STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045416	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberlane Health & Rehabilitation	2002 Timberwood Road El Dorado, AR 71730

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47916 Based on observations, interviews, record review, review of resident meal slips, and facility policy review, the facility failed to honor meal preferences for 1 (Resident #52) sampled resident with a standing order for 2 glasses of tea to ensure good hydration. This failed practice had the potential to affect 4 (Resident #7, #43, #47, #58) sampled residents that were observed for dining to ensure proper hydration and nutrition. Findings include: A review of the Medical Diagnosis portion of Resident #52's health record revealed diagnoses of type II diabetes, stroke, and dysphagia. 1. On 08/26/24 at 12:25 PM, Resident #52 was observed coughing very strongly in the dining room and stated they (Resident #52) needed more tea. There was about 1/2 inch of tea colored fluid and ice observed in a cup. The meal slip showed Resident #52 had standing orders for two 8-ounce cups of tea. 2. On 08/26/24 at 12:39 PM, Assistant Director of Nursing (ADON) #5 came to the table and was asked to look at Resident #52's meal slip. ADON #5 confirmed Resident #52 did not get two cups of tea, and confirmed the meal slip showed a standing order for two 8-ounce cups of tea. When asked for the reason Resident #52 gets two 8-ounce cups of tea, ADON #5 said, It is [Resident #52's] preference. 3. On 08/29/24 at 09:20 AM, the Director of Nursing (DON) was asked who is responsible for making sure residents received their meal preferences. The DON stated dietary staff discuss preferences with residents, and the Certified Nursing Assistants (CNAs) or staff should check the tray and go back to the kitchen if something is wrong. When asked why it is important for residents to receive their standing orders or preferences, the DON stated that they wanted to honor the resident's wishes. 4. On 08/29/24 at 11:20 AM, the DON provided a policy titled Food and Nutrition Services Staff which did not address food preferences of the residents.

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

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48390 Based on interview, record review, and policy review, the facility failed to convey a resident's personal funds to the individual or representative administering the individual's estate within 30 days for 1 (Resident #235) of 1 sampled resident for whom the facility-maintained trust accounts per a list provided by the Administrator on 08/2/2024 at 3:33 PM. The findings are: l. Resident #235 was documented as having transferred to a different facility according to resident's Discharge Summary on 05/01/2024. 2. A document titled Timberlane Health and Rehabilitation Trust-Current Account Balance As of 08/27/2027 documented that a trust account for Resident #235 contained a closing balance of $120.00. 3. On 08/29/24 at 10:29 AM, the Surveyor asked the Business Office Manager (BOM) to identify the date Resident #235 had discharged . The BOM verified that Resident #235 was discharged on [DATE]. The Surveyor asked the BOM how long the facility was permitted to convey residual funds in trust accounts. The BOM indicated 30 days. 4. On 08/29/2024 at 11:01 AM, the Surveyor asked the Administrator how long the facility was permitted to convey funds after a resident discharge. The AD indicated 30 days. 5. A policy titled Policy & Procedure Patient Trust was provided by the Administrator on 08/29/2024 at 3:42 PM. The policy did not address the return of resident funds upon resident discharge or death.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48390 Based on record review and interview, the facility failed to ensure written notification of transfer/discharge to another facility was provided to the resident and/or resident's representative, and the state Ombudsman, to protect the rights of 1 (Resident #83) of 1 sampled resident who transferred to a different facility in the last 90 days. 1. Review of a NSG/MD Discharge Summary for Resident #83 revealed the resident was discharged from the facility on 06/07/2024. a. On 08/29/2024 at 10:50 AM, the Administrator (AD) was asked who keeps up with the discharges and sends them to the state Ombudsman. The AD indicated that she did. The AD was then asked if a resident is transferred to another facility, is a notification sent to the Ombudsman. The AD indicated that she keeps a list for the month and at the end of the month it is sent to the Ombudsman. The AD was asked if Resident #83 should be on the transfer log for June? The AD indicated that Resident #83 should be but was left off. b. A Policy titled Transfer or Discharge Documentation provided by the Administrator on 08/29/2024, did not address notifications to the Ombudsman.