

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observations, interview, and record review, the facility failed to ensure residents have a right to a dignified existence for one resident (unidentified resident) of one resident reviewed for resident rights. The facility failed to ensure one staff member was not on the phone while assisting one resident with their meal. This failure could cause residents to have a negative psychosocial outcome. Findings included: Observation on 07/23/2025 at 12:23PM revealed LVN F was on the phone while assisting a resident (unidentified) during lunch. During an interview on 07/24/2025 at 12:29PM LVN F revealed he was on the phone with the doctor while assisting a resident with their meal. He stated it was not okay to be on the phone while assisting residents with their meals. He explained it drew attention away from the resident, they could pick up something they should not put in their mouth, and its disrespectful. He stated he would not have liked it (if he was in the resident's position) and would want the utmost respect. During an interview on 07/24/2025 at 02:03PM with DON revealed while staff assist residents with their meals, she expected staff to sit next to the resident, assist one resident at a time, to make sure they clean and sanitize their hands before assisting each resident. She stated it was not acceptable for staff to be on the phone while assisting a resident. She further stated an in-service was done the month prior regarding the topic. She explained it was not okay for staff to be on the phone because staff would not be giving the resident their full attention, it can be a HIPAA issue, and its not professional; staff should try to find someone else to assist the resident so they can talk to the doctor. She stated the policy was a to not be on the phone in the patient care area. Record review of the facility's policy Resident Rights revised December 2016 reflected: Policy Statement Team members shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence be treated with respect, kindness, and dignity</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: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations, interviews, and record review, the facility failed to provide a clean and homelike environment for three of five residential halls (Hall 200, Hall 300, and Hall 400) reviewed for a safe, clean, comfortable, and homelike environment. The facility failed to ensure six air duct registers were free of small black spots, rust, paint chipping and securely fit into ceiling tiles. These failures could place residents at risk for decline in health and decreased quality of life due to living in unclean and non-homelike environment. Findings included: Observation on 07/22/2025 at 10:26AM in Hall 200 revealed: S One ceiling air duct register covered with small black spots. S One ceiling air duct register, with rust and peeled paint chips. Observation on 07/24/2025 at 11:59AM in Hall 300 revealed: S Two ceiling air duct registers covered with small black spots and rust S One ceiling air duct register covered with small black spots Observation on 07/24/2025 at 12:07PM in Hall 400 revealed: S One ceiling air duct register with small black spots in a white ceiling tile with small black spots lining the air duct register. The ceiling air duct register did not securely fit in the ceiling tile. An interview on 07/24/2025 at 01:11PM with the maintenance manager revealed housekeeping was responsible for cleaning the air ducts and maintenance replaces air duct registers. The maintenance manager explained he will talk with staff about maintenance requests, but staff must put in a work order. This surveyor showed the maintenance manager an image of the condition of one air duct register located in Hall 200; he stated that housekeeping would clean the air duct register, but maintenance would replace the air duct register based on its dirty appearance. The maintenance manager stated the substance on the air duct was not black mold, but it may be mold or dirt. The maintenance manager discussed that to resolve the problem with the air duct registers, he would replace them. An interview on 07/24/2025 at 01:45PM with the housekeeping manager revealed housekeeping staff was responsible for maintaining cleanliness of the air duct registers and maintenance replaces air duct registers. The housekeeping manager stated housekeeping staff cleaned resident rooms every day. She expected the air duct registers to be checked daily; if housekeepers see an issue, they inform her or nurses so a maintenance work order can be placed. The housekeeping manager stated housekeeping staff will check all air duct registers and make a list of the ones that need replaced. During an interview on 07/24/2025 at 02:03PM with the DON revealed room rounds are done to check the condition each room. The DON stated that she had not checked air duct registers. This surveyor showed the DON an image of the condition of one air duct register located in Hall 200, and she stated she will now check the air duct registers closely. She stated she would report the condition of the air duct register to housekeeping to have it cleaned. The DON stated