STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145694	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKESHORE REHAB & HEALTHCARE	3401 HENNEPIN DRIVE JOLIET, IL 60435

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, record review and interview the facility failed to implement appropriate fall prevention measures; properly assess and supervise residents deemed at risk for falls and/or elopement; and safely transfer residents from surface-to surface. This applies to 4 of 8 residents (R2, R3, R5, R10) reviewed for accidents/hazards in a sample of 18. Findings include 1). The Face Sheet documents R2 is [AGE] years old and was admitted on [DATE] with [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) dated 4/8/2020 shows R2 has cognitive impairment. The Elopement Risk Assessments dated 3/31/2020 documents R2 is at risk for elopement. Based on elopement risk, the assessment required the DON (Director of Nursing) to complete and sign the next section indicating how R2 ambulates, open doors, fear being away from home and if he sleeps at night. The section was left blank and there was no signature by DON. The assessment also reads the DON must implement necessary protocols and address elopement risk on initial care plan. Review of R2's Care Plans showed no care plan for elopement risk. R2's Risk for Falls Care Plan dated 4/20/2020 documents R2 has behaviors, confusion, history of falls, gait/balance problems, weakness, poor communication/comprehension, is unaware of safety needs, and wanders. On 9/17/2020 V1 (Administrator) was asked to provide a list of residents who had eloped from the facility in the year 2020. V1 stated there were no residents who had eloped in 2020. The physician's orders [REDACTED]. There's no date or documented reason for the discharge. There's also no signature indicating who obtained the order. Review of nursing progress notes in R2's medical record dated 4/13/2020 at 5:00 PM, documents R2 exited through a door behind staff. The last documented progress note for R2 was dated either 4/14/2020 or 4/16/2020 (illegible). There were no nursing notes after this date. On 4/13/2020, the day R2 walked behind employees through an exit door, another elopement risk screen was initiated. This time the screening noted that R2 was able to ambulate and push a door open. However, once again the section was incomplete and not signed by the DON. Although it is now noted that R2 can push a door open and had exited behind employees, there was still no care plan to address elopement. On 9/22/2020 at 12:47 PM, V6 (Social Worker) stated R2 eloped out of a window. V6 stated the police were notified, and R2 was either located by the police or his son. V6 stated R2 left the faciity on his own. V6 added that R2 has memory impairment and is very confused. V6 also stated that V1 (Administrator) followed up on the case. On 9/22/2020 at 12:58 PM, V1 again denied the facility had elopements in 2020. V1 stated R2 did not elope. When informed that V6 confirmed elopement, V1 stated she was indeed informed on 4/30/2020, R2 exited through a window. V1 stated the facility then searched the perimeter but did not find R2 so they notified the police and R2's family. V1 stated this is not considered an elopement because R2 was eventually safely located. V1 then stated she has an investigation file, but no incident report was completed. Located in the file was local police Missing Persons Form #20- 7 pertaining to R2. Review of the investigation file shows on 4/30/2020, R2 pushed the screen out of his bedroom window, secured his belongings and exited through the window. Written statements by V17 (Registered Nurse), and V18-V22 (all Certified Nursing Assistants/CNAs) document staff had not seen R2 since the beginning of the shift. Staff reportedly went to his room around dinner time and assumed he was in the bathroom. However, no one checked if he was there. Then around 9:00 PM, staff noticed R2's window was open with the screen pushed out and his belongings missing. The last documented time an employee saw R2 was between 2:15-2:30 PM. On 9/23/2020 at 1:44 PM, V8 (R2's Son) stated he absolutely did not plan on R2 leaving the facility. V8 stated he found out R2 had left when R2 contacted him. V8 stated the facility did not contact him and no one has reached out to him. V8 stated he did not send R2 back to the facility because if he got out once, he will do it again. V8 also stated he does not feel the facility could keep R2 safe. On 9/24/2020 V1 stated the facility has reached out and spoken to R2's son. On 9/25/2020 at 2:23 PM, V17 (RN/Registered Nurse) stated she got to work on 4/30/2020 and did not look for R2 until she went to provide his medication. V17 stated it was around dinner time and she assumed R2 was in the bathroom because the light was on and door was shut. V17 stated after she finished passing medication to all other resident's she went back to R2' around 8:30 PM. Shortly thereafter, according to V17 an employee noticed R2 was missing. V17 stated she does not think R2 is a wanderer. V17 also stated she was not aware of R2 being an elopement risk. V17 also stated no one has ever given her report that R2 wanders or has gone through the door behind employees. On 9/28/20 at 10:40 AM, V1 (Administrator) stated the policy is for staff to make rounds on all residents at the beginning of the shift, every 2 hours and as needed. 2). The Face Sheet shows R10 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) dated 9/13/2020 shows R10 has cognitive impairment, requires extensive staff assistance with transfers, toilet use, and personal hygiene. The MDS also documents R10 is not steady with surface-to-surface transfers and is only able to stabilize with staff assistance. The fall risk screen dated 9/9/2020 shows R10 is at risk for falls The incident reports document falls on the following dates for R10: 2/25/2020 at 4:30 PM- observed on floor near nursing station; 3/21/2020 at 11:15 AM- sitting next to wheelchair on buttocks in dining room; 4/1/2020 at 2:20 PM-slipped out of wheelchair near nursing station; 6/26/2020 at 7:00 AM- falling from wheelchair in hallway. Hit her head; 7/6/2020 at 6:00 AM- fell by nursing station with nosebleed. On 9/25/2020 at 3:00 PM, the fall interventions were reviewed with V13 MDS (Minimum Data Set) Nurse. V13 stated the following interventions were in place for R10: Fall 2/25/20- 4:30 PM- observed on floor near nursing station- V13 stated intervention was to place non slip dycem in R10's wheelchair. Fall 3/21/20- 11:15 AM- sitting next to wheelchair on buttocks in dining room- V13 stated frequent monitoring was added. The care plan shows this intervention should've been in place on 3/9/2020. V13 could not explain how often staff were to monitor R10. Fall 4/1/2020 -2:20 PM, slipped out of wheelchair near nursing station- when asked about new interventions, V13 stated R10 was assessed and noted to have cognitive impairment and not able to follow directions. This was already noted in R10's admitting diagnoses. There were no new interventions noted on R10's care plan. Fall 6/26.20 - 7:00 AM- falling from wheelchair in hallway, hit her head- V13 stated at the time staff placed R10 behind the nursing station and completed neuro checks. No new care plan intervention added to prevent falling from chair. Fall 7/6/2020-- 6:00 AM, fell by nursing station with nosed bleed. V13 stated R10 was placed on 1:1 sitter placed at that time. No new care plan interventions. Review of R10's care plans show the last time the care plan was updated was 3/9/2020. Review of the falls show R10 has had multiple falls in visible areas and yet there was no adequate monitoring to prevent these falls. On 9/18/2020 at 2:20 PM, V11 (CNA/Certified Nursing Assistant) assisted R10 to the toilet. V11 transferred R10 to the toilet without using a gait belt. After R10 was done, V11 pulled R10 to a standing position and wiped R10's buttocks as R10 held onto the handrail. As V11 secured R10's briefs, R10 was shaking and rocking backwards. R10 started screaming and V11 was stating don't sit down. V11 placed her hands around R10's waist while struggling to hold her. The surveyor had to place R10's wheelchair behind her so V11 could sit R10 down. V11 then stated she will take R10 to the bed and pull her pants up. V11 wheeled R10 to her bed and again, without use of a gait belt had R10 stand and lean over the bed. V11 then secured R10s pants and sat her back in the wheelchair. At this time, it was noted there was no dycem in R10's wheelchair as per intervention on 2/25/2020. On 9/25/2020 at 12:36 PM, V1 (Administrator)

