STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055885	A. Building B. Wing	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Country Drive Care Center	2500 Country Drive Fremont, CA 94536

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40619 Based on observation, interview and record review, the facility failed to develop a baseline care plan for one of six residents (Resident 351) within 48 hours of admission to the facility. This failure ha the potential to not providing an effective, person-centered and quality resident care. Findings: Resident 351 is a [AGE] year old, admitted [DATE], with diagnoses including Hypertension (high blood pressure), difficulty in walking and hyperlipidemia (cholesterol in the blood), Hemodialysis(treatment of filtering waste and water from your Blood). During the initial facility tour on 5/15/23 at 10:30 am, observed Resident 351 in bed with Oxygen at 2L/min, lying on a low air loss bed, turned to her left side facing the glass sliding door. A follow up visit with Resident 351, on 5/17/23, at 10:05 am, observed resident in bed turned to left side facing the glass sliding door. Resident 351 said ouch when surveyor introduced self to resident. Did not verbalize any words or response to questions asked by surveyor. During an interview with AD, on 5/17/23, at 11 am, AD stated, no assessment done yet, resident was only admitted last Sunday 5/14/23. During a review of the 20 pages document titled Initial Baseline Care Plan dated 5/14/23, the document did not indicate initial goals, ADL (activities of daily living) needs/goals, nutritional needs/goals, special treatments and procedures, bowel and bladder, skin integrity concerns, medical diagnosis requiring care, physician's orders, medication, discharge planning, any interdisciplinary team members contribution, any family contribution. During an interview with the DON, on 5/18/23, at 11:21 am, the DON stated, the baseline care plan was not completed within 48 hours of admission. DON further stated, the SSA just called the family to schedule conference and discuss the baseline care plan. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facilty policy and procedure (P&P), titled Baseline and Comprehensive, dated 11/2017, the P&P indicated, .policy of this facilty to develop upon admission .an interim .care plan for the resident .(1) A baseline care plan will be implemented within 48 hours of admission. (2) Addresses immediate resident's need .(3)Will provide the residents and representative with a written summary of the baseline care plan .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40619 Based on observation, interview and record review, the facility failed to review and revise a comprehensive plan of care for one of six residents, (Resident 27), when her wounds were healed and wanted to get out of bed and do more things outside the facility. This failure had the potential for Resident 27 to cause further decline of mobility and psychosocial issues. Findings: Resident 27 is a [AGE] year-old female admitted in December 2021 with diagnoses including protein-calorie malnutrition; type 2 diabetes mellitus (blood sugar disorder) and contracture (shortening or stiffening) of muscles. The minimum data set (MDS- assessment tool), brief interview for mental status (BIMS), dated 12/14/22, score 13, indicating intact cognition. During the initial tour of the facility, on 5/15/23 at 10:38 am, observed Resident 27 lying in bed. A follow up visit with Resident 27 on 5/17/23, at 11 am, observed Resident 27 is still in bed. When asked if she had been getting up, she stated ,I do not get up at all . I had a lot of sores but now I'm better .I want a mobile wheelchair to get around. When asked about discussing her concerns with anyone in the facility, Resident 27 stated, I have not seen a social worker. I have not attended any meeting or care conference to discuss my care .I want to talk to my doctor to know more about my condition .I had blood test done but no one had discussed results with me .I requested a copy of my records couple of months back when I was at the other hall but have not received it yet .I asked again for a copy of my record but had not gotten it yet .I really want to know about my care .I want to be prepared to go and live outside but I do not know how to go about .I heard from someone who is now in an assisted living that I can be evaluated and be referred to some services . During a record review of the Multidisciplinary Care Conference 1 Notes, dated 6/29/22, the note indicated, social worker and activity department in attendance and did not indicate resident participation. During an interview with SSA and SSD, on 5/17/23, at 1:44 pm, SSA stated, he had just started two months ago, he sets up care conferences now, following the MDS schedule and had not receive any information of pending ancillary referrals nor any social service needs of residents. The SSD who was present during the interview stated, he just started last Wednesday. During a review of the active Order Summary Report, dated 5/18/23, the Order Summary Report indicated, out of bed for meals-upright in chair for eating with meals. During a review of the Policy and Procedure (P&P) titled Care Plan Goals and Objectives, dated 11/2012, the P&P indicated, .will incorporate goals and objectives .1(a) Resident oriented .