STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING 00 B. WING	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SCENIC HILLS AT THE MONASTERY	710 SUNRISE DRIVE FERDINAND, IN 47532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaint IN00429678. This visit included a State Residential Licensure Survey. Complaint IN00429678 - No deficiencies related to the allegations are cited. Survey dates: March 7, 8, 11, 12, and 13, 2024. Facility number: 000534 Provider number: 155493 AIM number: 100267220 Census Bed Type: SNF/NF: 66 SNF: 17 Residential: 36 Total: 119 Census Payor Type: Medicare: 8 Medicaid: 44 Private: 16 Other: 15 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by Scenic Hills at the Monastery that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Scenic Hills at the Monastery. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennie Deyne	Admin	03/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure appropriate labeling and storage of medications for 2 of 3 medication carts (500 Hall Cart and 300 Hall Cart) with 11 of 16 residents reviewed for Medication Storage. (Residents 9, 4, 77, 28, 20, 17, 46, 14, 43, 23, and 18) Findings include: 1. During an observation on 3/12/24 at 1:03 p.m. of the 500 Hall medication cart with RN 4, the following concerns were observed: a. Resident 9's had two Levemir FlexTouch insulin pens in the top drawer of the medication cart. The	F 0761	Completion date: 3/30/24 1 Resident # 9, 4, 77, 28, 20, 17, 46, 14, 43, 23, 18 were affected with no adverse effects. Resident #9's insulin pen and nasal spray were immediately discarded. Resident #4's insulin pen was immediately discarded. Resident #77's eye drop bottle was immediately discarded. Resident #28's nasal spray and medications in foil packets were immediately discarded. Resident #20's inhaler was immediately stored with mouthpiece down. Resident #17's pouch containing	03/30/2024

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	first pen was dated with an open date of 1/30/24, and had approximately 150 units left in it. The second pen had an open date of 2/7/24. The best use by date indicated to use within 42 days. In the same bag, was a bottle of flonase nasal spray. The pharmacy labeling had been partially ripped off and had no identifying information. The medication was not in the original packaging. It was lying on its side. There was no open date on the medication and it was approximately three-quarters of the way used. The record for Resident 9 was reviewed on 3/13/24 at 9:00 a.m. The diagnosis included, but was not limited to, diabetes mellitus. During an interview on 3/12/24 at 1:04 p.m., RN 4 indicated the pen dated for 1/30/24, should have been discarded. They did not usually open date nasal sprays. She believed they only dated eye drops and insulin. The physician's order, dated 2/6/24, indicated the resident received Levemir FlexTouch insulin, 14 units, once daily. The order was discontinued on 2/8/24. During an interview on 3/13/24 at 10:50 a.m., the Clinical Support Nurse indicated the resident's insulin had been changed from Levemir to Lantus. The Levemir should not have been in the cart if it was discontinued. b. There was a Novolog Flex Pen in the medication cart with no prescriptive labeling. It was dated with an open date of 3/11. There was no year on the date. The expiration date was 12/31/25. The medication was in a clear plastic bag with Resident 4's first and last name and room number		the antibiotic were immediately discarded. Resident #46, 14, 43, 23, 18's inhalers were immediately stored with mouthpiece down. 2 All residents have the potential to be affected. House wide medication cart audits were conducted to ensure medications were dated properly and stored correctly. Licensed staff educated on proper medication storage and labeling, discarding expired and discontinued medications. 3 As a measure of ongoing compliance, the DHS or designee will conduct random med carts weekly x4, then every other week x2 months, then monthly x3 months for expired or discontinued medications, beyond use date meds, proper labeling, and proper storage of inhalers. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	written on the bag in permanent marker. c. There was a bottle of Lumigan 0.1 mg/mL (milligrams per milliliter) in the top right drawer. The medication was not in the original pharmacy packaging and had no pharmacy labeling. During an interview on 3/12/24 at 1:06 p.m., RN 4 indicated the eye drops belonged to Resident 77. The record for Resident 77 was reviewed on 3/13/24 at 9:10 a.m. The diagnosis included, but was not limited to, glaucoma. The physician's order, dated 10/5/23, indicated the resident received Lumigan 0.01% 1 drop to the left eye at bedtime for glaucoma. d. There was a clear plastic bag with a bottle of Flonase and 6 individual foil medication packets inside it. The Flonase had no open date and the tamper evident seal had been broken. The label indicated the medication belonged to Resident 28. The six medication packets had no prescriptive labeling to identify the ordering physician or the resident they belonged to. One packet was opened, with the medication still inside it. The packet indicated it was myrbetriq 50 mg. There were two packets which were identified as torsemide, 20 mg; one packet identified as ondansetron, 4 mg; and one packet identified as warfarin, 3 mg. During an interview on 3/12/24 at 1:10 p.m., RN 4 indicated she assumed the packets of medication also belonged to Resident 28 since they were in the bag with her Flonase. The record for Resident 28 was reviewed on 3/13/24 at 9:15 a.m. The diagnoses included, but			