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) stated employees are required to use a gait belt for one person transfers. R10's Care Plan for transfers reads: Resident needs help transferring in and out of the bed or chair. Interventions- the resident is not able to help with a transfer at all and will need the assistance of 2 staff and a mechanical lift to move from bed to chair and back. On 9/25/2020 at approximately 4:00 PM, V24 (Certified Nursing Assistant/CNA) assisted R10 from bed to wheelchair. There was no dycem in the chair. V24 stated he had not put a dycem in R10's wheelchair and had not been made aware R10 needing a dycem. 3). The Face Sheet documents R3 is [AGE] years old and has admitting [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) dated 3/3/2020 shows R3 does not have cognitive impairment. The MDS shows R3 is totally dependent on staff for bed mobility. The MDS observation period shows transfers did not occur. The admissions performance section for mobility including transfers reads: Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity The Concern Form dated 5/21/2020 documents R3 was complaining of pain upon discharge from facility and her son believes she was not safely transferred from bed to chair. There's also a disciplinary action form dated 6/3/2020 for V15 (Registered Nurse) for violation of company and safety rules. On 9/24/2020 at 3:53 PM, V1 (Administrator) stated V15 no longer works for the facility. V15 quit after disciplinary action. V1 stated V15 and an unknown CNA transferred R3 from bed to chair by using a bed sheet. V1 stated R3's transfer status is with mechanical lift. V1 stated the employees didn't use a mechanical lift because V15 wanted to get it done. R3's Care Plans dated 3/22/2020 were reviewed, although the care plans documented R3 has fracture related to fall, there were no instructions informing staff how to safely transfer R3. 4). The Face Sheet shows R5 was admitted with [DIAGNOSES REDACTED]. The incident reports show R5 had the following falls: Incidents - 7/17/19- 7 pm, observed lying on floor, 9/8/19 4:20 AM- observed kneeling in hall on knees, very confused- 9/20/19 4:04 pm- resident room found sitting on floor by nurse. Juice and water on floor IV (intravenous fluid) line to hand bleeding. 10/9/19- 6:00 pm- found sitting on floor in room no injury- contributing factor weak, unsteady gait 10/12/19 6:28 PM- resident room, alarm heard- found on floor 12/4/19- observed wheelchair by bedside. fell going to bathroom [ROOM NUMBER]/5/19- found lying on floor next to bed- placed pad alarm to bed intervention 12/10/19- observed lying on back on floor mat next to bed, On 9/25/2020 at 2:57 PM, V13 (MDS/Care Plan) reviewed the care plan and identified the following interventions for R5: V13 stated R5 is confused and requires supervision. Fall 7/17/2020- V13 stated R5 was observed on the floor with feces on him. Intervention place on toileting schedule. V13 could not state what the toileting schedule was. Fall 9/18/2020- V13 stated R5 was noted kneeling in the hall and very confused. Intervention reorient resident, remind him to use his wheelchair and refer to Physical/Occupational therapy (PT/OT). V13 stated she did not document this intervention. Fall 9/20/2020- Found sitting on the floor with juice and water. Also noted with intravenous (IV) in hand and was bleeding. Alone in his room. This incident occurred at 4:04 PM, and V13 stated intervention was to inform resident to get some sleep. V13 also stated intervention added was refer to PT/OT. However, this was a previous intervention. Fall 10/9/19- Fall on floor, again in resident room alone at 6:00 PM. V13 stated intervention is to educate him to lock his brakes on the chair. Fall 12/4/19- Fall in room at 9:30 PM. V13 stated R5 was attempting to go to toilet. Resident now has skin tear on right elbow 2cm X 1.5cm. V13 stated intervention is to educate R5 to use the call light. There was no follow up on the previous intervention to place R5 on a toileting program, and no documented program. Fall 12/5/19- 9:30 PM, found lying on floor next to bed. Stated he fell and hit his head. Floor mats given. V13 stated R5 was given a bed alarm at this time. V5 stated, though not in use now, year 2019 pad alarms were given to all residents deemed high risk for falls. Fall 12/10/19- R5 found lying on his back on the floor mat. There was no new intervention added. V13 stated the intervention was to continue to monitor. R5's care plan does not show follow up on interventions as R5 continued to fall while being alone in his room/attempting to go to toilet etc. Most falls were during evening hours. The policy for Falls reads: 5). If a resident sustains a fall while a resident, staff should attempt to identify possible causes of the fall. 6). Based on evaluation of an existing fall, pertinent interventions will be implemented by staff such as, but not limited to: resident education if appropriate, staff re-education regarding transfer techniques and safety during ADL care, resident footwear, appropriate lighting, maintaining close proximity of frequently used items, medication reviews, toileting programs, use of hip protectors, referral to therapy for strengthening/coordination/balance, addressing medical issues such as [MEDICAL CONDITION] and dizziness, and tapering. Discontinuing or changing problematic medications, use of fall prevention programs that provide more frequent supervision and restraints, if warranted.