STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARRINGTON PLACE	**600 FULLWOOD LANE MATTHEWS, NC 28105**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain a safe environment by repairing an electrical cord with twist on wire connectors for one of one observed drain chemical pump (at the three compartment sink in the kitchen) and failing to have a non-combustible covered ash receptacle in one of two designated smoking areas (employee smoking area). Findings included: 1. An observation conducted in the kitchen on 3/9/20, which started at 9:25 AM, revealed a time activated chemical pump utilized to dispense drain maintenance chemicals. The pump was observed to have a power cord which was observed to have been repaired with two twist on wire connectors and then wrapped in electrical tape. The repaired cord connected the pump to a wall outlet and was observed to have been on the tiled floor next to the wall. A second observation conducted in the kitchen on 3/11/20, which started at 11:09 AM, revealed a time activated chemical pump utilized to dispense drain maintenance chemicals. The pump was observed to have a power cord which was observed to have been repaired with two twist on wire connectors and then wrapped in electrical tape. The repaired cord connected the pump to a wall outlet and was observed to have been on the tiled floor next to the wall. A third observation conducted in the kitchen in conjunction with an interview with the Assistant Dietary Manager (ADM) and the Maintenance Director was conducted on 3/12/20, which started at 10:26 AM. The observation revealed a time activated chemical pump utilized to dispense drain maintenance chemicals. The pump was observed to have a power cord which was observed to have been repaired with two twist on wire connectors and then wrapped in electrical tape. The repaired cord connected the pump to a wall outlet and was observed to have been on the tiled floor next to the wall. The ADM stated she was unaware the power cord for the pump had been repaired using twist on wire connectors and stated she would notify the Maintenance Director. When the Maintenance Director arrived, he stated he was also unaware the power cord, which connected the pump to a wall outlet, had been repaired using twist on wire connectors and electrical tape. He said it was not the correct way to repair the cord and the correct way was to replace the whole cord from the plug which went to the wall outlet to the pump. He stated neither he nor someone from the facility maintenance department had repaired the power cord for the pump with the twist on wire connectors. He further stated the facility did not handle the maintenance of the pump and believed the company who serviced the chemicals also serviced the pumps and it was that company who had made the repair. He stated he would contact the company immediately so the power cord could be properly repaired. During an interview conducted on 3/12/20 at 2:21 PM with the Administrator he stated he believed it was the contractor who had made the repair to the power cord to the pump. He further stated the maintenance department of the facility conducted no electrical repairs. A phone interview was conducted on 3/17/20 at 11:41 AM with a service technician from the company who produced the time activated chemical pump utilized to dispense drain maintenance chemicals. He stated the pump had not been manufactured with twist on wire connectors to splice the power cord. He said twist on wire connectors were an inappropriate and unsafe repair for the power cord. He stated a proper repair would have been to replace the power cord with one single cord from the pump to the plug which goes into the wall outlet. 2. An observation was conducted of the employee smoking area on 3/10/20 at 3:18 PM. The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room [ROOM NUMBER]. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white plastic chair, 2 small round black metal tables, and 2 melamine round ash trays with cigarette butts in them. A second observation was conducted of the employee smoking area on 3/11/20 at 8:57 AM. The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room [ROOM NUMBER]. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white plastic chair, 2 small round black metal tables, and 2 melamine round ash trays with cigarette butts in them. An interview was conducted with Housekeeper #1 on 3/11/20 at 8:59 AM at the employee smoking area. She stated the employee smoking area was utilized by not just employees who smoke but also residents who smoke. The housekeeper stated cigarettes were allowed to burn out in the ash tray and then were dumped into the trash can at the smoking area, the housekeeper gestured and pointed toward the non-metal trash can with a domed top and hinged doors. The housekeeper stated there was no other container to deposit the cigarette butts and ashes into beside the trash can she pointed to. A third observation was conducted of the employee smoking area on 3/12/20 at 11:04 AM in conjunction with an interview with the Maintenance Assistant (MA). The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room [ROOM NUMBER]. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white plastic chair, 2 small round black metal tables, and 2 melamine round ash trays with cigarette butts in them. The MA stated there was not a non-combustible covered receptacle to deposit cigarette butts and ashes into. He further stated typically housekeeping was the department responsible for ordering items such as the receptacle to deposit ashes and cigarette butts into. A fourth observation was conducted of the employee smoking area on 3/12/20 at 11:04 AM in conjunction with an interview with the Housekeeping Director (HD). The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room [ROOM NUMBER]. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white plastic chair, 2 small round black metal tables, and 2 melamine round ash trays with cigarette butts in them. The HD stated there was not a non-combustible covered receptacle to deposit cigarette butts and ashes into. She further stated her employees would not put cigarette butts and ashes into the trash can which was at the smoking area. She stated she would order a non-combustible covered receptacle to deposit cigarette butts and ashes into. During an interview conducted on 3/12/20 at 2:21 PM with the Administrator he stated he did not believe cigarette butts and ashes were being deposited into the trash can and he felt that if the cigarette butts were extinguished and deposited into the trash can with the liner it was not a violation.