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	were not limited to, atrial fibrillation, hypertension, chest pain, long-term use of anticoagulants, and GERD (gastroesophageal reflux disease). The physician's orders included, but were not limited to, torsemide 20 mg, administer 40 mg twice daily for edema, which started on 3/8/24, warfarin 3 mg daily, which started on 2/19/24, Flonase 50 mcg/act, which started on 1/26/24, Myrbetriq 50 mg at bedtime, which started on 3/11/24, and Zofran 4 mg three times daily, which started on 1/25/24. e. Resident 20's Ventolin 90 mcg/act (micrograms per actuation) inhaler was lying on its side in the top drawer of the medication cart. The storage instructions on the side of the medication box indicated to store the inhaler with the mouthpiece down. The medication had been used, and had 186 doses remaining. The record for Resident 20 was reviewed on 3/13/24 at 9:15 a.m. The diagnoses included, but were not limited to, unspecified cough and allergic rhinitis. The physician's order, dated 3/8/24, indicated the resident received albuterol sulfate 90 mcg/act, two puffs twice daily. 2. During an observation of the 300 Hall medication cart on 3/12/24 at 1:21 p.m. with LPN (Licensed Practical Nurse) 7, the following concerns were identified: a. In the top drawer of the medication cart was a clear plastic pill crusher packet, containing 4 yellow capsules which were imprinted with "amox 500 gg849". The packet had Resident 17's first initial and last name, as well as "Amoxicillin 2,000"			

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	written on it in black permanent marker. During an interview on 3/12/24 at 1:22 p.m., LPN 7 indicated the medication was Resident 17's amoxicillin. She was supposed to take 2,000 mg of amoxicillin prior to a dental cleaning appointment. They had pulled it out of the emergency drug kit to administer to her and the appointment had been rescheduled several times, so they had placed it in the medication cart that way. They did not typically store medications like that. She would have gotten rid of the medication by disposing of it. The record for Resident 17 was reviewed on 3/13/24 at 9:18 a.m. The diagnoses included, but were not limited to, osteoarthritis left knee and polyosteoarthritis. The physician's order, dated 2/5/24, indicated to administer amoxicillin 500 mg, four capsules one hour prior to her dental cleaning on 3/5/24. The order was discontinued on 3/4/24. The nurse's note, dated 3/4/24 at 2:28 p.m., indicated the resident's Dentist had contacted the facility and rescheduled the appointment for 4/9/24 at 1:00 p.m. with instructions to administer the amoxicillin prior to the appointment. During an interview on 3/13/24 at 10:55 a.m., the Clinical Support Nurse indicated when the resident's appointment had been canceled on 3/4/24, her order had been discontinued. She had a new order in place for the new appointment on 4/9/24. The nurses should have discarded of the amoxicillin from the first order appropriately. They could have either sent it back to pharmacy, or if they were going to keep it they could have put it in an envelope like the ones they send home			