clean air duct registers are important because resident rooms should be homelike, and so that the residents stay healthy and don't have issues because of a dirty air duct register. Record review of the facility policy Homelike Environment revised February 2021 reflected: Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation. The community team members and management maximize, to the extent possible, the characteristics of the community that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable well-being for one resident (Resident #54) of seven residents reviewed for care plans. The facility failed to complete care plans addressing Resident #54's behavior of picking and scratching at wounds on her arm, or her skin condition. This failure could affect residents by placing them at risk for not receiving care and services to meet their needs. Findings included: Review of Resident #54's face sheet, dated 07/22/25, reflected she was an [AGE] year-old female, admitted on [DATE], with diagnoses which atopic neurodermatitis (a type of eczema which causes intense itching, leading to thick, leathery patches of skin), stroke affecting her left side, and anxiety disorder. Review of Resident #54's admission MDS assessment, dated 06/17/25, reflected she was usually able to understand others, and was usually able to be understood. She had a BIMS score of 13, indicating intact cognition. The document reflected no concerns regarding her mood, mental status, or behavior. Resident #54 used a wheelchair, and had one-sided impairment. While Resident #54 was noted to be at risk for skin breakdown, no skin issues were noted in the document. Review of Resident #54's Medication Administration Records and Treatment Administration Record from her admission on [DATE] through 06/22/25 reflected no orders having to do with the care of the resident's skin problem on her arms, or her behavior of picking and scratching. Review of Resident #54's order summary, dated 07/24/25, reflected an order for Triple Antibiotic External Ointment (Neomycin- Bacitracin-Polymyxin) Apply to Left outer elbow topically two times a day for Skin tear, started on 07/23/25. Review of Resident #54's care plans reflected the following:- The resident has an ADL self-care performance deficit r/t Date Initiated: 06/04/2025 The resident will maintain current level of function in [sic] through the review date. Date Initiated: 06/04/2025 Revision on: 07/22/2025 Target Date: 09/18/2025 BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 06/04/2025 (.) PERSONAL HYGIENE: The resident requires (SPECIFY assistance) by (X) staff with personal hygiene and oral care. Date Initiated: 06/04/2025- The resident has potential/actual impairment to skin integrity of the (SPECIFY location) r/t Date Initiated: 06/04/2025- The resident will maintain or develop clean and intact skin by the review date. Date Initiated: 06/04/2025 Revision on: 07/22/2025 Target Date: 09/18/2025 Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Date Initiated: 06/04/2025 Identify/document potential causative factors and eliminate/resolve where possible. Date Initiated: 06/04/2025 Pad bed rails, wheelchair arms or any other source of potential injury if possible. Date Initiated: 06/04/2025 An interview and observation on 07/22/25 at 10:51 AM with Resident #54 revealed her to be alert, and sitting in her wheelchair in her room. Resident #54 had two round scabbed areas, surrounded by flaky skin (approximately the size of a dime, including the flaky areas), and a vaguely rectangular spot of open skin approximately a centimeter and a half wide, and three centimeters long, appearing like the skin had been scraped off. When asked about the sores on her arm, the resident started to scratch and pick at one of the round areas, and explained she was a picker and that she fell at home, before she came to the facility, and scraped a bunch of skin off. She said it never healed all the way, because she constantly scratched and picked at them. Resident #54 said they would get better, then get bad again, because she could not leave them alone. She said the facility had wrapped her arm, to help her remember to leave the wounds alone, but it itched so she took it off. She did not remember if they had tried anything else. She said she was not upset by the sores, and she had always been a picker. An interview on 07/23/25 at 2:59 PM with RN A revealed she thought Resident #54 had problems with her skin on her arm when she was admitted . She said it would heal, then she would pick and scratch at it, and it would open up again. She said they wrapped her arm sometimes to discourage her from picking it, but she took the wrap off. An interview on 07/23/25 at 3:18 PM with CNA B revealed he was not sure how long Resident #54 had the problem with her skin on her arm, but he remembered that it was an on-going issue with her, and it got better, then it got worse again. An interview and observation on 07/24/25 at 10:14 AM with Resident #54 revealed the open wound on her arm appeared to be missing more skin than on previous observation, and she was actively scratching her arm when the surveyor entered the room. Her arm, in the area of the wound, had developed some redness (a possible sign of infection.) She was wearing a fabric sling on her left arm. She said she thought it was to keep her from scratching, but she did not like it</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained free of accident hazards as is possible for 1 (Resident #42) of 15 residents and 6 residents on the south suites hall reviewed for accidents and hazards in that; 1. Resident #42 had an electrical extension cord and a multiple receptacle plug-in adaptor in his room.2. The facility failed to secure the exit door at the end of south suites hall. This failure could place residents at risk of harm due to wondering or elopement.1. Record review of Resident #42's face sheet, dated 07/22/25, reflected he was a [AGE] year-old man, admitted to the facility on [DATE], with diagnoses of stroke, depression, uncontrolled blood sugar, hemiplegia and hemiparesis following cerebral infraction affecting the left non-dominant side (this is the paralysis and numbness after a stroke on the left side), limited mobility, and age related nuclear cataract in both eyes (this is the clouding and yellowing of the lens in the eyes causing blurred vision). Record review of Resident #42's quarterly MDS assessment, dated 06/05/25, reflected Resident #42 had a BIMS score of 15, indicating that he was cognitively intact. Resident #42 had a clear speech and was able to understand others and was understood by others. Resident #42. Resident #42's range of motion was impaired on one side of his upper body and lower body. He was able to feed herself with only moderate assistance from staff (helper does less than half the effort.) He was always continent of bowel and bladder. Review of Resident #42's care plan, 06/26/25, reflected the following:Problem: Resident #42 barricaded himself in the room to keep staff out, he was agitated with having a roommate and smashing into front sliding doors causing damage.Goal: Resident #42 would have fewer episodes of behaviors through the next review date. Interventions: -Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.-Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. In an observation and interview on 07/22/23 at 10:40 AM, it was revealed that Resident #42 was in his room seated in a motorized wheelchair, he had a laptop and multiple cords under his bed. There was a standard wall dual outlet plate on the wall by his headboard and plugged into the wall outlet was a four-outlet adapter extender plugged into the wall and the adapter had four long cables plugged into it including a white extension cord with a flexible cable that had a plug on one end and a two-pong outlet on the other end. Resident #42 said all the staff were aware he had the adaptor and extension cords. He said the facility had talked to him a few months ago that the cords were a tripping hazard, but he did not agree the cords were a tripping hazard because he got assistance from staff to get up from his bed to the wheelchair and back. Interview with the housekeeper on 07/24/25 at 10:55 AM, revealed that she cleaned Resident #42's room and she said he had too many cords in his room which made it difficult to clean his floors. She said she did not report the extension cord because she thought he was allowed. She said she had not received any in-service on extension cords and power strips but that she was aware they were a fire hazard. In an interview with maintenance personnel on 07/24/25 at 11:02 AM, revealed different management personnel were assigned and designated to monitor different areas of the facility and during a rounding a few weeks ago it had come to his attention that Resident #42 had an extension card in his room. He said he had notified the nursing department including ADM about Resident #42 having an extension cord. He said Resident #42 did not like him, so he did not go into his room unless it was to fix something. He said nursing was responsible for monitoring residents' rooms and if something needed to be fixed, they would notify maintenance, but he was not allowed to remove or search residents' belongings. He said space heaters, electric blankets, power cords, and extension cords were not allowed in the facility. He said these items were a fire hazard and could start a fire. In an interview with DON on 07/24/25 at 2:02 PM, it was revealed the ADON's were responsible for room rounds on different hallways however the two ADON's were new and had not yet been assigned the responsibilities of room rounds. She said the nursing staff was responsible for monitoring the residents' rooms and reporting issues to the necessary departments. She said the staff were having a difficult time with Resident #42 because he did not allow them to touch anything in his room. She said he usually refused to have his room cleaned as well. She said the risk of using an extension cord was it could start a fire. In an interview with ADM on 07/24/25 at 3:00 PM, it was revealed she was not aware that Resident #42 had an extension cord prior to today. She said she had removed and stored the extension cord in her safe after discovering it today. She said she filed a grievance for Resident #42 regarding the power</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	

