

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347</p> <p>Based observation, interview and record review, the facility failed to 1) Ensure 1 resident (Resident #93) had the ordered Cervical collar (C-collar) on while up in wheelchair, 2) Ensure 1 resident (Resident #138) had accurate admission documentation, and 3) Ensure 1 resident's (Resident #137) wound care was done per physician's orders, resulting in the potential for increased cervical damage, decreased wound healing, and incomplete admission assessment.</p> <p>Findings Include:</p> <p>Resident #93:</p> <p>Review of the Face Sheet, physician orders, progress notes and nursing notes dated 1/28/25 through 2/13/25, care plans dated 2/12/25 and Kardex (dated 2/13/25), revealed Resident #93 was [AGE] years-old, alert with confusion and communication deficit, admitted for rehab on 1/28/25, and was dependent of staff for assist with Activities of Daily Living (ADL). The resident's diagnosis included, Acute kidney failure, dehydration, history of stroke, diabetes, chronic kidney disease, heart failure, cognitive communication deficit, muscle weakness, and spinal stenosis, cervical region (neck area).</p> <p>During medication pass done on 2/13/25 at 1:00 p.m., it was observed the resident's C-collar (due to cervical stenosis and not having surgery-collar prescribed) was sitting on her room dresser next to the door. At this time the resident was sitting in her wheelchair.</p> <p>During an interview done on 2/13/25 at 1:00 p.m., Nurse, LPN I stated yes, she is supposed to have it (the C-collar) on when sitting up.</p> <p>Review of the physician order dated 2/6/25, stated Aspen collar (type of C-collar) to be worn while sitting up and walking.</p> <p>Review of the facility ADL care plan dated 2/12/25, stated aspen collar on for all transfers (while in the up-right position).</p> <p>Resident #93 attended Resident Council on 2/13/2025 at 11:30 AM, the resident was observed to not have on her C-collar for the duration of the hour long meeting. Resident #93 was hunched over in the wheelchair, with her head angled down and chin almost touching the top of her chest.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Kardex dated 2/13/25, revealed the resident was to wear the C-collar during transfers and toileting (while in the up-right position).</p> <p>Review of the facility Physical Therapy Evaluation for Resident #93 dated 1/29/25, stated Aspen collar when up.</p> <p>38471</p> <p>Resident #137:</p> <p>On 2/12/2025 at 10:09 AM, Resident #137 was observed resting in bed, she shared she was recently admitted but resided at home with her husband prior too. When asked if she had any wounds on her body, she stated on her toe and pulled up the blanket. Resident #137 had a wound dressing on her right great toe that was dated 2/10 with initials LS. The resident was not certain if the dressing had been changed since her admission to the facility.</p> <p>On 2/12/2025 at approximately 1:00 PM, a review was completed of Resident #137's medical records and it indicated she admitted to the facility on [DATE] with diagnoses that included, Pulmonary Embolism, Chronic Kidney Disease, Syncope and Collapse, Dementia and Hypertension. Further review yielded the following:</p> <p>Physician Orders:</p> <p>Wound to R (right) toe, change daily and prn (as needed). Cleanse well with NS (normal saline), pat dry, apply xeroform gauze to wound bed, cover with 2 x 2 gauze and wrap with kerlix. Ordered on 2/10/2025 to begin on 2/11/2025.</p> <p>Admission Assessment- 2/10/2025</p> <p>Skin- .right great toe, shearing to skin on top of great toe.</p> <p>February 2025 TAR (Treatment Administration Record):</p> <p>TAR was marked off by Nurse K as completed on 2/11/2025. The nurses' initials do not match what was written on Resident #137's wound dressing.</p> <p>On 2/13/2025 at 2:20 PM, Wound Nurse J stated Resident #137 admitted on [DATE] and she completed her initial skin assessment yesterday (as upon admission she will completed a secondary comprehensive skin assessment). When asked if she recalled the date and initials on the wound dressing prior to the assessment, she reported she could not recall. Wound Nurse J was asked if the facility would expect dressing changes to be completed per the order and she stated yes that is the expectation. Nurse J was asked if there were any nurses with the initials observed on 2/10/2025 and she reported she was not sure. Nurse J was informed of the observations made on 2/10/2025, she stated the facility would investigate it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/2025 at 3:55 PM, Nurse K was queried regarding Resident #137's dressing change that was documented as completed on 2/11/2025 on the TAR. Nurse K explained on 2/11 she entered the resident's room to complete the dressing change and had her sign admission paperwork as she was refusing for other staff members. Resident #137 signed the admission consents, but she refused the dressing change to her toe. Nurse K stated she forgot to go back and strike it out in the TAR.