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	medications in, but it would need to have the appropriate identifiers on it. b. In the top drawer of the medication cart were several inhalers lying down on their sides, each with the packaging indicating to store the inhalers with the mouthpiece down. The inhalers included one albuterol 90 mcg/act inhaler for Resident 46; two albuterol 90 mcg/act inhalers for Resident 14; one albuterol 90 mcg/act for Resident 43; one Advair 115/21 mcg/act inhaler and two albuterol 90 mcg/act inhalers for Resident 23; and one albuterol 90 mcg/act inhaler for Resident 18. During an interview on 3/12/24 at 1:25 p.m., LPN 7 indicated she had not been aware they were supposed to be stored with the mouthpieces down. The residents' clinical records were reviewed on 3/13/24 at 9:05 a.m. The records indicated all of the residents (Residents 46, 14, 43, 23, and 18) had current physician orders for the observed inhalers. During an interview on 3/12/24 at 3:00 p.m., the Consultant Pharmacist indicated the inhaler instructions were something that had change in wording in the recent past. They were interpreting the instructions of storing the medication with the mouthpiece down as indicating to store the inhalers upright. The most current Labeling of Medications and Biologicals policy, included, but was not limited to, "... Facility staff should date the label of any multi-use vial when the vial is first accessed... If a multi-dose vial has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer			

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	specifies a different (shorter or longer) date for that opened vial... all expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining..." The most current Medication Storage in the Facility policy, included, but was not limited to, "... Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier... Procedures... A. The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the Unites States Pharmacopedia (USP). Medications are kept in these containers. Facility personnel may not transfer medications from one container to another or return partially used medication to the original container... C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label... H. Outdated, contaminated, or deteriorated medications... are immediately removed from inventory..." 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(5) 3.1-25(k)(7) 3.1-25(o)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

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	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was served and stored under sanitary conditions during 3 of 3 kitchen observations. This deficiency had the potential to affect 81 current residents who received meals from the kitchen. Findings include: 1. During the initial tour of the kitchen with the Dietary Manager on 3/7/24 at 9:10 a.m., the following concerns were observed: - The fryer had a moderate amount of brown crumbs in the oil. The Dietary Manager indicated it was last used at yesterday's dinner. - In the dry storage room under the vinegar and soy sauce shelf, there was a brown dried spill with food particles in it which measured 3 inches in length and 8 inches in width. A white piece of paper was under the bean shelf in the corner. - There were 2 jelly packets, 1 pink and 1 yellow sweetener packets under the cereal shelf. - The egg storage drawers had multiple yellow	F 0812	Completion Date: 3/30/24 1 No residents were affected by the alleged deficient practice. Fryer, Egg storage, grill, sandwich station, stove top, plateholder, and flat top all immediately cleaned. Dry storage and all floor cleanliness concerns were immediately corrected. 2 No residents were affected by this alleged deficient practice. The dining services team to be educated on proper cleaning, storage and proper dishware handling. As a measure of ongoing compliance, the ED or designee will round to ensure kitchen area cleanliness and absence of food particles, crumbs and proper clean dishware handling five times weekly x4 weeks, then every other week x2 months, then monthly x3 months.	03/30/2024

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	spots on the bottoms. - The grill had a heavy coating of charred black debris on the grates; the ledge in front and back of the grates had a heavy build up of black debris. - The inside bottom shelf of the sandwich station had several white spots on it. Inside the condiment station, there was a heavy accumulation of orange cheese shreds and food particles. - The stainless steel wall behind the stove, grill and fryer had a moderate build up of grease. - The stove top around the burners had a moderate accumulation of yellow and brown spills and food crumbs. The backsplash had a heavy build up of brown splatters and grease. - The floor under the fryer, bilateral sides of the fryer, right side of the stove and right wall next to the freezer had a moderate amount of white spots, streaks and grease. - The front of the fryer and stove had streaks running down the length of them and the fryer was sticky to the touch. The bottom of the stove door had brown streaks. - The metal plate in front of the temperature controls at the bottom of 2 of 2 hot carts that went to the dementia units had a heavy accumulation of brown crumbs. - The bottom edge on the front of the steamer had a heavy accumulation of tan food particles. - The right side of the flat top next to the stove had a heavy accumulation of brown splatters and grease. 2. During a kitchen observation on 3/8/24 at 2:00 p.m., with the Dietary Manager, the following concerns were observed: - The same issues identified on 3/7/24 at 9:15 a.m. remained. - A dietary aide was observed holding dishes she		3 As a quality measure, the DHS or designee will review any findings and corrective action weekly in QAPI meetings until achieved compliance, then at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted	

