had been added to the podiatry list when they came in January.

Observation and interview were conducted on 3/2/22 at 9:50 AM, Nurse #5 stated when wound care assessment included a head-to-toe assessment Nurse #5 stated she had been treating the resident for wounds on her bottom and had not checked any other part of the resident's body. The assessment would include checking between toes for skin conditions and report to physician if additional treatment was needed. She confirmed she had not checked the resident's toenails.

An interview was conducted on 3/2/22 at 9:57 AM, the Social Work Director (SWD) stated the podiatrist visits the facility every three months and any diabetic resident would be added to the schedule when nursing reported a resident needed podiatry services. The SWD confirmed Resident #20 had not been on the podiatry list in the last 5 months. She further stated nursing was provided with a clinic form to be completed when any resident needed to be scheduled for outside services. She added there was no system in

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place if a resident missed the scheduled day for podiatry services due to other appointments. SWD further stated she was currently working on a schedule now for podiatry services to include new residents as of 3/2/22. Nursing was responsible for letting the social work department know when outside/clinic services were needed.

An interview was conducted on 3/2/22 on 11:20 AM, The Administrator stated nurse aides and nursing was responsible for ensuring residents skin/toenails etc. were being checked and cleaned during personal care. Nurse aides should report to nursing any resident that needed podiatry services. Nurse Aides could cut resident toenails that were not diabetic and should be cleaning and checking between toes to ensure thorough cleaning. The wound care nurse should also be checking resident ' s feet when performing wound care of affected area and documenting on the wound care list the resident needed podiatry services. The Administrator added the feet should be checked for all residents when skin assessments were being completed and the condition of the resident ' s feet/toenails should be reflected on the assessment. Nursing should be notifying the social workers to let them know when a resident needed to be seen by any outside service by completing the clinic form. The Administrator stated there was no direct system in place to ensure residents who missed appointments would receive a follow-up appointment. In addition, the Administrator added nursing should be cutting resident toenails in between appointments until the resident could be scheduled, if they were unable report to nurse practitioner.

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3)
Resident #87 was admitted to the facility on 02/08/22 with diagnosis that included metabolic encephalopathy, coronary artery disease, pneumonia, congestive heart failure and hypertension.

A review of the comprehensive minimum data set assessment dated 02/08/22 indicated Resident #87 was severely cognitively impaired, required 1-person assist with activities of daily living (ADL) and rejected care.

A review of Resident #87 plan of care dated 02/08/22 revealed a focus of ADL self-care deficit and risk for pressure injuries. Interventions were put into place to assist Resident #87 in meeting these goals such as providing assistance with ADL care and weekly skin checks.

A review of weekly skin check dated 2/22/22 did not reveal any assessments regarding Resident #87 toenails.

Observations conducted on 02/28/22 at 10:00am and 03/01/22 at 8:30am revealed Resident #87 lying in bed with both feet exposed. Resident #87's bilateral (both) toenails were about 1-2 centimeters long, jagged with debris under the nails.

Interview with Nurse Aide (NA)#4 on 03/02/22 at 8:30am stated NAs were allowed to cut residents' toenails that were not diabetics. NA#4 further stated that Resident #87 could have his toenails cut but nursing staff but was unsure why this had not been completed.

Interview with Nurse #2 on 03/03/22 at 11:30am

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stated Resident #87 has had some increased confusion during his most recent admission and at times had been resistant to care with numerous occasions of attempts to get out of bed without assistance. Nurse #2 further stated that given his behaviors and staff prioritizing his safety it is likely that the condition of his toenails had been overlooked.

An interview was conducted on 3/2/22 at 11:20 AM with the Administrator stated nurse aides and nursing was responsible for ensuring residents skin/toenails. was being checked and cleaned during personal care. Nurse aides should report to nursing any resident that needed podiatry services. Nurse Aides could cut resident toenails that were not diabetic and should be cleaning and checking between toes to ensure thorough cleaning. The wound care nurse should also be checking resident's feet when performing wound care of affected area and documenting on the wound care list the resident needed podiatry services. The Administrator added the feet should be checked for all residents when skin assessments were being completed and the condition of the resident's feet/toenails should be reflected on the assessment. Nursing should be notifying the social workers to let them know when a resident needed to be seen by any outside service by completing the clinic form.

