STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455574	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Weatherford	521 W 7th St Weatherford, TX 76086

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident became eligible for Medicaid of the items and services that were included in nursing facility services under the State plan and for which the resident may not be charged, those other items and services that the facility offered and for which the resident may be charged, and the amount of charges for those services, and inform each Medicaid-eligible resident when changes were made to the items and services for 2 of 3 residents (Resident #6 and Resident #32) reviewed for resident rights. The facility failed to ensure Residents #6 and Resident #32 were given a paper copy of the NOMNC (notice of Medicare non coverage) with information on how to appeal the decision when residents were discharged from skilled services at the facility prior to covered days being exhausted.This failure could place residents at risk for not being aware of their right to appeal the decision to end Medicare coverage for skilled services, changes to provided services, and their financial responsibilities. Findings include:1. Record review of Resident #6's NOMNC (Notice of Medicare Non-Coverage), dated 08/06/2025 revealed no evidence of a signature by the resident or resident representative. The effective date of coverage of the current Medicare services will end on 08/08/2025. A written note stated verbal NOMNC given to POA at a phone number on 08/06/2025 due to resident diagnosis of cognitive impairment. Record review on 02/12/2026 of Resident #6's electronic face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnosis which included Metabolic Encephalopathy, Seizures or convulsions and Spastic Quadriplegic Cerebral Palsy. Record review of Resident #6's quarterly MDS, dated [DATE], revealed Section C, cognitive patterns, BIMS score 99, which indicated severely impaired cognition. Resident #6 Therapy services for at least 15 minutes a day on one or more days in last 7 days: Speech-Language Pathology and Audiology Services, Occupational Therapy and Physical Therapy.Record review of Resident #6's Care Plan, dated 01/07/2026 revealed the resident had limited physical mobility related to contractures. Intervention PT, OT referrals as ordered.Record review of Resident #6's Physician orders, dated 02/01/2026, revealed an order written 01.21.2026 Continue OT services for modalities 3 times a week times 4 weeks. PT ordered for therapeutic activities, therapeutic exercises, neuromuscular re-education and group therapy 3 times week times 8 weeks beginning 12.02.2025.Record review of Resident #32's NOMNC, dated 12.31.2025, revealed no evidence of a signature on the form. The effective date coverage of Medicare Services will end 01.02.2026. A written note on the form stated verbal notification given to son 12.31.2025 at 4:25 PM.Record review of Resident #32's electronic face sheet revealed [AGE] year-old-male admitted on 12.23.2025 with the following diagnosis Hyperkalemia , Acute respiratory failure with hypoxia (insufficient supply of oxygen), muscle weakness, Encephalopathy (Brain dysfunction).Record review of Resident #32's MDS dated [DATE], revealed Section C, cognitive patterns, BIMS score 15, which indicated cognitively intact cognition. Section O-Special (continued on next page)

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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment, Procedures, Programs. ST 273 minutes of therapy. OT 300 minutes of therapy. PT 320 minutes of therapy.Record review of Resident #32's care plan, dated 01/06/2026, focus-The resident has an ADL self-care performance deficit related to Musculoskeletal deficit. Intervention-PT/OT evaluation and treatment as per physician orders.Record review of Resident #32's physician orders, dated 02/01/2026, revealed Admit to facility for Medicare part A skilled services. PT/OT/ST to evaluate and treat.During a telephone interview on 02/12/2026 at 1:38 PM, LPN A-MDS coordinator stated she gave verbal notification to Resident #6' POA of beneficiary notification and NOMNC information. The LPN stated she gave verbal information to Resident #32's family member. LPN A stated she verbally told them she would leave a copy of the form in the resident's room for them to pick up when they visited. LPN A stated she did not document on the form that a copy was left in the room or if the representative/POA had picked it up .During a telephone interview on 02/12/2026 at 1:57 PM, Resident #32's family representative stated he remembered someone called him and told him about Resident running out of skilled days, but they never gave him a form, and he never saw one in Resident #32's room, and he never signed anything. During an interview on 02/12/2026 at 3:45 PM, the ADMN stated the preferred method was actual written consent, unless it's a situation where the family was out of state and were not able to come in and sign. The ADMN stated she was not aware of there being no signatures on the NOMNOC. The ADMN stated her expectations were the NOMNOCs be completed. The ADMN stated the Social Worker, business office and the MDS coordinator were responsible for getting the form signed in person by the resident or the resident's representative. The ADMN stated at the very least the form should have been discussed with the responsible party over the phone. The ADMN stated ultimately the failure came back to her. The ADMN stated the harm to the residents could have been the residents did not