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide incontinent care for residents. This applies to 5 of 5 residents (R8, R9, R10, R11, R12) reviewed for incontinent care in a sample of 18. Findings include: 1). The Face Sheet shows R10 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) dated 9/13/2020 shows R10 has cognitive impairment, requires extensive staff assistance with transfers, toilet use, and personal hygiene. The MDS also documents R10 is frequently incontinent of urine and always incontinent of bowel. On 9/18/2020 at 2:20 PM, V11 (CNA/Certified Nursing Assistant) assisted R10 to the toilet. R10 was wearing an adult brief which had urine and feces. V11 placed R10 on the toilet, and R10 had a large bowel movement. While standing behind R10, V11 wiped R10's buttocks with disposable wipes. V11 did not wipe R10's labia or perineum. V11 also did not cleanse R10's inner thighs which had feces on them. After V11 was done cleaning R10 she was asked to wipe R10's inner thighs and perineum. V11 wiped and there was still feces on the disposable wipe. V11 then took the same wipe and wiped R10's labia. The Care Plan 9/8/2020 reads: Resident needs help with toileting. Interventions- the resident is not able to participate in the task at all and will need staff to move, cleanse, and dress them. This may require the assistance of 2 people to be done thoroughly and safely. 2). The Face Sheet shows R11 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS dated [DATE] shows R11 has cognitive impairment, requires extensive staff assistance with toileting and is always incontinent of bowel and bladder. On 9/18/2020 at 11:45 AM, R11 was mobile throughout the facility via wheelchair. At 1:00 PM, R11 was still roaming around per staff. At 2:30 PM, V11 (CNA) was asked who was R11's care giver. V11 stated she got R11 up this morning. V11 then provided incontinence care for R11. R11 was wearing an adult brief, along with a peri-pad. Both were saturated with urine from front to rear, and side to side. V11 stated R11 has not been changed because she got him up at 7:30 AM, and she placed the peri-pad in his briefs. V11 stated the CNA assigned to take care of R11 left this morning and no one has provided care since she got him up. V11 stated she was unable to cover the unit as she has 20 assigned residents and the schedule does not reflect the number of CNAs working. 3). The Face Sheet shows R12 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS dated [DATE] shows R12 has cognitive impairment, requires extensive assistance with toileting and hygiene and is always incontinent of bowel and bladder. On 9/18/2020 at approximately 12:00 PM, R12 was awake in bed lying on his back. At 1:20 PM, R12 was in the same position. At 3:00 PM, R12 was still lying on his back. V11 and V12 (both CNAs) stated they are not assigned to R12. Both CNAs stated the assigned CNA left this morning and they were too busy to care for R12. V11 then checked R12's adult briefs. R12's brief was saturated with urine and feces from front to rear and sided to side. The bed linen was soiled with a brownish yellow stain. There was also a peri-pad in R12's brief which was saturated as well. R12's buttocks were reddened. There were multiple food particles in R12's briefs. 4). The Face Sheet shows R9 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS dated [DATE] shows R9 requires extensive assistance with toileting and is always incontinent of bowel and bladder. On 9/18/2020 at 11:30 AM, R9 was in her wheelchair. At 2:00 PM, R9 was still in the chair. Her pants were visibly soiled with urine around the pelvic and thigh area. V9 and V10 (both Certified Nursing Assistants) placed R9 to bed to check and change her. Visualization showed R9's adult brief was saturated with urine from front to rear and left to right. The urine had saturated through R9's pants and onto the wheelchair. V9 stated she and V10 got R9 up at 7:00 AM and has not provided incontinence care since. R9 stated no one has provided incontinence care this shift. 5). The Face Sheet shows R8 is [AGE] years old and has dementia. The MDS dated [DATE] shows R8 has cognitive impairment, requires extensive assistance with hygiene and toileting and is always incontinent of bowel and bladder On 9/18/2020 at 11:30 AM, R8 was sitting in the chair in her room. The sling to the mechanical lift was underneath R8. At 12:30 PM, R8 was in the same position. V9 and V10 (both Certified Nursing Assistants/CNAs) then came and took R8 to the dining room for lunch. After lunch the employees brought R8 back to her room and did not provide incontinence care. As of 2:00 PM, R8 was still in the chair with no incontinence care provided. At 2:30 PM, V9 and V10 were asked to observe R8's skin. R8 was wearing an adult brief which had a peri pad inside. The peri-pad was saturated with urine. The adult brief was saturated with urine from the