An interview conducted with the Physician Assistant on 03/03/22 at 10:04am stated that residents who are diabetic or have vascular disease should be seen by a Podiatrist. If the residents do not have any risk factors, then Nursing can take care of the toenails. The Physician Assistant further stated that Resident #87 does not have any risk factors and therefore

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F 687	Continued From page 12 nursing can take care of the toenails.	F 687		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record reviews, the facility failed to provide a therapeutic diet for finger foods as ordered by the physician for 1 of 3 residents reviewed for nutrition (Resident #103). The findings included: Resident #103 was admitted to the facility on 11/09/21 with diagnoses that included a femur fracture, legal blindness, and age-related cognitive decline. A review of the resident's medical record revealed an order dated 11/18/21 for a regular diet with finger food texture. A progress note by Dietitian #2 dated 01/31/22 revealed Resident #103 had triggered for significant weight loss and had variable meal intake. His diet order was for a regular diet with finger foods.	F 808	Resident #103□s diet was changed to Regular Diet on 3-22-2022 per physician order. Staff continue to assist resident with meals as directed by plan of care. All residents have the potential to be affected by the alleged deficient practice. By 3-23-2022 the nursing management team will review residents□ meals weekly x 12 weeks to ensure the served meal is what was ordered by the physician. The results of the audits will be brought through the monthly QA&A meeting for the diet order of all residents is appropriate and meeting their nutritional needs. The plans of care of residents noted to be affected will be updated as deemed necessary. Direct care staff, dietary and therapy staff will be educated by Nursing Management by 3-29-2022 regarding providing diet as ordered by the physician. Nursing management will randomly audit 5 months for recommendations and need	3/31/22

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	345458	A. BUILDING _____ B. WING _____	C 03/03/2022

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The quarterly minimum data set (MDS) dated 02/14/22 revealed Resident #103 had moderate cognitive impairment. He needed assistance with activities of daily living (ADLs) and required staff supervision with eating. The MDS indicated Resident #103's vision was severely impaired, and he experienced weight loss.

The care plan dated 02/14/22 revealed Resident #103 was at risk for decreased nutritional status related to his fair oral intake, need for finger foods, and significant weight loss. Interventions included staff assistance with meals as needed, provided diet as ordered, monitored intake, and monitored diet tolerance.

Observation of the lunch meal on 02/28/22 at 12:47 PM revealed the resident had the following items on his tray: chicken, noodles with a sauce substance, peas, diced fruit, and a roll. The resident attempted to eat independently. His meal ticket revealed he was on a regular diet and needed finger foods.

In an interview with Nurse # 1 on 03/01/22 at 12:20 PM, she stated staff sometimes helped Resident #103 with his meals. Staff would describe the meal to Resident #103 and tell him where the food items were located on his plate. Nurse #1 explained the resident ate well and received supplements.

Observation of the lunch meal on 03/01/22 at 12:30 PM revealed Resident #103 was eating independently in his room. His tray included meat, rice in a sauce substance, cooked sliced carrots, and a roll. There was a clear liquid on the floor at his feet and an empty cup on his bedside table. His meal ticket indicated he was on a regular diet for further reviews.

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F 808	Continued From page 14	F 808		

and needed finger foods. The meal ticket was blank in the area designated for "feed ability." Resident #103 stated eating his meals were like "hide-and-go seek." He stated he ate independently, but sometimes staff assisted him.

On 03/01/22 at 12:55 PM, an interview was conducted with Nurse Aide (NA) #1. She stated resident #103 needed limited assistance with his meals, and he required staff setup for his meals.

In a follow up interview with NA #1 on 03/02/22 at 12:35 PM, she stated Resident #103 ate regular food. She assisted the resident by breaking up his meats and setting up his tray. The resident needed cues to tell him what food was on his tray and the food's location.

During an observation on 03/02/22 at 12:40 PM, activities assistant #1 came to Resident #103's room to set up his tray. She informed Resident #103 of what was on the tray and stated she would assist him to eat because there were no finger foods today. The resident's meal included turkey and gravy, mashed potatoes, cooked zucchini, and a roll. When interviewed, the activities assistant stated she was not sure how often finger foods were not served. She explained she knew he was on finger foods because he had a sight issue.