F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and staff interviews, the facility failed to flush a resident ' s feeding tube before or after the administration of a liquid protein supplement and failed to store a tube feeding syringe with the plunger separated from the syringe for 1 of 1 sampled resident reviewed for feeding tube (Resident #72). Findings included: Resident #72 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent annual Minimum Data Set

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

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.

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) assessment dated [DATE] assessed Resident #72 to be cognitively intact and to receive less than 501 calories per day by feeding tube. 1. The facility policy Administering medication through feeding tubes (no date) was reviewed and the policy stated, in part: Flush the tube with 30 milliliters (ml) of room temperature water . prior to administering medications . flush tube with 30 ml of room temperature water at the end of all medication administration. A physician order [REDACTED]. There was no order to flush the feeding tube before or after the liquid protein supplement. The administration of Resident #72 ' s liquid protein by his feeding tube was observed on 3/11/2020 at 12:10 PM with Nurse #2. Nurse #2 diluted the resident ' s liquid protein with water, inserted the syringe and poured the diluted liquid protein into the syringe. Nurse #2 allowed the liquid protein to infuse by gravity into the feeding tube and then she disconnected the syringe and closed the feeding tube. Some of the liquid protein was noted to remain in the feeding tube. Nurse #2 did not flush the feeding tube before administering the liquid protein or after administering the liquid protein. Nurse #2 was interviewed on 3/11/2020 at 12:21 PM. Nurse #2 reported Resident #72 received the liquid protein by feeding tube at 8:00 AM, 1:00 PM and 8:00 PM. Nurse #2 reported she had administered the liquid protein at 8:00 AM and had flushed the tubing before and after the administration. When asked why she had not flushed the tube during the observation, Nurse #2 reported she was nervous and had forgotten. Nurse #2 reported she was not aware there was not an order to flush the feeding tube before and after the liquid protein. The Director of Nursing (DON) was interviewed on 3/12/2020 at 11:35 AM. The DON reported Nurse #2 was nervous during the observation and had realized she had administered the liquid protein incorrectly as soon as she completed the task. The DON reported she had not observed Nurse #2 administering medications by feeding tube, but a pharmacy consultant had observed her administer medications by feeding tube on 7/31/2019 and no issues were observed. The DON reported an in-service was schedule for 3/26/2020 for all nursing staff regarding medication administration by feeding tube. The DON reported that it was her expectation that feeding tubes were flushed before and after medications. The Administrator was interviewed on 3/12/2020 at 2:08 PM. The Administrator reported it was his expectation that feeding tubes were flushed before and after medication administration. 2. The administration of Resident #72 ' s liquid protein by his feeding tube was observed on 3/11/2020 at 12:10 PM with Nurse #2. The feeding tube syringe was noted to be stored in a plastic bag with the date 3/11/2020 marked on it. There were visible drops of water in the tip of the feeding tube syringe. The feeding tube syringe was noted to have the plunger inserted into the syringe. Nurse #2 removed the syringe from the plastic bag and used the syringe to administer the liquid protein supplement. Nurse #2 rinsed the syringe and replaced the plunger into the syringe and placed the syringe in the plastic bag. There were visible drops of water in the tip of the feeding tube syringe. Nurse #2 was interviewed on 3/11/2020 at 12:21 PM. Nurse #2 reported Resident #72 received the liquid protein by feeding tube at 8:00 AM, 1:00 PM and 8:00 PM. Nurse #2 reported she had administered the liquid protein at 8:00 AM using the syringe she used for the 1:00 PM administration. Nurse #2 reported she had put the plunger back into the syringe at 8:00 AM. Nurse #2 reported she was aware she should not have put the plunger back into the syringe after rinsing the syringe out, but she was nervous. The Director of Nursing (DON) was interviewed on 3/12/2020 at 11:35 AM. The DON reported Nurse #2 was nervous during the observation and had realized she had stored the tube feeding syringe incorrectly soon as she completed the task. The DON reported an in-service was schedule for 3/26/2020 for all nursing staff regarding medication administration by feeding tube. The DON reported that it was her expectation that feeding tubes syringes were stored with the plunger separated from the syringe. The Administrator was interviewed on 3/12/2020 at 2:08 PM. The Administrator reported it was his expectation that feeding tubes syringes were stored correctly.