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	was removing from the clean side of the dishwasher against her soiled uniform. - A yellow packet of sweetener was inside the bottom of the ice cream freezer. 3. During a kitchen observation on 3/13/24 at 10:00 a.m., the following concerns were observed: - The outside lid of the 3 compartment flour bin had a light sprinkle of flour on top. On the top, the handle and the side of the bin had tan spots on them which ran down the side of the bin. - There was a heavy accumulation of light and dark brown food particles in the oil and the front ledge. The fryer was also sticky to the touch. Dietary Cook 1 indicated at this time that she thought it might have been used last night for the french fries. - The plate holder had a heavy accumulation of food crumbs around the base. - The tray under the steamer had a heavy accumulation of brown crumbs and food particles in it. - The right side of the flat top next to the stove had a heavy accumulation of brown streaks and grease. - The bottom edge and plate in front of the controls of the 2 carts that went to the dementia units had a heavy accumulation of brown crumbs. - The floor under and bilateral sides of the fryer and the right side of the stove and wall next to the fryer had a moderate amount of white spots and streaks. - The stove top around and under the burners had a moderate accumulation of yellow and brown spills and food crumbs. - The outside of the sandwich station was heavily streaked which ran down the outside on all sides. - The 2 egg drawers had several yellow spots on the bottom inside. - The grill grates and the ledge in front of the			

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	grates had a heavy accumulation of black debris. - In the dry storage room under the shelf with the vinegar and soy sauce bottles, the same spill identified on 3/7/24 at 9:10 a.m. and 3/8/24 at 2:00 p.m. remained. The As-Completed cleaning schedules, dated 3/11/24, indicated only the following areas had been completed: - Cook Weekly Cleaning List: Clean stove top burners and change foil. - AM Cook Daily Cleaning List: Skim and wipe down fryer. Clean flat top. Wipe down all tables and equipment. Sweep and mop kitchen. Spot sweep. - AM Aide Cleaning List: Carts wiped down and properly cleaned. Sweep and mop at end of shift. - PM Aide Cleaning List: Dishes washed and put away properly. Carts wiped down and properly cleaned. Sweep and mop at end of shift. A facility policy related to the kitchen cleanliness was not provided, the Assistant Dietary Manager only provided the As-Completed cleaning schedules. 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Recertification and State Licensure Survey and the Investigation of Complaint IN00429678. Complaint IN00429678 - No deficiencies related to the allegations are cited.	R 0000	The submission of this plan of correction does not indicate an admission by Scenic Hills at the Monastery that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the	

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SCENIC HILLS AT THE MONASTERY	710 SUNRISE DRIVE FERDINAND, IN 47532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Survey dates: March 7, 8, 11, 12, and 13, 2024. Facility number: 000534 Residential Census: 36 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on March 14, 2024.		residents of Scenic Hills at the Monastery. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was served and stored under sanitary conditions during 3 of 3 kitchen observations. This deficiency had the potential to affect 36 of 36 current residents who received meals from the kitchen. Findings include: 1. During the initial tour of the kitchen with the Dietary Manager on 3/7/24 at 9:10 a.m., the following concerns were observed:	R 0273	R273 Food and Nutritional services Completion date: 3/30/24 1 No residents were affected by this alleged deficient practice. Kitchen cleaned to remove crumbs, grease and food particles. 2 All residents have potential to be affected. The dining services team were educated on cleaning practices, cleaning schedule and proper clean dishware handling.	03/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING 00 B. WING	03/13/2024