</p> <p>Resident #138:</p> <p>During initial tour on 2/12/2025, Resident #138 was observed resting in bed, he shared he was just readmitted to the facility and slept amazing. Observed his right upper arm which had an IV in place, Resident #138 was uncertain what it was used for in the hospital and if they will utilize it at the facility. Review was conducted of his admission skin assessment and admission progress note and the IV was not noted.</p> <p>On 2/12/2025 at 3:23 PM, Wound Nurse J and MDS (Minimum Data Set) Nurse L shared they completed a skin assessment on Resident #138 and in his right arm upper arm was a peripheral IV. Upon removing the IV they found it was not inserted into his body and the internal catheter was folded into the dressing. They were asked if this should have been listed on his admission assessment and they stated it should have.</p> <p>On 2/13/2025 a review was conducted of Resident #138's clinical record, and it indicated he admitted to the facility on [DATE] with diagnoses that included, Dehydration, Adult Failure to Thrive, Guillain- Barre Syndrome and Dysphagia. Further review yielded the following:</p> <p>Progress Notes:</p> <p>2/11/2025 at 20:39: Resident admitted from Covenant for weakness, failure to thrive. Resident has 18 french Foley with 30cc (cubic centimeters) of H2O (water), for retention following with urology. Resident alert x 4, active bowel sounds in all 4 quadrants .</p> <p>2/12/2025 at 13:56: right upper arm peripheral IV dressing removed, internal catheter notes on dressing, puncture site healed.</p> <p>Review was completed of the facility policy entitled, Skin Management Facility Guidelines, reviewed January 2022. The policy stated, Conduct baseline head to toe skin assessment on each resident upon admission, readmission .complete follow ups on all areas of identified skin impairments .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	
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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471</p> <p>Based on interview and record review the facility failed to effectively monitor four (#6, 91, 137 & 138) residents of 7 residents reviewed for unnecessary medications, resulting in improper indications for usage and duplicate therapy without rationale.</p> <p>Findings Include:</p> <p>Resident #6:</p> <p>On 2/14/2025 at 10:05 AM, a review was conducted of Resident #6's clinical record and it indicated she admitted to the facility on [DATE] with diagnosis that included, Pneumonia, Heart Disease, Depression and Anxiety. Further review yielded the following:</p> <p>Physician Orders:</p> <p>Buspirone HCl Oral Tablet 10 MG- given 1 tablet by mouth two times a day related to anxiety disorder. Ordered on 1/22/2025.</p> <p>Duloxetine HCl oral capsule delayed release sprinkle 60 MG- give 1 capsule by mouth one time a day related to anxiety disorder. Ordered on 1/25/2025.</p> <p>According to the U.S. Food and Drug Administration, Cymbalta (Duloxetine) is indicated for use for the treatment of major depressive disorder (MDD). It is unknown why Resident #6 does not have the appropriate indication of usage documented for their administration of Cymbalta.</p> <p>Resident #91:</p> <p>On 2/14/2025 at approximately 10:00 AM, a review was conducted of Resident #91's clinical record and it indicated he admitted to the facility on [DATE] with diagnoses that included, Cellulitis, Diabetes, Atrial Fibrillation, Chronic Kidney Disease and Depression. Further review yielded the following:</p> <p>Physician Orders:</p> <p>Nortriptyline HCl Oral Capsule 50 MG Give 1 capsule by mouth at bedtime related to DEPRESSION, UNSPECIFIED</p> <p>Cymbalta Oral Capsule Delayed Release Particles 60 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day related to DEPRESSION.</p> <p>Resident #91 is being administered dual medication therapy for his diagnosis of depression, there was no documentation located from the physician regarding the rational for duplicate therapy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	