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) front to rear and side to side. V9 stated the night shift got R8 up, and she has not been checked and changed this shift. V9 stated she did not put the peri-pad in R8's briefs. V9 stated the policy is to check and change residents every 2 hours but the schedule has changed drastically. Both employees stated there are 6 CNAs on the schedule for the unit, however there's only 4 working which makes it hard to get the work done. On 9/28/20 at 10:40 AM, V1 (Administrator) stated the policy is for staff to make rounds on all residents at the beginning of the shift, every 2 hours and as needed. The policy titled perineal/incontinence care reads: 4. Staff should be mindful of the need and/or requirement for use of adaptive equipment when providing ADL care. 6. For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. 7. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide sufficient staffing to meet care needs of the residents. This applies to 8 of 15 residents (R8, R9, R10, R11, R12, R14, R15, R16) reviewed for staffing in a sample of 18. On 9/17/2020 the Census provided by the facility showed a total of 97 residents. Findings include: 1). The Face Sheet shows R11 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS dated [DATE] shows R11 has cognitive impairment, requires extensive staff assistance with toileting and hygiene. On 9/17/2020 at 3:00 PM, R11 was roaming the facility in his wheelchair wearing a flannel pajama set. On 9/18/2020 at 11:45 AM, R11 was wearing the same clothing from the previous day. R11's clothes had multiple stains and food particles on them. His shoes had lots of brown crusting caked on it as well as other stains. R11's wheelchair had food crusting on the arm rest and chair. At 2:30 PM, R11 was wearing the same clothing. V11 CNA (Certified Nursing Assistant/CNA) stated she got R11 up this morning around 7:30 M and placed a peri-pad in his adult brief. R11 was wearing the same pad. His brief was heavily saturated with urine from front to rear. V11 stated the CNA assigned to R11 left this morning and no one has provided care for him. V11 stated she has 20 assigned residents and could not go take care of R11. V17 (Nurse) stated she did not know where the assigned CNA was or what time she left. 2). The Face Sheet shows R8 is [AGE] years old and has dementia. The MDS dated [DATE] shows R8 has cognitive impairment, requires extensive assistance with hygiene and toileting and is always incontinent of bowel and bladder On 9/18/2020 at 11:37 AM, R8 was in the reclining chair. R8's reclining chair was dirty. There were multiple crusting and food stuck to the chair. As of 2:00 PM, R8 was still in the chair with no incontinence care provided. At 2:30 PM, V9 and V10 were asked to observe R8's skin. R8 was wearing an adult brief which had a peri pad inside. The peri-pad was saturated with urine. The adult brief was saturated with urine from the front to rear and side to side. V9 stated the night shift got R8 up, and she has not been checked or changed this shift. V9 stated the policy is to check and change residents every 2 hours but the schedule has changed drastically. Both employees stated there are 6 CNAs on the schedule for the unit, however there's only 4 working which makes it hard to get the work done. 3). The Face Sheet shows R9 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS dated [DATE] shows R9 is not cognitively impaired. The MDS also shows R9 requires extensive assistance with toileting and hygiene. On 9/18/2020 at 11:30 AM, R9 was in her wheelchair. R9's wheelchair had multiple stains and crusting on it. At 2:00 PM, R9 was still in the chair. Her pants were visibly soiled with urine around the pelvic and thigh area. V9 and V10 (both Certified Nursing Assistants) placed R9 to bed to check and change her. Visualization showed R9's adult brief was saturated with urine from front to rear and left to right. The urine had saturated through R9's pants. V9 stated she and V10 got R9 up at 7:00 AM and has not provided incontinence care since. R9 stated no one has provided incontinence care this shift. 