(2) .reviewed by all staff involved .(3) .reviewed and revised .(c) .quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Policy and Procedure (P&P), titled Care Plan Comprehensive, dated 8/25/21, the P&P indicated, the facility's interdisciplinary team, in coordination with resident and his or her family must develop and implement a comprehensive person-centered care plan for each resident .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45091 Based on observation, interview, record review, the facility failed to ensure one of 21 sampled residents (Resident 251), had clean and groomed fingernails. This failure had the potential to cause Resident 251 pain, injury, and infection. Finding: During a concurrent observation and interview on 5/16/23, at 10:04 a.m., Resident 251's fingernails were long, and dirty with black matter inside the nails. Resident stated,, they told staff about it and staff didn't do anything about it. Resident 251 stated it was upsetting. During a concurrent observation and interview on 5/17/23, at 1:02 p.m., with Director of Nursing (DON), Resident 251's fingernails were observed. DON stated Resident's 251's fingernails were long and dirty. During an interview on 5/17/23, at 1:25 p.m., with licensed vocational nurse (LVN) 3, LVN 3 stated Resident 251's long and dirty fingernails should have been identified on admission and were a risk for infection. During an interview on 5/18/23, at 11:01 a.m., with CNA 1, CNA 1 stated, they cleaned and cut Resident 251's fingernails on 5/17/23. CNA 1 stated, CNAs should have checked Resident fingernails every day and notified the nurse if they were long and dirty. CNA 1 stated, Resident 251's fingernails were missed and should have been checked and cleaned earlier. During a review of Resident 251's Order Summary dated 5/18/23, the Order Summary indicated Resident 251 was admitted on [DATE]. During a review of Resident 251's Brief Interview for Mental Status (BIMS, a screening tool used to assess cognition), dated 5/8/23, the BIMS indicated Resident 251 had intact cognition. During a review of the facility's policy and procedure (P&P) titled, Fingernail/ Toenails, Care of, Revised 2012, the P&P indicated, .nails are clean and trimmed regularly .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42766 Based on observation, interview, and record review, the facility failed to obtain a physician's order for oxygen administration for one of four sampled residents (Resident 150). This failure had the potential to place Resident 150 at risk for incorrect oxygen treatments and jeopardize Resident 150's health and wellbeing. Findings: Resident 150 was admitted to the facility on [DATE] with admitting diagnoses that included weakness and lack of coordination. During an observation on 5/15/23, at 11 am, Resident 150 was observed sitting in a chair by her bedside, with oxygen (O2) via nasal cannula (a two-pronged plastic tubing used to deliver oxygen therapy through the nose), attached through the long tubing to the oxygen concentrator ((a medical device for oxygen therapy, it takes in air from the room and filter out nitrogen). Resident 150's O2 was observed at 2 Liters per minute (L/min). During an observation on 5/17/23, at 11:05 am, Resident 150 was observed sitting in her wheelchair. Resident was waiting for the physical therapist per family. Resident with oxygen nasal cannula on but tubing not attached to the oxygen concentrator set at O2 1 liter. When asked, Resident stated she was currently having a little shortness of breath. During a concurrent record review and interview with Licensed vocational nurse LVN 3 stated, Resident 150 is on O2 at 2L and believe there is a doctor's order. LVN 3 searched for the physician order for oxygen for Resident 150 in the electronic health record but could not find it. LVN 3 stated, I don't see any order for oxygen in electronic and would verify in hard chart. She looked in the hard paper chart for the physician order for O2 and could not find it. LVN acknowledged there was no physician order for oxygen. During a review of the facility's policy and procedure (P & P) titled, Nursing Policies and Procedures Manual. Dated November 2012, the P & P indicated OXYGEN . Procedures for Documentation: Obtain or verify physician's order .a. mode of delivery b. Liter flow rate. C. Duration of therapy, i.e., continuous, prn shortness of breath, or .as specified by the physician.