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 - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	
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 - Many</p>	<p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen observed for food safety. The facility failed to ensure the stand-by refrigerator free of personal food items. The facility failed to ensure the walk-in refrigerator food items were dated, labeled and securely stored. The facility failed to ensure the walk-in freezer food items were dated, labeled and securely stored. The facility failed to ensure the dry storage food items were dated, labeled and securely stored. The facility failed to ensure that canned good food items were free of dents. The facility failed to ensure that dishwashing protocol was followed. The facility failed to ensure that prepared foods were held correctly and maintained safe temperatures. These failures could place residents at risk for foodborne illnesses. Findings included: Observation on 07/22/2025 at 09:03AM of the walk-in refrigerator revealed the following: Deli sandwiches dated 7/21/25 in an unsealed plastic bag and no use by date. Unsealed plastic bag of lettuce in a box dated 7/14 and no use by date. Unsealed plastic bag of sausage patties, with no label and no use by date. Open package of turkey deli meat, with no use by date. A saran wrapped piece of unsliced deli meat, with no label of the type of deli meat and no use by date. A saran wrapped block of slice cheese dated 7/20/25, with no label of the type of cheese and no use by date. Brown gravy in a metal pan with a lid, dated 7/20/25 and shelf life 7/27/2025. The lid loosely covered the pan and did not securely seal the gravy. An interview on 07/22/2025 at 09:07AM the DM stated guess not when asked if the gravy was properly sealed and proceeded to discard the gravy. Observation on 07/22/2025 at 09:09AM of the walk-in freezer revealed an unsealed bag of frozen lima beans. Observation on 07/22/2025 at 09:12AM of the dry storage closet revealed the following: A can of peach slices with a hole puncture and yellow-orange liquid on the bottom of the can. An open bag of grits dated 7-3-2. A large container labeled Yellow Corn, with no date. A large container labeled Bread Crumbs dated 2/6/25, with no use by date. A large container labeled Dry Cereal, with no opened on or use by date and label the cereal type. A large container labeled Honey Nut Rings, with no opened on or use by date. An interview on 07/22/2025 at 09:18 AM with the DM revealed she was not aware of the puncture on the canned good of peaches. She explained that punctured and dented canned goods can lead to the risk of rust and contamination and the residents can get sick as a result of eating the foods. The DM stated she expected every food item to be dated and labeled when received. She further stated opened food items were supposed to be in Ziploc bags, with the date the food item was opened, and a use by date. She explained the importance of dating, labeling, and sealing foods was so the staff know if foods were safe to use after opening and to avoid contamination because residents can get sick. Observation on 07/23/2025 at 11:21AM upon reentry to the kitchen revealed the following: An uncovered tray of breadsticks on the steam table. Peanut butter pie sitting on meal trays. Observation on 07/23/2025 at 11:40AM of lunch food temperature check revealed the following: The temperature of the peanut butter pie was 64 F. Cook A was observed washing a strainer using the 3-compartment sink. [NAME] A proceed to wash the strainer in the 1st compartment. In the 2nd compartment, [NAME] A turned on the faucet and rinsed the strainer with running water. The cook then sat the strainer out to air-dry. An interview on 07/23/2025 at 11:45 AM with the DM revealed that the temperature for cold foods should be 41 F. She proceeded to substitute the dessert with ice cream because the holding temperature was above 41 F. She stated cold foods can be held on ice to maintain appropriate temperatures before being placed on trays. The DM stated food not covered exposes them to contamination. An interview on 07/23/2025 at 11:54 AM with [NAME] A revealed the cook does utilize the 3-compartment sink to clean dishes. [NAME] A stated dishes are to be washed, rinsed, and then sanitized the dishes in the 3-compartment sink. She explained the 3rd compartment was to be used for sanitizing dishes; the sink was filled with the sanitizing solution and the solution was tested using a chemical test strip. [NAME] A stated she did wash the strainer and it was clean. At this time the DM intervened and stated the strainer was not cleaned based on the policy for 3-compartment sink use for sanitizing dishes in quaternary ammonia. Record review of the facility's Food Storage policy, dated 2018 reflected: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Procedure: 1. Dry storage rooms. d. To ensure freshness, store opened and milk items in tightly covered containers. All containers must be labeled and dated. 2. Refrigerators. d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage 3. Freezers e. Store frozen foods in moisture-proof wrap or containers that are</p>		