have time to prepare for discharge from therapy and would not be aware of the appeals process. Record review of the facility's policy titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices not dated revealed: Residents are informed in advance when changes will occur to their bills. Policy Interpretation and Implementation: Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) IF the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). The resident (or representative) is informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Notice of Medicare Non-Coverage (CMS form 10123) If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage is issued to the resident at least two calendar days before benefits end. The Notice of Medicare Non-Coverage informs the residents of the pending termination of coverage and of his/her right to an expedited review by a Quality Improvement Organization.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to be free from physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms for 1 of 8 residents (Resident #3) reviewed for freedom from physical restraints. 1. The facility failed to obtain documentation and/or consent identifying the medical symptoms being treated and an order for a pommel cushion for Resident #3's pommel cushion.2. The facility failed to ensure Resident #3's movement was not restricted, due to a pommel cushion This failure could place residents at risk of unnecessary restriction of their freedom of movement (any change in place or position for the body or any part of the body that the person is physically able to control). Findings include: Record review of Resident #3's electronic face sheet, dated 02/12/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with a reentry admission on [DATE]. Resident #3 had diagnosis which included: Dementia, malnutrition, anxiety disorder, depression, hypertension (high blood pressure) and dysphasia (unable to talk) Record review of Resident #3's Quarterly MDS, dated [DATE], revealed the BIMS score was blank. Further review of the MDS, revealed: Section E: Behavior: E0100. Potential Indicators of Psychosis: Z. None of the above (delusions or hallucinations). E0200. Behavioral Symptoms: A. Physical behavior symptoms directed towards others - behavior of this type occurred 1 to 3 days, B. Verbal behaviors symptoms directed towards others - behavior not exhibited, C. Other behavioral symptoms not directed towards others - behavior not exhibited. E0900: Wandering - 1 (Behavior of this type occurred 1 to 3 days). Section GG: Functional Abilities. GG 0122: Mobility Devices C. Wheelchair Section P0100: Physical Restraints and Alarms: Not used. Record review of Resident #3's consents, on 02/12/2026, revealed no evidence of a signed consent for the pommel cushion. Record review of Resident #3's progress notes, dated 01/02/2026, revealed Nursing Note Text: Resident is no longer sliding to the edge of the chair seat after pummel cushion installation. Record review of Resident #3's progress notes, dated 01/05/2026, revealed; Note Text: IDT Met and discussed root cause of fall. resident continues to lack safety awareness and attempts to get up frequently and falls. Pommel seat applied to wheelchair. During an observation on 02/11/2026 at 11:10 AM, revealed Resident #3 was sitting in a wheelchair at the nurse's station. He had a pommel cushion in his chair. During an interview on 02/12/2026 at 1:37 PM, revealed Resident #3's Representative stated she went to see Resident #3 and asked the nurse what the pummel was for, the nurse explained to her it was used to keep him from falling out of his wheelchair. She stated she had not signed a consent nor had she been called prior to the facility placing it in his wheelchair. During an interview on 02/12/2026 at 1:52 PM, the DON stated Resident #3 fell so much they had to figure out some other process to prevent him from falling. She stated the facility tried other things and had to resort to the pummel and used this for his safety. The DON stated this was to prevent Resident #3 from continuing to fall out of his wheelchair. The DON stated she did not consider this to be a restraint and therefore did not feel there needed to be consent. She stated, the pummel should have an order in Resident #3's medical chart from the physician. During an interview on 02/12/2026 at 2:21 PM, Resident #3's primary Doctor stated she was not notified of the pommel cushion, until today when the DON called, after the pummel cushion was in place. The Doctor stated he was aware of it, at times, but at other times wasn't. She stated she was aware of the pommel cushion when she spoke to the DON earlier in the afternoon (02/12/2026) and asked if there were any concerns. The Doctor stated to her it may be a concern because it was considered a restraint and was not aware it was put in place. She stated his family should have been notified prior to putting the pommel in (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place since it was considered a restraint. The Doctor stated since it was considered a restraint there also needed to be a consent that told them of the risks and the benefits of using it. She stated preventing him from being hurt or injuring himself was a big deal, but if it was considered a restraint and his family should have be aware. During an interview on 02/12/2026 at 2:42 PM, the ADON stated she considered the pommel cushion a restraint. She stated the policy was to speak to the physician and attain an order prior to placing the pommel cushion in Resident #3's wheelchair. During an interview on 02/12/2026 at 