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to maintain a medication refrigerator temperature within a range (,[DATE] degrees Fahrenheit (F)) recommended by the manufacturers' of medications stored in 1 of 4 medication refrigerators (100 Hallway); failed to label [MED] vial with opened date and/or expiration date; failed to label saline irrigation solution and large plastic irrigation syringe with a resident name and open date; failed to dispose of a box of expired protein supplement powder with 14 doses left in 1 of 8 medication carts. Findings included: On [DATE] at 10:30 AM a review of the [DATE] refrigerator temperature log located in the medication storage room on the 100 hall revealed that all 6 temperatures noted through [DATE] were below the acceptable range of ,[DATE] degrees F and 4 days had no temperature recorded. Recorded temperatures were 34F on [DATE], 30F on [DATE], 32F [DATE], 30F on [DATE], 30F on [DATE] and 34F on [DATE]. [DATE], 6, and 9 had no temperatures recorded. The following medications were in the refrigerator that required the medication storage range to be ,[DATE]F per the medication packaging: 2 [MEDICATION NAME] pens, 3 Trulicity [MED] pens, 2 [MEDICATION NAME] 30 ml bottles. The temperature of the medication refrigerator in the 100 Hallway Medication Room on [DATE] at 01:45 PM was 30 F. This was verified by Nurse #2. On [DATE] at 10:52 AM an inspection of the 4 medication carts for the 100 and 200 halls was completed with the Unit Manager (UM #1). In the medication cart for rooms ,[DATE], opened and unlabeled patient care supplies were found in the medication cart drawer. This included an opened irrigation syringe in a plastic container and a partially full bottle of 250cc saline found in the medication cart drawer. UM #1 stated she did not know why it was there. Nurse #2 stated these supplies were used for suprapubic catheter or gastrostomy tube irrigation. On [DATE] at 11:15 AM a review of the medication cart on the 200 hallway was completed with UM #1. A box of protein supplement powder with 14 packets was found with the manufacturer expiration date of [DATE]. The box had an open date of [DATE] written on it in black marker. Also, on the 200 hallway medication cart, it was noted that a plastic container, with a [MEDICATION NAME]vial inside. A date of [DATE] was written on the plastic container. No dates were present on the [MED] vial. The date of [DATE] on the plastic container did not specify if it was the opened date or the expiration date. An interview with Nurse #3 was done on [DATE] at 11:20 AM regarding the expired protein supplement. She stated when the protein supplement was taken from the medication stock in the medication room supply cabinet, the expectation was that they checked for the expiration date. An interview with the Director of Nursing (DON) was done on [DATE] at 11:35 AM regarding the unlabeled [MED], expired medication, refrigerator temperature logs and temperatures and the open saline flush and irrigation supplies. She stated if the label was on the box or bottle, it would be nice if the date was on the medication vial. She stated that they should make sure the date that was labeled was clear as to whether it was the open date or the expiration date. She stated that the refrigerator temperature should be checked every night and recorded, staff should have checked the expiration date on the protein supplement box when it was opened and the opened saline and syringe should not have been on the cart. On [DATE] at 1:59 PM an interview with the DON was done regarding the medication refrigerator in the 100 hallway, and the temperature reading of 30F and thick ice that was in the freezer section inside the refrigerator. The DON stated her expectation that maintenance would be notified when the temperature is out of range. An interview with the Administrator on [DATE] at 02:44 PM was conducted. He stated that his expectation for the medication storage areas was that staff would follow policies and the regulations, and medications would be stored within date, [MED] vials were dated correctly, patient care items were in the appropriate place and medication refrigerators were checked and within the correct temperature range.