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37925 Based on record review and interview, the facility failed to ensure a comprehensive care plan addressed a high-risk medication, insulin, to ensure planning was completed for individualized and appropriate care and services for 1 (Resident #43) of 18 (Residents #7, #8, #10, #12, #16, #40, #43, #47, #49, #54, #57, #58, #59, #64, #77, #79, #135 and #286) sampled residents whose care plans were reviewed. The findings are: Resident #43's Medical Diagnosis section of the electronic health record, not dated, was reviewed and indicated a diagnosis of inadequate controls of levels of sugar in the blood (diabetes). The Order Summary dated 08/29/2024 was reviewed and indicated an order for Glargine insulin (a long acting, synthetic form of insulin) 100 units/milliliter (Unit/ML) and was dated 01/14/2024. The instructions were to inject 64 units subcutaneously (under the skin=SQ) one time a day for diabetes. A Care Plan dated 08/22/2024 was reviewed and indicated Resident #43 could have skin integrity issues and had issues with vision, both related to diabetes. The care plan did not indicate any care measures for diabetes, address Glargine insulin usage, or include any adverse reactions or signs and/or symptoms to monitor the resident for. The annual Minimum Data Set (MDS) with an assessment reference date of 06/29/2024 was reviewed and indicated Resident #43 had a Brief Interview for Mental Status score of 15, which indicated cognitively intact. This MDS indicated the resident received insulin injections, a high-risk drug class, during the last seven days or since admission or entry. On 08/28/2024 at 3:58 PM, the Director of Nursing (DON) was interviewed and asked to review Resident #43's annual MDS medication section for June of 2024. She confirmed the annual MDS for June 2024 indicated the resident had received insulin injections and there was a number 7 in the box. She was asked to review the resident's care plan and she confirmed there was no indication for insulin usage or signs and/or symptoms to monitor the resident for. She was asked who was responsible for completing the care plans and she stated the MDS Coordinator. She was asked what drives the care plan and she stated the MDS assessment. She confirmed insulin, a high-risk medication, should be care planned. She was asked to review Resident #43's order summary and asked if there was an order to monitor the resident for signs and or symptoms of insulin use and she confirmed there was no order. A Care Plans, Comprehensive Person-Centered policy, with a revision date of December 2016, provided by the Nurse Consultant was reviewed and indicated this type of care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and was developed for each resident. This policy indicated the comprehensive person-centered care plan would incorporate identified problem areas and risk factors associated with identified problems and would be developed within seven days of the completion of the required comprehensive assessment (MDS).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, record review, interview, and facility policy review, it was determined that the facility failed to properly lift a resident with the legs open on a mechanical lift for 1 (Resident #79) resident to ensure the mechanical lift was balanced to prevent accidents or injuries based on 1 of 1 observation. The findings are: 1. A review of an in-service topic Skills Fair: Mechanical Lift Use, (Dated, 06/27/2024) revealed that Certified Nursing Assistant (CNA) #8 had been in-serviced on how to use a mechanical lift. 2. A review of resident 79's Care Plan, (Revised, 08/19/2024) revealed that Resident #79 requires a mechanical lift with 2-person assistance due to impaired mobility. 3. On 08/26/2024 at 10:05 AM, CNA #8 and CNA #3 entered Resident #79's room with a mechanical lift. CNA #8 rolled the mechanical lift under the bed with the legs in a closed position. The Surveyor observed CNA #8 raise Resident #79 from the bed and rolled the resident to the center of the room with the legs in the closed position. 4. On 08/26/2024 at 10:12 AM, CNA #8 was asked what process was used for raising and lowering residents from the bed with a mechanical lift. CNA #8 confirmed that the legs of the mechanical lift are supposed to be in the open position but confirmed that she does not know why. During the interview CNA #8 was asked if she has been in-serviced on the mechanical lift, and CNA #8 confirmed that she was in-serviced. 5. During an interview with the Director of Nursing (DON) on 08/29/2024 at 09:35 AM, the DON confirmed staff are in-serviced on transferring residents by mechanical lifts. The DON was asked what the process was for raising and lowering a resident with a mechanical lift. The DON stated 2 staff members should be present, and the legs should be in the open position to keep the mechanical lift balanced, because the lift could tip over if the legs are in the closed position. 6. On 08/29/2024 at 11:20 PM, the DON provided a policy titled Safe lifting and Movement of Residents, (Revised, 12/2007) revealed staff are observed for competency, and skills technique in lifting and moving residents in order to protect residents and staff, and to prevent accidents or injuries. A user manual for the [named] mechanical lift was not received. 49413