4:07 PM, the DON stated the staff failed to put the order in the electronic record. The physician order should have been placed in the electronic medical record prior to the pommel cushion being in use. She stated the MDS, DON, ADON and the physician were responsible for monitoring this type of restraint. The DON stated the Doctor should have been consulted for the order prior to being used. She stated she felt the pommel cushion was discussed with the doctor prior to being used and was the last alternative to keep him from getting out of his wheelchair and falling. The DON stated there was no consent for the pommel cushion, and if she considered it a restraint there would have been a consent. She stated the failure occurred with not being more thorough with the IDT and having a better checks and balance in place for monitoring and for all nursing staff to have performed a better job. Record review of the facility's policy Use of Restraints, dated 2001, revealed; Policy statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff. Convenience stores for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing reevaluation for the need for restraints will be documented.Policy Interpretation and Implementation; Physical restraints are defined as a manual method or physical or mechanical device, material or equipment attached or Adjacent to the residence body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to 1's body.The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot move a device in the same manner in which the staff applied it, given that residence physical condition. (I. E., rather than climbed over, and this restricts his or her typical ability to change position or place, That device is considered a restraint.A description of the residence. Medical symptoms. (i.e., An indication of the characteristic of a physical or psychological condition) that warranted the use of restraints;.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 6 medication carts (cart #1) reviewed for medication storage.The facility failed to ensure medication cart #1 was locked and secured while unattended.This failure could place residents at risk of a drug diversion. Findings include:During an observation on 02/10/2026 at 10:55 AM, on south side of the facility, across from the nurses' station, revealed the overflow medication cart (Cart #1) was unlocked and unattended. One male resident in a wheelchair approximately four feet from Cart #1 was observed. The medication cart contained blister packs of blood pressure medications, anti-diabetic medications, diuretics, potassium supplements, anti-platelet medications and blood thinners.During an interview on 02/10/2026 at 11:00 AM, LVN B stated Cart #1 was new and only had overflow medications stored in the cart. The LVN stated she was responsible for ensuring Cart #1 was locked when not in use. The LVN stated she got called to the secure unit and forgot to lock the medication cart. The LVN stated if a resident opened the medication cart, they could have possibly taken a medication that was not intended for them and could have caused them to have a negative reaction. The LVN stated she monitored for ensuring the medication cart was locked when not in use.During an interview on 02/12/2026 at 12:00 PM, the DON stated the medication carts should have been locked when not in use. The DON stated if a medication cart was unlocked and unattended a resident, visitor or staff could steal or ingest a medication that was not meant for them and possibly have an adverse reaction. The DON stated the nurses should have monitored the medication carts to ensure they were locked when not in use. The DON stated she did not have a set routine to monitor the medication carts. The DON stated because she was not present when this occurred, she did not know how this failure occurred.Record review of the facility's policy titled Medication Labeling and Storage Policy statement, dated 2001, revealed The facility stores all medications and biologicals in locked compartments under the proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and ImplementationMedication Storage1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner.4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility kitchen reviewed for kitchen sanitation. The facility failed to ensure foods were properly stored, labeled, and dated in the refrigerator and freezer.The facility failed to ensure the floors in the pantry and back hallway were kept clean to avoid buildup of grease, dirt, and dust in the faculty's only pantryThe facility failed to keep the kitchen area maintained in a clean manner to keep the floors, food surfaces, and cooking areas free of debris.The facility failed to ensure the stove was maintained in a clean manner to avoid liquid from seeping from underneath, maintain the drip pans in a safe manner, and keep the back drop free of grease and food splatter.The facility failed to ensure kitchen staff used proper hand washing and sanitation procedures when handling and serving food. The facility failed to ensure kitchen staff did not touch food directly with their hands.The facility failed to ensure kitchen staff used hairnets properly to secure hair was not exposed while in the kitchen. These failures could place residents at risk of cross contamination and food borne illness.The findings include: During an observation on 02/10/2026 at 11:04 a.m., when checking the the side-side stand up refrigerator on the back wall of the kitchen, observed a white, Styrofoam container without a label or date on the outside of the container that