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	- The fryer had a moderate amount of brown crumbs in the oil. The Dietary Manager indicated it was last used at yesterday's dinner. - In the dry storage room under the vinegar and soy sauce shelf, there was a brown dried spill with food particles in it which measured 3 inches in length and 8 inches in width. A white piece of paper was under the bean shelf in the corner. - There were 2 jelly packets, 1 pink and 1 yellow sweetener packets under the cereal shelf. - The egg storage drawers had multiple yellow spots on the bottoms. - The grill had a heavy coating of charred black debris on the grates; the ledge in front and back of the grates had a heavy build up of black debris. - The inside bottom shelf of the sandwich station had several white spots on it. Inside the condiment station, there was a heavy accumulation of orange cheese shreds and food particles. - The stainless steel wall behind the stove, grill and fryer had a moderate build up of grease. - The stove top around the burners had a moderate accumulation of yellow and brown spills and food crumbs. The backsplash had a heavy build up of brown splatters and grease. - The floor under the fryer, bilateral sides of the fryer, right side of the stove and right wall next to the freezer had a moderate amount of white spots, streaks and grease. - The front of the fryer and stove had streaks running down the length of them and the fryer was sticky to the touch. The bottom of the stove door had brown streaks. - The metal plate in front of the temperature controls at the bottom of 2 of 2 hot carts that went to the dementia units had a heavy accumulation of brown crumbs. - The bottom edge on the front of the steamer had		3 As a measure of ongoing compliance, the ED or designee will round to ensure kitchen area cleanliness and absence of food particles, crumbs and proper clean dishware handling five times weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action weekly in QAPI meetings until achieved compliance, then at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted	

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	a heavy accumulation of tan food particles. - The right side of the flat top next to the stove had a heavy accumulation of brown splatters and grease. 2. During a kitchen observation on 3/8/24 at 2:00 p.m., with the Dietary Manager, the following concerns were observed: - The same issues identified on 3/7/24 at 9:15 a.m. remained. - A dietary aide was observed holding dishes she was removing from the clean side of the dishwasher against her soiled uniform. - A yellow packet of sweetener was inside the bottom of the ice cream freezer. 3. During a kitchen observation on 3/13/24 at 10:00 a.m., the following concerns were observed: - The outside lid of the 3 compartment flour bin had a light sprinkle of flour on top. On the top, the handle and the side of the bin had tan spots on them which ran down the side of the bin. - There was a heavy accumulation of light and dark brown food particles in the oil and the front ledge. The fryer was also sticky to the touch. Dietary Cook 1 indicated at this time that she thought it might have been used last night for the french fries. - The plate holder had a heavy accumulation of food crumbs around the base. - The tray under the steamer had a heavy accumulation of brown crumbs and food particles in it. - The right side of the flat top next to the stove had a heavy accumulation of brown streaks and grease. - The bottom edge and plate in front of the controls of the 2 carts that went to the dementia units had a heavy accumulation of brown crumbs.			

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	- The floor under and bilateral sides of the fryer and the right side of the stove and wall next to the fryer had a moderate amount of white spots and streaks. - The stove top around and under the burners had a moderate accumulation of yellow and brown spills and food crumbs. - The outside of the sandwich station was heavily streaked which ran down the outside on all sides. - The 2 egg drawers had several yellow spots on the bottom inside. - The grill grates and the ledge in front of the grates had a heavy accumulation of black debris. - In the dry storage room under the shelf with the vinegar and soy sauce bottles, the same spill identified on 3/7/24 at 9:10 a.m. and 3/8/24 at 2:00 p.m. remained. The As-Completed cleaning schedules, dated 3/11/24, indicated only the following areas had been completed: - Cook Weekly Cleaning List: Clean stove top burners and change foil. - AM Cook Daily Cleaning List: Skim and wipe down fryer. Clean flat top. Wipe down all tables and equipment. Sweep and mop kitchen. Spot sweep. - AM Aide Cleaning List: Carts wiped down and properly cleaned. Sweep and mop at end of shift. - PM Aide Cleaning List: Dishes washed and put away properly. Carts wiped down and properly cleaned. Sweep and mop at end of shift. A facility policy related to the kitchen cleanliness was not provided, the Assistant Dietary Manager only provided the As-Completed cleaning schedules.			