An interview was conducted with the dietary manager on 03/02/22 at 2:05 PM. He stated finger foods included items such as sandwiches and french fries. Dietary staff knew if a resident was on finger foods by the meal ticket information that printed for each resident. Staff would see that a resident was on finger foods when plates were prepared. A resident who was ordered finger

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F 808	Continued From page 15 foods would only receive a regular texture diet if it was requested. In an interview with the director of nursing (DON) on 03/03/22 at 10:25 AM, she stated staff were educated to give residents the correct diet. Resident #103 was being assisted with meals and staff knew to follow his plan of care for eating. The resident could have both finger foods and regular texture foods. Finger foods were provided to promote independence. If Resident #103 received non-finger foods, staff assisted him with eating. An interview was conducted with Dietitian #1 on 03/03/22 10:58 AM. She explained resident #103's risk for impaired nutrition included pressure wounds, need for finger foods, and a variable intake. Resident #103 had finger foods ordered to promote independence but could receive regular foods too. Staff assisted him at times by telling him where his utensils and food was on his tray. In an interview with the administrator on 03/03/22 at 2:10 PM, she explained staff looked at each resident's tray when they passed them out to be sure residents received the correct diet. Resident #103 received finger foods due to his visual impairment. The nurse or nurse aide would be responsible for ensuring he had eating assistance when he did not receive finger foods.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		3/31/22

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F 812	Continued From page 16 §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 observations, staff interviews and record review, the facility failed to ensure the following kitchen equipment was clean: the stove, the oven, 1 fish fryer, 5 compartment steam tables, 3 enclosed and 1 open meal carts, 1 condiment cart and 2 plate warmers. Findings included: 1.During an initial kitchen tour on 2/28/22 at 8:15 AM, the following observations were made: a. The 9-burner stove had a large volume of heavy grease build up on the stove burners, walls, and fronts of the stove. There were large amounts of burnt foods, dried liquid encrusted and splatters throughout the stove area. The stove continued to have encrusted burners with heavy grease build up and food debris. b. 2 ovens had a large volume greasy buildup, dried food, and liquids on the inside and outside.	F 812	The 9-burner stove, two ovens, fish frier, five compartment steam tables, meal carts, condiment cart, 2 plate warmers were cleaned by the dietary department on 3-4-22. All residents have the potential to be affected by the alleged deficient practice. All dietary staff were educated on 3-4-22 by the Administrator to include the cleaning schedules for the kitchen equipment and daily cleaning of cooking surfaces. Dietary manager will monitor and sign off that cleaning was completed utilizing the kitchen cleaning checklist. The checklist will be maintained, and the dietary consultant or Administrator will review weekly and sign off on the checklist that the areas are clean and sanitized. The checklists will be brought through the monthly QA&A meeting for 3 months for	

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F 812	Continued From page 17 The grease buildup was encrusted on doors/shelves where foods were being cooked. There was a large volume of dried grease buildup was observed on the fronts of the ovens and on the walls. c. The fish fryer had large volumes of dried brown/yellow liquid matter encrusted on edges inside/outside. In addition, the fryer had heavy grease and food build up inside/outside, food products behind the frier. d. The 5 compartment steam tables had large volumes of dried food and liquid matter encrusted on the edges inside/outside. In addition, the steam table also had left over food in standing water, the pans were heavy encrusted with brown matter and burnt food items. e. The 4 meal carts were stored in the kitchen was dirty with leftover food. The carts had large volumes of encrusted dried food and liquids. f. The 1 condiment cart where dry food products were stored had several different compartments that had dried liquids, food crumbs and particles inside. The outside cart also had dried liquids running down the fronts/sides of the cart. g. The 2 plate warmers had 2 rows of clean plates stored in the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around. An interview was conducted on 2/28/22 at 8:20 AM, the Dietary Manager (DM) stated he was responsible for ensuring the kitchen staff kept the equipment clean and orderly. He added the	F 812	recommendations and need for continued monitoring.	

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kitchen equipment should be cleaned weekly in accordance too the kitchen cleaning checklist.

A follow-up observation was conducted on 3/2/22 at 11:35 AM, the following observations were made: the 5-compartment steam table, 4 meal carts, 2 plate warmers and condiment cart had not been cleaned following the initial tour on 2/28/22.

An interview was conducted on 3/2/22 at 11:40 AM, the Dietary Manager (DM) stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist. The DM confirmed the identified kitchen equipment had not been cleaned.

An interview was conducted on 3/2/22 at 11:46 AM, the Dietary Consultant stated she visited the facility on a weekly basis and was responsible for checking and monitoring the kitchen staff to ensure the dietary manager was maintaining the cleanliness of the kitchen. The Dietary Consultant observed the condition of the identified area and confirmed additional cleaning was necessary.

An interview was conducted on 3/2/22 at 12:00 PM, the Administrator stated the dietary manager was responsible for ensuring the kitchen was cleaned and maintained. The expectation would be for the Dietary manager to ensure all kitchen cleaning protocols were in place and followed in accordance too kitchen sanitation guidelines.