held a gray substance in a liquid. The Dietary Manager threw the food away. A large Ziplock bag that contained sliced turkey with no label, date, or use by date was observed. During an observation on 02/10/2026 at 11:10 a.m., observed two (2) plastic bags of yellow sliced bread with no label, date, or use by date in the large side-by-side freezer, located on the back wall of the kitchen and three (3) clear bags of small green brussels sprouts with no label, date, or use by date. The Dietary Manager threw the bags out. There was a clear plastic bag with small, yellow pancakes that contained ice crystals inside the bag, with no label, date, or use by date. During an observation on 02/10/2026 at 11:15 a.m., when checking the large side-by-side stand up refrigerator located in the front of the kitchen, observed a plastic container of purple jelly with no label, date, or use by date on the container, the lid was not properly sealed. The Dietary Manager attempted to seal the container, but the lid would not fit the container properly with an accurate seal. During an observation on 02/10/2026 at 11:20 a.m., in the pantry observed a large plastic container of corn flakes and a large container of fruit loop cereal with the lids not properly sealed. The Dietary Manager attempted to put the lids on the plastic containers, but both lids would not fit the containers properly with an accurate seal. The pantry floor was black in the middle area, and the tiles were lighter under the shelves. The floor was sticky and had several scuffs in the black substance. The substance was in the hall outside the pantry to the outside back door. During an observation on 02/10/2026 at 11:22 a.m., observed a liquid substance that came from under the back of the stove located in the kitchen. The substance felt greasy and was a cloudy color. In between the stove and fryer was buildup of grease that contained particles of an unknown substance. The window sill above the sink had stains and dirt build up. An industrial toaster with a large amount of toast crust build up was caked on the bars of the top and bottom trays. There was burnt stains on the back of the stove, which was greasy to the touch, when pulled out, the stove trap contained a black crusty substance on old, used tinfoil. During an observation on 02/10/2026 at 11:29 a.m., observed the [NAME] removed her gloves and put on a new pair without washing her hands after she picked up clean plates and continued to scoop food out of the containers at the serving table. During an observation on 02/10/2026 at 11:31 a.m., observed a tray on a shelf that held dishes that contained crumbs of an unknown source beside clean (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dishes that were to be used for service on a shelf located on the back wall of the kitchen. During an observation on 02/10/2026 at 11:35 a.m., observed the Dietary Aide cut the plastic wrap off a pumpkin pie, walk to the sink and rinse the scissors off under the faucet, then walked back to the food preparation table located in the middle area of the kitchen. The Dietary Aide picked up five (5) card board pie boxes and walked over to a 55-gallon trash container, picked up the lid and threw the boxes inside and replaced the lid. The Dietary Aide walked back to the prep table and picked up a stack of glasses and began placing the glasses on a serving tray. The Dietary Aide wore the same gloves, did not wash her hands, or change gloves. During an observation on 02/10/2026 at 11:39 a.m., observed the Dietary Aide pick up a stack of cups while wearing gloves, rubbed her left ear and pushed her hair back, then continued to place cups on a serving tray. Observed the Dietary Aide's hairnet did not fit properly. Observed a large amount of hair that hung out of the hair net with several strands that hung down approximately three (3) inches on the left side. The hair net exposed approximately two (2) inches of hair across her temple. During an observation on 02/10/2026 at 12:00 p.m., at the holding station, observed the [NAME] picked up a bread roll with her gloved hand and placed on a plate. The [NAME] took her gloves off and put on a new pair without washing her hands. The [NAME] pushed the serving cart with trays toward the door then walked back to the holding station. The [NAME] removed several plates from the plate holder, with her thumb and forefinger touching the eating surface and placed down the serving line. The [NAME] placed her full hand on the eating surface of the plates, touched the side of her nose, and placed her hand, full palm across the eating surface of the plate. The [NAME] did not change gloves or wash her hands. During an observation on 02/10/2026 at 12:10 p.m., at the serving station, observed the [NAME] scratched her nose on her sleeve, picked up new plates and placed them on the serving station. The [NAME] went over to the stove and picked up a pan of dinner rolls and placed them by the serving station. The [NAME] picked up a roll with her gloved hand and placed the roll on a serving plate. During an observation on 02/10/2026 at 12:30 p.m., at the serving station, observed the [NAME] scooped broccoli on to a plate and used her thumb and forefinger to touch the broccoli on the outside of the plate. The [NAME] touched the broccoli multiple times. During an interview on 02/10/2026 at 1:15 p.m., the [NAME] said she was trained on proper sanitation but forgot to wash her hands. The [NAME] said if she touch something like a surface, she should wash her hands. The [NAME] said she was trained to wash her hands in between changing