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, interviews, record review, and facility document review, the facility failed to have a process in place to identify refrigerated narcotic expiration or use by dates to ensure refrigerated narcotics were returned to the pharmacy in a timely manner affecting 3 (Resident #63, #64, #185) sampled residents, and the facility failed to ensure periodical accounting for all controlled narcotics, antianxiety medication, affecting 1 deceased (Resident #185) sampled resident discharged from the facility on [DATE] to prevent possible loss or misappropriation of resident medications. Findings include: 1.a. On [DATE] at 02:36 PM, Licensed Practical Nurse (LPN) #9 was observed removing 3 bottles of antianxiety medication belonging to Resident #63, #64, and #185 and 1 bottle of opioid pain medication belonging to Resident #63 from the refrigerated, permanently affixed medication drawer located in the [DATE]/700 Hall medication room. LPN #9 confirmed the 4 opened bottles of medication were undated. LPN #9 and LPN #10 confirmed they could not tell when the medication bottles were opened but the fill dates on the bottles are from [DATE]-[DATE]. During an interview, LPN#9 and LPN #10 were asked for the expiration date of the opened medications and both LPNs confirmed they did not know. LPN #9 stated if a medication is expired it might not be effective. b. On [DATE] at 03:00 PM, the Assistant Director of Nursing (ADON) #6 and Nurse Consultant were asked how to tell if an open bottle of antianxiety medication or opioid pain medication was expired. ADON #6 was observed looking at an antianxiety medication, and the Nurse Consultant stated the label is covering that information, and confirmed if narcotics are expired, they would want to send them back to the pharmacy right away to prevent diversion. c. On [DATE] at 12:00 PM, the Nurse Consultant told the Surveyor an antianxiety medication would expire 90 days after being opened, and depending on how it is stored opioid pain medication could expire in as little as 7 days after it is opened. 2.a. On [DATE] at 02:40 PM, Licensed Practical Nurse (LPN) #9 confirmed Resident #185 had 1 bottle of antianxiety medication. LPN #9 stated she will need help finding narcotic page 116 because Resident #185 was deceased . LPN #9 and LPN #10 stated they were counting narcotic pages 87 (Resident #64), 95 (Resident #63) and 96 (Resident #63), but they were not counting Resident #185's medication, found on narcotic page 116 because Resident #185 was deceased . b. During an interview with the Assistant Director of Nursing (ADON) #6 On [DATE] at 03:12 PM, the Surveyor asked what process staff were expected to follow when a resident died or was discharged . ADON #6 confirmed that staff are to turn the medications in to the Director of Nursing (DON) as soon as possible so they can be returned to the pharmacy. When asked why the facility would expect narcotics to be returned as soon as possible, ADON #6 said the medication could be stolen. The Nursing Consultant stated that when a person dies their medication page is not brought forward to a new narcotic page anymore, and the medication should be given to the DON to return to the pharmacy to prevent diversion. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On [DATE] at 03:13 PM, ADON #6 provided narcotic book page 116 showing a balance of 29.5 ml of antianxiety medication. The Nurse Consultant stated Resident #185 only had 1 dose on [DATE]. LPN #9 confirmed that during the narcotic count she assumed the other nurse had narcotic page 116, and confirmed it was not being counted. ADON #6 and Nurse Consultant were asked if they had any concerns with a narcotic not being accounted for since [DATE], and the Nurse Consultant stated that if they had a dishonest nurse the narcotic could have been stolen and they would not have known. d. A review of a policy titled Storage of Medications, (Revised, [DATE]) revealed that nursing is responsible for the storage of medications being stored properly. Drugs that are out of date or have deteriorated should be sent back to the pharmacy or destroyed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47916 Based on observations, interviews, document review, and facility policy review, the facility failed to ensure hydrocortisone 1/2% was stored in a locked compartment and not left at the bedside for 1 (Resident #8) to prevent the risk for accidental overdose, or injury. This failed practice had