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44771 Based on interview and record review, the facility failed to ensure dialysis (a treatment to remove extra fluid and waste products from the blood when the kidneys cannot) communication records were completed for three residents (Resident 201, Resident 54, and Resident 56) out of 5 sampled residents. This failure has the potential to miss signs of illness such as fever or bleeding, which could lead to hospitalization . Findings: A review of Resident 201's admission record indicated admitted [DATE] with a diagnosis of end stage renal disease (the last stage of long-term kidney disease where the kidneys no longer work), with a dependence on renal dialysis. A review of Resident 54's admission record indicated an admitted [DATE] with a diagnosis of end stage renal disease with a dependence on renal dialysis. A review of Resident 56's admission record indicated an admitted [DATE] with a diagnosis of hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease and dependence on renal dialysis. During a record review of Resident 201's Order Summary Report, dated 5/18/23, Order Summary Report indicated, Resident 201 was to have dialysis three times a week on Tuesdays, Thursdays, and Saturdays. During a record review of Resident 54's Dialysis Communication Record, dated 4/22/23, the Dialysis Communication Record section Post Hemodialysis Assessment indicated, blank areas as well as section labeled Graft Assessment. During a record review of Resident 56's Dialysis Communication Records, dated from 2/10/23 until 4/24/23, the Dialysis Communication Records indicated missing information for post-hemodialysis assessment section in the dialysis records dated 2/10/23, 2/22/23, 3/24/23, 4/10/23, and 4/24/23. During a concurrent interview and record review of Resident 201's Dialysis Communication Records, dated 5/16/23 and 5/17/23, with Registered Nurse (RN 1), RN 1 confirmed the Dialysis Communication Records had missing information in the pre-hemodialysis assessment on 5/16/23, and post-hemodialysis assessment on 5/17/23. RN 1 stated it was important to assess the resident prior to and after coming back from the dialysis center. He stated there needs to be communication with the dialysis center if there are any changes in the resident such as infection, illness. RN 1 further stated it is important to monitor the resident for any bleeding from the dialysis access site since that would be an emergent situation. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Dialysis, Coordination of Care & Assessment of Resident, dated 1/2018, policy indicated, 2. While at the skilled facility: This facility as direct responsibility for . the customary standard care provided by the facility and the following: [.] 2. Monitoring of vital signs post dialysis or per physicians order

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42766 Based on observation, interview, and record review, for one of three sampled residents (Resident 15), the facility failed to document an adequate indication and diagnosis for the use of Seroquel (a medication used to treat certain mental/mood condition). This failure placed Resident at unnecessary risk for adverse consequences related to the use of Seroquel. Findings: During a review of Resident's 15 face sheet, the face sheet indicated Resident 15 was admitted on [DATE] (originally admitted on [DATE]), with diagnoses that included Alzheimer's disease [a degenerative disease and is the most common cause of dementia (gradual loss of memory and decision-making capacity)]. During a review of Resident 15's Minimum Data Set (MDS- an assessment tool used to direct resident care dated 4/20/23 indicated a brief interview for mental status (BIMS, a brief scanner to help detect cognitive impairment) indicated score of 01 indicating Resident 15 had severe cognitive impairment. During a review of the physician order dated 5/18/23 had a Seroquel order (dated 11/1/21) 25 milligrams (mg) Give 3 tablet by mouth two times a day m/b people are stealing her belongings related to Psychotic disorder with delusions due to known physiological condition. Also had a Lorazepam order (dated 4/11/21) 1 mg Give 1 tablet by mouth two times a day for m/b physical and verbal aggression related to anxiety disorder. During a review of MDS for Resident 15's active diagnoses, the MDS indicated diagnoses that included Anxiety disorder, Manic depression (bipolar disease), Psychotic disorder (other than Schizophrenia), Alzheimer's disease. During a review of Resident's 15 care plan for Seroquel medication, the revised care plan dated 3/8/23 indicated Box warning for use of Seroquel - Seroquel (quetiapine) is not approved for the treatment of patients with Dementia-related psychosis and care plan dated 4/29/21 indicated Geriatric use: increased mortality in elderly patients with Dementia-related psychosis. During an interview with Assistant Director of Nursing (ADON) on 5/17/23, around 8:30 am, ADON indicated, Resident was taking Seroquel for psychotic disorder. ADON stated, she was unable to find any history of mental illness (before admission) for Resident 15. During a review of the Level 1 Pre-Admission Screening and Resident Review (PASRR - a tool that helps identify possible serious mental illness or related conditions) dated 1/23/20, indicated Resident had no diagnosis of mental disorder such as Schizophrenia/Schizoaffective Disorder, Psychotic/Psychosis, Delusional, Depression, Mood disorder, Bipolar, or Panic/Anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's Medication Administration record/behavior data for Seroquel. ADON did not provide one for the month of April 2023 as requested. Review of the behavior data dated 3/1 to 3/31 2023, 5/1 to 5/16 2023, indicated zero (0) number of behavior episodes per shift. During a review of the Medication Regimen Review (MRR) done by the pharmacy consultant, for March and April 2023. The MRR for March 2023 indicated no recommendations. The MRR for April 2023 dated 4/19/23, indicated, Psych Referral to CHE Behavioral Health Services recommended at this time. During an interview with ADON on 5/17/23 at around 2:20 pm and 5/18/23, at 8:20 am, ADON stated Pharmacy consultant's recommendation dated 4/19/23 has not been acted upon due to the transition of the facility to a new owner and they would be acting now. ADON verified that she was aware of the box warning (a type of warning that appears on the package insert for certain prescription drugs) of Seroquel for Resident 15 in Resident's care plan, and they were monitoring Resident for side effects. During an interview with ADON on 5/18/23, at 1:22 pm, ADON stated, she was unaware that the there was misdiagnosis of Resident 15's indication for Seroquel. According to the manufacturer, Seroquel is not approved for the treatment of patients with dementia-related psychosis (Reference www.nih.gov)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 38491 Based on observation, interview, and record review, the facility failed to ensure medication error rate of less than 5% when three errors were observed in 36 medication pass opportunities which resulted in 8.33 % medication error rate. The errors as follows: Dorzolamide HCl solution 2%, (used to lower high eye pressure), Fish Oil capsule (Omega -3 Fatty acids- supplements) and Multivitamin with minerals medications were omitted for Resident 43, during medication pass observation on 5/16/23. This failure had the potential to put resident (Resident 43) at risk for harm and/or adverse consequences. Findings: During medication pass observation and concurrent interview with LVN 1 on 5/16/23, at the beginning of 8:50 AM, at the doorway of Resident 43's room, Licensed Vocational Nurse (LVN) 1 was preparing Resident 43's medications with gloves on. LN 1 was observed administering the following medications via G-tube (Gastrostomy tube- a tube inserted through the wall of the abdomen directly into the stomach) to Resident 43: Amiodarone HCL (anti arrhythmic-a type of drug that is used to help the heart stay in a normal rhythm)50 mg (milligram, a unit of measurement) 1/2 tablet, Vitamin C 500 mg, Keppra (antiepileptics- a type of drug that is used to prevent or treat seizures) 500 mg one tablet, Senna (Laxative) 8.6 mg 2 tablets. LVN 1 crushed the medication individually and put in an individual medication cup. LVN 1 diluted each crushed medication with 20 cc to 30 cc (cubic centimeter- measure of volume in the metric system) of water in each cup. After the prepared medications were administered to Resident 43, LVN 1 washed her hands and stated she was done giving resident 43's medications and asked the resident if he preferred yoghurt to eat. During Medication Reconciliation (the process of comparing a patient's medication orders to all the medications that the patient has been taking to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions) on 5/16/23 at 10:30 AM, with the Director of Nursing (DON), Resident 43's Medication Administration Record (MAR) dated 5/16/23 was reviewed. The MAR indicated the Domazoline eye drops, Multivitamin with minerals and Fish oil 1 capsule 1000 mg were documented as being administered during the medication pass observed on 5/16/23 at 8:50 AM, in addition to the medications listed above. During an interview with the Director of Nursing (DON) on 5/17//23 at 10:30 AM, the DON stated, her expectations for the nurses during medications administration via G-tube included ensuring the right medication, correct dosage, administered at the right time, the right route and right resident. The DON stated the nurses should be giving the medication as ordered. She added LVN 1 was given an Inservice regarding medication pass and will follow it up. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled SPECIFIC MEDICATION ADMINISTRATION PROCEDURES dated 4/2008, indicated 11B1 PROCEDURE FOR ALL MEDICATIONS To administer medications in a safe and effective manner. There was no information indicated for omitted medications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38491 Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 43) was free of significant medication errors when the Amiodarone HCL (anti arrhythmic-a type of drug that is used to help the heart stay in a normal rhythm) and Keppra (antiepileptics- a type of drug that is used to prevent or treat seizures) medications for Resident 43 were not entirely administered via gastrostomy tube (G-tube- a tube inserted through the wall of the abdomen directly into the stomach). This failure resulted for Resident 43 not to receive an accurate dosage and full therapeutic effect of the medications which could potentially lead to more serious medical complications. Findings: A Review of Resident 43's Order Summary Report active orders as of 5/16/23, indicated an order on 2/6/23 for Amiodarone HCL 50 milligram (mg- a measure of weight) once a day for Cardiac Arrythmia (irregular heartbeat) and