gloves. The [NAME] said she normally did but forgot today. The [NAME] said she also knew she was not supposed to touch food with her hands. The [NAME] said she normally put vegetables like broccoli in small bowls but during the observation, she touched the broccoli to keep it from falling off the plate. The [NAME] said the facility was running low on dishes. The [NAME] said a negative consequence of not washing her hands could be cross-contamination and bacteria. The [NAME] said she followed a cleaning schedule, and she had a list of tasks she was responsible to complete. The [NAME] did not give an explanation for why the tasks had not been completed. The [NAME] said she was responsible to ensure food was labeled and dated. The [NAME] said she was also responsible to throw out food that was outdated. The [NAME] said this was necessary to keep the food from spoiling and others eating contaminated food. During an interview on 02/10/2026 at 1:32 p.m., the Dietary Aide said she had been trained on proper hand washing but did not wash her hands due to her nerves. The Dietary Aide said she was not aware she was supposed to wash her hands when she changed gloves and would do so in the future. The Dietary Aide said a negative consequence of not washing her hands could be bacteria, germs, or cause the residents to become sick. The Dietary Aide said she normally covered her hair with her hairnet, but the hairnet would rise up and expose her hair. The Dietary Aide said not covering all her (continued on next page)

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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 - Some	hair could cause hair to drop into the food. The Dietary Aide said all staff were responsible to clean the kitchen and if she noticed a food item in the refrigerator or freezer that was not dated, she would throw it out. During an interview on 02/12/2026 at 9:52 a.m., the Dietary Manager said the kitchen had been short staffed and the staff's actions did not meet her expectations. The Dietary Manager said touching the trash can lid, touching hair, or face and not washing their hands was unacceptable. The Dietary Manager said the staff should be aware of the need to wash their hands when changing gloves and she said this did not meet her expectations. The Dietary Manager said unlabeled food was unacceptable because the food could be expired or could cause illness. The Dietary Manager said staff should never touch food with their hands and she said this was something she would train the staff on. The Dietary Manager said the overall cleanliness of the kitchen needed improvement and was unacceptable. The Dietary Manager said before she was hired, the kitchen did not have a cleaning schedule. The Dietary Manager said the unacceptable practices would affect the quality of the food and could cause cross-contamination and could make anyone who ate out of the kitchen ill. The Dietary Manager said the floor of the pantry was a dark color because the floor had not been cleaned. She said she mopped the floor after the observation and the tiles were lighter in color. The Dietary Manager said the lack of not mopping in the pantry area was unacceptable to her. The Dietary Manager said the kitchen staff are responsible for cleaning and mopping the floors. The Dietary Manager said she was new to her position and was still in the process of developing a cleaning schedule. The Dietary Manager said before she took the position, there was no cleaning schedule posted. During an interview on 02/12/2026 at 3:58 p.m., the Administrator said she was disappointed with the issues found with the kitchen and the issues were unacceptable. The Administrator said touching food, not washing hands, and an unclean environment could cause cross contamination. The Administrator said the facility was responsible for a very fragile environment and the issues were unacceptable and needed to be addressed. Record review of the facility's policy, Food Storage, dated 2023, revealed food would be stored in an area that was clean, dry, and free from contaminants. Plastic containers with tight fitting covers or sealable plastic bags must be used for storing grain products or opened packages. All containers or storage bags must be legible and accurately labeled and dated. Leftover food should be stored in covered containers and clearly labeled and dated before being refrigerated. Record review of the facility's policy, Cleaning and Sanitation of Dining and Food Service Areas, dated 2023, revealed a cleaning schedule would be posted for all cleaning tasks, and staff would initial the as completed. Staff would be held accountable for cleaning assignments. Record review of the facility's policy, Sanitization, dated 11/2022, revealed the all kitchens, kitchen areas, and dining areas were kept clean. All equipment, food contact surfaces and utensils are cleaned using heat or chemical sanitizing solutions. Record review of the facility's policy, Hand Washing, dated 2023, revealed employees would wash their hands as frequently as needed throughout the day using proper hand washing procedures. Hands and exposed portions of arms should be washed immediately before engaging in food preparation:a. when entering the kitchen at the start of the shiftb. after touching bare human body parts other than clean hands wristf. after handling soiled equipment or utensilsg. during food preparation, as often as necessary to remove soil or contamination and prevent cross contamination when changing tasksi. before donning disposable gloves for working with food and after gloves are removed.