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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #137:</p> <p>On 2/12/2025 at approximately 1:00 PM, a review was completed of Resident #137's medical records and it indicated she admitted to the facility on [DATE] with diagnoses that included, Pulmonary Embolism, Chronic Kidney Disease, Syncope and Collapse, Dementia and Hypertension. Further review yielded the following:</p> <p>Physician Orders:</p> <p>Quetiapine Fumarate Oral Tablet 25 MG - give one tablet by mouth at bedtime for Alzheimer's.</p> <p>It can be noted Resident #137 does not have a diagnosis of Alzheimer's and it was not clear in her clinical record the necessity for the antipsychotic medication.</p> <p>Resident #138:</p> <p>On 2/13/2025 a review was conducted of Resident #138's clinical record, and it indicated he admitted to the facility on [DATE] with diagnoses that included, Dehydration, Adult Failure to Thrive, Guillain- Barre Syndrome, Depression and Dysphagia. Further review yielded the following:</p> <p>Physician Orders:</p> <p>Duloxetine HCL (hydrochloride) Oral capsule delayed release sprinkle 30 MG (milligram)- Give 1 capsule at bedtime for mental health. Give with 60 mg duloxetine to equal 90 mg. Ordered on 2/11/2025.</p> <p>Duloxetine HCL (hydrochloride) Oral capsule delayed release sprinkle 60 MG-Give 1 capsule at bedtime for mental health. Give with 30 mg duloxetine to equal 90 mg at bedtime. Ordered on 2/11/2025.</p> <p>Progress Notes:</p> <p>2/11/2025 at 22:28: Duloxetine HCl Oral Capsule Delayed Release Sprinkle 30 MG Give 1 capsule by mouth at bedtime for Mental health Give with 60 mg duloxetine to equal 90 mg.</p> <p>Resident #138 has the appropriate diagnosis to be administered his depression medication but the indication listed was mental health, it is unknown how or why this occurred.</p> <p>On 2/13/2025, Social Worker F was queried regarding the residents psychotropic medications and varying concerns.</p> <p>Resident #6: Social Worker J stated the Cymbalta is treating the resident's diagnosis of depression and she was unsure as to why it was indicated for antianxiety.</p> <p>Resident #91: Social Worker J reported she had not been monitoring duplicate therapy for facility residents and stated she did not have the rationale within the charting regarding why both were needed.</p> <p>Resident #137: Social Worker J reviewed the diagnosis list and stated the resident does not have a diagnosis of Alzheimer's and did not have an answer as to why that was listed as the indication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	
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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #138: Social Worker J explained he is utilizing Duloxetine for his diagnosis of depression and mental health should not have been utilized as an indication for usage. She further stated she does not monitor the indications for usage for residents' psychotropic medication usage.</p> <p>Review was completed of the facility policy entitled, Psychotropic Medication Assessment and Monitoring, revised April 2019. The policy stated, .Psychotropic medications are only prescribed when necessary to treat a specific diagnoses and documented condition .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 4 medication carts were clean and sanitized for a census of 34 residents who receive medications, resulting in the potential for cross contamination.</p> <p>Findings Include:</p> <p>[NAME] Hall Medication Cart:</p> <p>During observation done on 2/12/25 at 11:27 a.m. on [NAME] Hall, the fourth medication drawer down was noted to have an excessive amount of dried on liquid medications on the bottom of the drawer. The Pro-State bottle had dried on drips on the sides and it had leaked onto the bottom of the drawer; no staff member had cleaned it up. Also, crushed meds-like substances and small pieces of paper were found in the corners of the fourth drawer along with the Milk of Magnesia bottle that had dried on medication drippings on the sides.</p> <p>During an interview done on 2/12/25 at 12:00 p.m., Nurse, LPN G stated I don't know who is supposed to clean the cart (medication cart).</p> <p>During an interview done on 2/13/25 at approximately 9:00 a.m., the Director of Nursing said she did not think the facility had a medication cart cleaning policy.</p> <p>Review of the facility Cleaning Medication Storage Areas policy dated January 2010, revealed how to clean the refrigerators, medication rooms and floors, and how to clean the top of medication and treatment carts only. No documentation of who was to clean the inside of medication carts was found.