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 and staff interviews the facility failed to maintain a safe temperature in one of four nourishment room/nurses ' station refrigerators (300 Hall Nurses ' Station), failed to maintain food service equipment without a debris build up on two of four pieces of cookline equipment (deep fat dryer and convection oven) observed for cleanliness, failed to maintain a level of quaternary ammonia between 200 to 400 parts per million in two of two sanitizer buckets checked for sanitizer level, failed to secure facial hair for one of two employees observed assisting in food preparation, and failed to allow food plates, bases, and covers to air dry prior to assemblage and stacking for three of three observations. Findings Included: 1. A review of a document titled, Quality Assurance (QA) of Nourishment Rooms, for the 300 Hall Nurses ' Station, for March 2020, was completed on 3/12/20. The document showed a recorded temperature greater than 40 degrees for

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) seven of the eleven days recorded for the month, 3/2/20-44 degrees, 3/4/20-42 degrees, 3/5/20-44 degrees, 3/6/20-44 degrees, [DATE]-44 degrees, 3/10/20-46 degrees, and 3/11/20-50 degrees (all measurements in Fahrenheit). All temperature readings were initialed by Nurse #1. An observation of the refrigerator at the 300 Hall Nurses ' Station refrigerator, conducted on 3/10/20 at 11:29 AM, revealed the thermometer inside of the refrigerator read 48 degrees Fahrenheit. The refrigerator was utilized to store resident food including, but not limited to the following perishable food items: milk, opened containers of apple sauce, juice containers, and yogurt. An observation of the refrigerator at the 300 Hall Nurses ' Station refrigerator, conducted on 3/11/20 at 4:17 PM, revealed the thermometer inside of the refrigerator read 48 degrees Fahrenheit. The refrigerator was utilized to store resident food including, but not limited to the following perishable food items: milk, opened containers of apple sauce, juice containers, and yogurt. An observation of the refrigerator at the 300 Hall Nurses ' Station refrigerator, conducted on 3/12/20 at 8:27 AM, revealed the thermometer inside of the refrigerator read 50 degrees Fahrenheit. A closer observation of the refrigerated perishable items revealed the following: 3 packs of sour cream, 4 butter packets, 3 containers of apple sauce, 2 opened one quart containers of nutritional supplement, 1 opened 1.4 quart container of opened thickened water, 34 4 ounce orange juice containers, 9 4 ounce apple juice containers, 1 4 ounce carton of 2% milk, 4 4 ounce yogurt containers, 1 4 ounce container of sliced watermelon, and 2 containers of cottage cheese/blueberry combination packages. An interview was conducted on 3/12/20 at the conclusion of the kitchen observation which started at 10:26 AM with the Assistant Dietary Manager (ADM). She sated if a nurse observed the temperature in a refrigerator at one of the nurses ' stations or nourishment rooms to be more than 40 degrees the nurse should inform her or maintenance department. An interview was conducted with the Maintenance Director of 3/12/20 at 11:45 AM and he stated he had not been informed nor was he aware of any work orders regarding the temperature for the refrigerator at the 300 Hall Nurses Station. The Maintenance Director added, the refrigerator at the 300 Hall Nurses ' Station was new and it was unlikely there was anything wrong with it. During an interview conducted on 3/12/20 at 12:04 PM, with the Director of Nursing, she stated if the refrigerator temperature was observed to be greater than 40 degrees Fahrenheit, it was her expectation for the nurse who observed and recorded the temperature to report the temperature to her and the maintenance director/maintenance department. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated the temperature in the refrigerators which store food should be 40 degrees or less. He further explained he believed there was a possibility the thermometer was not working correctly, and it was stuck at 50 degrees. He said they had replaced the thermometer into the refrigerator. He said he would have expected if a reading was discovered of the thermometer in a refrigerator to have been above 40 degrees then the employee should have used a thermometer to check the actual temperature of the perishable products in the refrigerator. He continued, if the temperature was above 40 degrees then the employee should refer to the policy of Food Storage for the Nourishment Rooms. During a phone interview conducted on 3/12/20 at 5:19 PM with Nurse #1 she stated she had recorded the refrigerator temperature as 50 degrees Fahrenheit on 3/11/20 while she was on the 11:00 PM to 7:00 AM shift starting on 3/11/20. She explained it had been a busy night and she had not had a chance to notify anyone regarding the temperature of the refrigerator. She said she should have notified the supervisor, or she should have written a work order regarding the refrigerator temperature of 50 degrees. She further stated she had documented the other temperatures which had exceeded 40 degrees Fahrenheit but believed she did not have to notify anyone as long as the temperature was 46 degrees Fahrenheit or less. 2. Observations of the kitchen conducted on 3/09/20 at 9:25 AM, 3/11/20 at 11:09 AM, and 3/12/20 at 10:26 AM revealed a buildup of grease on the right side of the deep fat fryer and the left side of the convection oven. An interview and observation were conducted with the Assistant Dietary Manager (ADM) on 3/12/20 at 10:26 AM. The ADM stated it was her expectation for the kitchen equipment, including the deep fat fryer and the convection oven, to be clean and free of grease/debris buildup. When the ADM observed the deep fat fryer and the convection oven, she stated they did not appear to be clean and were both in need of being cleaned. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for the kitchen equipment to be reasonably cleaned and when he had observed the deep fat fryer and the convection oven, he stated it appeared as if they had not been recently cleaned. 3. During a kitchen observation conducted on 3/11/20, which started at 11:09 AM, Dietary Aide #3, who had unrestrained facial hair, was observed pouring 15 cups of iced tea and placed covers on them. He was also observed putting a pan of uncooked Brussels sprouts into the steamer oven while not wearing a beard guard to restrain facial hair. An interview was conducted on 3/12/20 at the conclusion of the kitchen observation which started at 10:26 AM with the ADM. She sated the facility had beard guards available to restrain facial hair and when an employee who had facial hair was actively preparing food, that individual should wear a beard guard. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for dietary staff who had facial hair and were active in the process of food preparation to have their facial hair restrained. 4. An observation was conducted in the kitchen on [DATE], which started at 9:25 AM. During the observation the third bay of the three compartment sink was observed to have had the faucet running water into the sink. The sink was observed to have had a label for sanitizer. The faucet water continued to fill the sink until the water overflowed out of the sink into the second sink, which was labeled as the rinse sink, and onto the flat area of the sink where there was a dish rack and large kitchen items on the rack, including a pot and a baking pan. Dietary Aide (DA) #1 was observed to go over to the sink, turn the faucet off, and dip a green bucket into the third bay of the sink. DA #3 then was observed wiping down two tray carts prior to the carts being taken outside to be washed. The water in the sink was observed to have been clear. During an observation conducted of the kitchen, which started at 11:09 AM on 3/11/20, the ADM was observed to fill a deep well bucket with sanitizer, in the third compartment of the three compartment sink, which was labeled sanitizer. The ADM was then observed washing, rinsing, and sanitizing utensils needed for the steam table to tray foods. The color of the sanitizing solution was observed to be a red color and it was dispensed from a hose which was connected to dispensing unit above another the first and second sinks. During an interview conducted during a kitchen observation on 3/12/20, which started at 10:26 AM, DA #1 stated she had checked the sanitizer level in the bucket after she had dipped the bucket in the sink and the quaternary ammonium (quat) sanitizer level was 200 parts per million (ppm). An interview was conducted in conjunction with an observation with the ADM and Certified Dietary Manager (CDM) during a kitchen observation which started at 10:26 AM on 3/12/20. The ADM was observed checking the quat level in a red bucket of sanitizer which was located by the coffee maker and a red bucket which was located under the steam table. The sanitizer solution had a clear appearance. The quat level was observed to have been 50 PPM in each. The ADM and CDM each stated in order for the quat to effectively sanitize the concentration needed to be in the range of 200-400 PPM. The ADM was then observed disposing of the sanitizer and stated she would fill them with fresh sanitizer. The ADM further stated their process was to fill the sink with sanitizer, test the concentration of the sanitizer solution, and if it was in the 200-400 PPM range, the red buckets were then filled from the sink. She stated there was no need to check the sanitizer concentration in the buckets when using that process. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for the sanitizer level to be at the recommended level to sanitize food preparation surfaces and kitchen equipment. 5. An observation of the kitchen was conducted on [DATE], which started at 9:25 AM. During the observation, 21 of 21 plates and bases were observed to have been stacked in a nesting manner with moisture between the plates and the bases. An observation of the kitchen was conducted on 3/11/20, which started at 11:09 AM. During the observation, 5 of 5 observed plates and bases were found to have been stacked in a nesting manner with moisture between the plates and the bases. The 5 observed plates and bases were used for resident food when the meal was being plated. An observation of the kitchen was conducted on 3/12/20, which started at 10:26 AM, in conjunction with an interview with the ADM and CDM. During the observation, 112 of 112 observed plates and bases were found to have been stacked in a nesting manner with moisture between the plates and the bases. In addition, 106 plate covers were found to have been stacked in a nesting manner with moisture on the covers. The ADM stated the plates, bases, and covers should all have been allowed to air dry prior to being stacked in preparation for meals to be plated. The CDM then directed the dietary staff to rewash all of the plates, bases, and covers. The ADM stated the facility had racks the plate covers and bases could air dry on and an observation was made of the rack and the plate covers and bases were observed to fit on the rack. Upon completion of washing some of the plates, bases, and covers, Dietary Aide (DA) #2 was observed stacking the freshly washed, and still wet with visible moisture, plates and bases. The CDM was then observed instructing DA #2 and other dietary staff to re-wash all of the plates and bases, again, which had just been stacked and allow them to dry prior to stacking them. The CDM stated she would educate the dietary staff on the importance of allowing food service equipment to air dry as part of the sanitation process. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for plates, covers, and bases to be allowed to air dry prior to stacking them.