the potential to affect 1 (Resident #8) sampled resident reviewed for storing medication at the bedside without self-administration rights. Findings include: a. A review of a policy titled Self-Administration of Medications, (Revised, December 2016) revealed the IDT team must assess a resident to see if they are safe for self-administration rights. Resident rooms are not considered a safe place for medication storage, and medications must be stored in a safe and secure area. Medications can be stored in the med carts, or in the medication room, but not in a residents room. b. 08/27/2024 08:50 AM, Resident #8 was observed eating from the resident ' s over the bed table with hydrocortisone cream 1/2% resting on the right side of the over the bed table. c. Licensed Practical Nurse (LPN) #7 checked the medication administration record (MAR) on 08/27/2024 at 08:56 AM, and LPN #7 confirmed there was not an order for steroid cream 1/2 % for Resident #8. LPN #7 accompanied the Surveyor to Resident 8's room and removed a tube of steroid cream from the over the bed table. LPN was asked if there are any residents with self-administration rights. LPN #7 said there were no residents with self-administration rights, because it is not safe and another resident could find the medication and put it in their eyes or mouth. d. On 08/29/2024 at 09:27 AM, the Director of Nursing (DON) was asked if they have any residents with self-administration rights, and the DON said no residents have self-administration rights. When asked for the process for self-administration rights, the DON said the process is to complete an assessment, notify the doctor and get an order, then it would need to be care planned, and it is important for residents to not have medication at the bedside so nursing can oversee what the residents are taking. 2.a. On 08/27/2024 at 02:30 PM, Licensed Practical Nurse (LPN) #9 was asked to identify 4 loose narcotic bottles from a double locked drawer of the 400/500/600/700 Hall refrigerator located in the medication room. LPN #9 was observed holding 1 of 4 bottles up to the light and studying the bottle before confirming it was an antianxiety medication belonging to Resident #63. b. On 08/27/2024 at 02:36 PM, LPN #10 verified a very faded bottle with a 95 on the cap was 7.75 ml (milliliter) of an opioid pain medication after placing it on the light of a cell phone. ADON #6 and the Nurse Consultant approached and were told LPN #10 was trying to identify 1 of 4 narcotics found locked in the medication room refrigerator. The Nurse Consultant looked at the bottle and confirmed that it should have already been sent back to the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 08/27/2024 at 01:04:05 PM, the Nurse Consultant provided a policy titled Storage of Medications, (Revised, April 2007) revealing nursing staff are responsible for maintaining medication storage in a clean, safe, and sanitary manner. Drug containers with improper labels should be returned to the pharmacy for proper labeling, and discontinued, outdated, or deteriorated drugs will be returned to the pharmacy or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49413 Through observation, interview, and policy reviews, the facility failed to ensure hand hygiene was conducted, that equipment, utensils, plates, cups, and food dome covers were clean and/or properly stored, and that food items had open and expiration dates. These failed practices has the potential to effect 33 sampled residents. The findings: On [DATE] at 9:37 AM, Dietary Aide #1 confirmed an orange whip dessert, uncovered on counter, should had been covered prior to walking away because flies or anything could have gotten in it. On [DATE] at 7:06 AM, the surveyor observed three coffee carafes were neither inverted nor had a cover. On [DATE] at 7:07 AM, the following was observed: 43 plates stacked upon each other leaned left without a cover; a pitcher of water for thinning cooked cereals was on the bottom shelf uncovered; a double basket deep fryer had unknown particles atop the grease, adhered to the baskets and ledge, with a built up brown sticky unknown substance in the outside top crease of the grease. On [DATE] at 7:22 AM, aluminum foil used as a cover for dessert bowls failed to cover the left side and front of the storage container. A trash can was touching the shelving unit where clean oven-mitts, vinyl gloves and aluminum foil were stored. On [DATE] at 7:28 AM, the dishwasher had chunks of unknown substance laying on top and smeared to the front and sides of the dishwasher. On [DATE] at 7:28 AM, in the dishwasher clean area seven bowls were not inverted on a tray, one cup and two scoops were not covered on the second shelf. The third shelf held two storage containers with various equipment and utensils not covered nor stored inverted. On [DATE] at 7:33 AM, 7:38 AM, 7:44 AM, and 7:49 AM Dietary Aide 1's fingers touched the insides of food dome covers. On [DATE] at 7:34 AM, 7:38 AM, 7:52 AM and 7:55 AM, the Cook's fingers touched the plate's surface where food is placed. On [DATE] at 7:45 AM, 68 food dome lids were open side up on the prep table without a cover. On [DATE] at 7:36 AM, 7:43 AM, 7:44 AM, 7:45 AM and 7:53 AM, Dietary Aide #1 used their left hand pushed the milk cart away from the serving line to take a meal tray to serving window, then returned to the serving line with the left hand pulled the milk cart to the serving area. Without washing hands, Dietary Aide #1 used the left hand to get a food dome cover with the finger touching the inside. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 7:47 AM, Dietary Aide #1 touched the inside surface of a cereal bowl lid. On [DATE] at 7:50 AM, Dietary Aide #1 left the serving line, opened room tray cart, with both hands pushed the cart towards the kitchen door. Dietary Aide #1 returned to the serving line, picked up a food dome lid with the left hand. Right hand held a pair of tongs. Dietary Aide #1 left serving line, with both items, opened the warming oven, removed a biscuit and returned to the serving line. Placed biscuit on plate then covered with food dome lid, without washing hands. On [DATE] at 8:01 AM, in the kitchen refrigerator the following failed to have an expired date: one bowl of tuna, two bowls of orange whip, one container of chicken and dumplings, one container of chicken salad, and one container of chicken noodle soup. On [DATE] at 8:05 AM, 14 eggs had been left over the stove for 60 minutes. The Dietary Manager confirmed eggs need to be put in the refrigerator immediately after use. There is concern of cross-contamination. On [DATE] at 8:12 AM, in the walk-in refrigerator a box of 40 four-ounce yogurts did not have an open date. On [DATE] at 8:14 AM, in the Walk-in freezer one 4.4 fluid ounce frozen kiwi-strawberry flavored smoothie was not sealed. On [DATE] at 8:20 AM, a pan with dried rice was uncovered in the dry goods storage room. On [DATE] at 8:21 AM, the following food items in bulk bins failed to have an open and expired date: rice, flour, cornbread mix, powdered milk, picante sauce, graham crackers and saltine crackers. On [DATE] at 8:30 AM. an open package of tortilla shells did not have a received or expiration date. On [DATE] at 8:34 AM, one 46 fluid ounce tomato juice had a dent next to the top seal. On [DATE] at 8:39 AM, a container of 10 tea bags had not been fully closed. On [DATE] at 8:41 AM, the Dietary Manager confirmed food items should have expiration date, as we don't want to give residents expired food for safety reasons. On [DATE] at 9:03 AM, the Dietary Manager confirmed food domes need to be on the rack, so they don't get dirty or knocked on the floor. The utensils, bowls, cups, and plates need to be covered to keep insects or something from dropping on them. This is a sanitary concern for residents. On [DATE] at 9:05 AM, the Dietary Manager confirmed the trashcan should not be touching clean shelving unit with items used for food. On [DATE] at 9:08 AM, the Dietary Manager confirmed the dishwasher should have been cleaned the night before, due to cross contamination. The deep fryer should have been cleaned with the cover over the grease bin. The deep fryer is used to cook for the residents. There is a concern of sanitation and cross contamination from old food on the grates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Timberlane Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 Timberwood Road El Dorado, AR 71730	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:10 AM, the Dietary Manager confirmed the orange whip dessert and water pitcher for hot cereal needed to be covered, anything could have gotten into them. On [DATE] at 9:13 AM, the Dietary Manager confirmed whenever staff leave the serving line or touch an item not used for serving hands must be washed before food is served. Staff should not touch the food surface area of plate; food dome lid or bowl covers with fingers or thumb. These are cross-contamination and sanitation concerns. An In-service Education Report for cleaning with signatures dated [DATE] was provided. Page two showed deep fryer weekend cleaning schedule task not signed as completed. Page four showed drain and clean fryer Thursdays. An In-service Training Module for Food Safety (,d+[DATE], Ben e. [NAME] Foods), signatures and date not provided. Page 6 showed always follow good receiving procedures. Hands should be cleaned after handling soiled equipment or utensils and after engaging in any other activities that contaminate the hands. An Employee Food Safety In-service: Maintaining and Cleaning Equipment (DMA Education Course, Second Edition by [NAME] [NAME], MS, RD, Updated 2012, www.ANFPonline.org), without signatures and date, showed page four Rule #2 clean equipment at the end of each use/day Essential for sanitation.