</p> <p>[NAME] Hall Medication Cart:</p> <p>During observation done on 2/12/25 at 12:00 p.m., on [NAME] Hall, the fourth medication drawer down was noted to have black colored dust, small pieces of papers and crushed-like meds on the bottom of it.</p> <p>During an interview done on 2/12/25 at 12:00 p.m., Nurse, LPN H stated We clean it (the medication cart) on our own.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>22347</p> <p>Based on observation, interview and record review, the facility failed to 1) Maintain food preparation and kitchen equipment in a sanitary and good working condition, and 2) Ensure all open and partly used foods were dated, resulting in an increased likelihood for food borne illness with hospitalization , and cross contamination affecting 34 residents who consumed oral nutrition from the facility kitchen of a total census of 34 residents.</p> <p>Findings Include:</p> <p>Review of the Public Health Service 2009 Food Code, adopted by the Michigan Food Law, effective October 1, 2012, Chapter 4-501.14 directs that equipment cleaning frequency is to be throughout the day at frequency necessary to prevent recontamination of equipment.</p> <p>On 2/12/25 at 10:00 a.m., during the initial tour of the main kitchen accompanied by small kitchen Dietary Manager B.</p> <p>Observation of the small facility kitchen was done on 2/12/25 at 10:00 a.m. with Dietary Manager B.</p> <p>-At 10:05 a.m., the large can opener blade was observed to have dried on food on it.</p> <p>-At 10:10 a.m., the dishwasher was opened by staff and it had a crusting of food on both sides and top on the inside. The staff was said the dishwasher was used daily.</p> <p>Observation of the main facility kitchen was done on 2/12/25 at 10:15 a.m., with Dietary Manager C.</p> <p>-At 10:15 a.m., Refrigerator #1 (Dairy) was observed to have dried on milk and food particles on the inside of the bottom and sides by the door.</p> <p>-At 10:16 a.m., the small ice machine was observed to have a light orange colored build-up near the water line; no top on it and next to the ice reservoir.</p> <p>-At 10:18 a.m., the microwave was observed to have dried food inside on the top, sides and glass plate. Also, when the microwave was moved, there was an excessive amount of food particles, dust and crumbs.</p> <p>-At 10:20 a.m., the juice machine was observed to have a build-up of dried juice between spigots'.</p> <p>-At 10:22 a.m., two open and partly used breads were found without any dates written or date stickers found.</p> <p>-At 10:23 a.m., the stove, fryer and the kitchen floor between them was observed an excessive amount of dried on foods, grease and dried liquid spills. The right grease container was black in color and unable to see through it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehab at Wellspring		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Rd Saginaw, MI 48603	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview done on 2/12/25 at 10:23 a.m., Dietary Manager C stated We are going to change the oil today.</p> <p>-At 10:25 a.m., an observation of a light gray colored trash bin filled to top with trash, a broken off top was noted to be sitting right next to a stack of clean and ready for use white plates.</p> <p>-At 10:30 a.m., the grill that was turned on with a pan cooking food was observed to be coated with dried foods and dried fluid spills; also, the bottom shelf was partly broken off.</p> <p>-At 10:30 a.m., the large can opener was observed to have dried on food and paint chipping off of the blade.</p> <p>-At 10:33 a.m., the large clean and ready for use floor mixer was observed to have dried on food particles at the attachment area, directly over the bowl.</p> <p>-At 10:35 a.m., the Kitchen Aid counter mixer was clean and ready for use was observed to have dried on food and frosting-like substance on the attachment area, directly over the bowl.</p> <p>Review of the facility kitchen duty list dated 2/11/25, revealed all the kitchen duties/job's had been done.</p> <p>-The kitchen policy stated At the beginning of each week print and hang all cleaning checklists at the centralized command center of the kitchen.</p> <p>-15 minutes prior to the end of each shift review the cleaning checklist with each associate to ensure all tasks are completed in a satisfactory manner.</p> <p>At the end of each week collect all the completed sheets. Staple the weeks completed checklists together and file by week.</p>