Keppra tablet 500 mg twice a day to be administered via G-tube for Epilepsy (a brain disorder that causes seizure). During the medication administration observation on 5/16/23, at 8:50 AM, Licensed Vocational Nurse 1 (LVN1) prepared and crushed 50 mg of Amiodarone tablet and 500 mg of Keppra tablet medications one at a time and put in an individual medication cup for Resident 43. LVN1 diluted each crushed medication with 20 to 30 cubic centimeters (cc-a measure of volume in the metric system) of water in each cup. LVN1 checked the placement of the G-tube and the gastric residual. LVN1 then proceeded to flush Resident 43's G-tube with 130 cc of water and started to pour the diluted medications via G-tube. LVN1 was observed flushing 20 cc of water after each medication administration via G-tube. After providing the medications, it was observed there were medication particles left in the cup of Amiodarone and Keppra medications. LVN1 then proceeded to discard the cups still with medication particles During an interview with the LVN 1 on 5/16/23, at 9:10 AM, LVN 1 verified and acknowledged that there were medication particles left in the Amiodarone and Keppra's medication cups after she administered the medications via G-tube. LVN1 stated she should have diluted the medication particles left in the cup with water and should have given to Resident 43 before discarding the cups. The LVN1 added she should have ensured there were no particles left in the medication cup which have altered the dosages of Amiodarone and Keppra medications administered to Resident 43. During an interview with the Director of Nursing (DON) on 5/17//23 at 10:30 AM, the DON stated, her expectations for the nurses during medications administration via G-tube included ensuring the right medication, correct dosage, administered at the right time, the right route and right resident. The DON stated when providing medications via G-tube, it is important to provide the crushed and liquid medications entirely. The DON added if there were particles left in the medication cup, it means the medication dosage was not fully given. The DON stated the dosage would not be accurate and would not have the full therapeutic effect of the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055885	A. Building B. Wing	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Country Drive Care Center	2500 Country Drive Fremont, CA 94536

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled 11A7: ENTERAL TUBE MEDICATION ADMINISTRATION dated 4/2008, indicated The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes .Enteral tubes are flushed with at least 30 ml of water before administering medications and after all medications have been administered .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055885	A. Building B. Wing	05/18/2023

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42766 Based on observation and interview, the facility failed to ensure dietary services followed proper sanitation for food service safety when: the three compartment sink was not maintained clean. This failure had the potential to cause cross contamination and an outbreak of food borne illness to 98 residents who received food from the kitchen. Findings: During a concurrent observation and interview, in the initial tour of the kitchen, on 5/15/23, at 10:03 a.m., with Dietary Supervisor (DS), observed the three compartment sink right counter with a green worn out sponge and a silvery mesh, a red bucket, an open box of traditional bakery cornbread mix, and surface of the counter was wet and dirty with brownish black and white food particles. The DS stated, they used the compartment sink for manual washing of dishes and pans and were currently using the dish machine. During a concurent observation and interview in a follow-up tour of the kitchen, on 5/17/23, at 10:17 a.m., there was a white residue on the side of the middle sink of the three compartment sink and vegetable food particles in the sink drain. On the side of the first sink was white food residue on the side, and a dirty green sponge with food particles on it, on top of the divider between the middle and first sink. The DS confirmed the three compartment sink was dirty, and will find out the staff who used it. During another interview, in the kitchen, on 5/17/23, at around 1 p.m., the DS agreed that it was not okay that the compartment sink was dirty earlier. DS stated, staff was supposed to be using the dish machine. According to the Federal Food Code (2022), Warewashing Equipment, Cleaning Frequency. A Wareashing machine; the compartments of sinks, basins, or other receptacles used for washing and rinsing equipment, utensils, or raw foods, or laundering wiping cloths; . shall be cleaned: (A) Before use; (B) Throughout the day at a frequency necessary to prevent recontamination of equipment and utensils and to ensure that the equipment performs its intended function; and (C) If used, at least every 24 hours . Warewashing Sinks, Use Limitation. If the wash sink is used for functions other than warewashing, such as washing wiping cloths or washing and thawing foods, contamination of equipment and utensils could occur.