4). The Face Sheet shows R12 is [AGE] years old and has [DIAGNOSES REDACTED]. The MDS dated [DATE] shows R12 has cognitive impairment, requires extensive assistance with toileting and hygiene. On 9/18/2020 at approximately 12:00 PM, R12 was awake in bed lying on his back. At 3:00 PM, R12 was still lying on his back. V11 and V12 (both CNAs) stated they are not assigned to R12. Both CNAs stated the assigned CNA left R12 this morning and no one has provided care since. V11 checked R12's adult brief. R12's brief was saturated with urine and feces from front to rear and sided to side and has soiled the bed linen. There was also a peri-pad in R12's brief which was saturated as well. There were multiple food particles in R12's brief. R12's buttocks were reddened. V17 (Nurse) stated she was not aware no one provided care to R12 all day. V17 stated she will go clean up R12. V17 stated she does not know what time V25 or V26 (CNAs) left. V11 and V12 stated they are the only 2 CNAs working on the 300 and 400 halls since the morning. The nursing assignment sheet dated 9/18/2020 for 6:00 AM- 2:30 PM showed 4 CNAs (V11, V12, V25, V26) assigned to the unit. 5). On 9/17/2020 at 2:30 PM, R14 and R15 were sitting in the hall. Both residents stated the facility serves cold food. R1 was awake inside her room. R1 stated the food is cold and not served on time. The residents stated lunch should be served at 12:00 PM but is often late. The residents also complained that supper isn't served until 7:30 PM on some days. On 9/18/2020 at 12:00 PM, lunch service was observed. Holding temperatures were taken and found to be within normal limits. Employees however did not bring trays on the units until 12:48 PM. Last tray observed being served was at 1:37 PM. Temperatures taken reflected: green vegetables 100 df, Potatoes 100 df. The mustard glazed beef was 84 df. The temperature was repeated on the meat with same results. On 9/18/2020 at 1:05 PM, R16 was sitting at the lunch table with her lunch. The meal container was open. R16 did not receive assistance until 1:20 PM. R10 was sitting at the table with R16. Even though R16's meal was there at 1:05 PM, R10's meal wasn't brought to her until 1:28 PM. On 9/28/2020 at 11:34 AM, V1 (Administrator) stated the facility is not short staffed.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, record review and interview the facility failed to serve palatable food and at proper temperatures. This applies to 6 of 6 residents (R10, R14, R15, R16, R17, R18) reviewed for dining in a sample of 18. Findings include: On 9/17/2020 at 2:30 PM, R14 and R15 were sitting in the hall. Both residents stated the facility serves cold food. R1 was awake inside her room. R1 stated the food is cold and not served on time. The residents stated lunch should be served at 12:00 PM but is often late. The residents also complained that supper isn't served until 7:30 PM on some days. On 9/18/2020 at 12:00 PM, the tray line was observed. Kitchen staff were placing food on the trays to serve to residents. Food temps were taken and found to be acceptable as follows: green vegetables 140 df (degrees Fahrenheit), potatoes 140 df, Mustard Glazed Beef 140 df. V4 dietary manager stated the kitchen staff starts dishing the lunch meal at 12:00 PM and they are on the units by 12:10 PM. As of 12:30 PM there was no lunch being served. At 12:48 PM lunch trays were brought on 100-200 units. At 1:05 trays were being brought to the 300-400 units. A test tray was placed on the cart. V4 came to the unit at 1:20 PM and assisted passing trays. The staff finished passing trays at 1:37 PM. The temperatures were taken on the test tray with V4. V4 stated she knows the temperatures are cold. Temps: green vegetables 100 df, Potatoes 100 df. The Mustard Glazed Beef was 84 df. The temperature was repeated on the meat with same results. On 9/18/2020 at 1:05 PM, R16 was sitting at the lunch table with her lunch. The meal container was open. No one was assisting R16. R10 whom also requires feeding assistance was placed at the table with R16. R10 did not have her meal currently. At approximately 1:20 PM, V17 (Nurse) began feeding R16. R10 was sitting at the table with no meal. At approximately 1:28 PM, V4 (Dietary Manager) brings a tray for R10. On 9/24/2020 at approximately 12:30 PM R17 and R18 stated the food is always cold. The policy titled Diets to meet the needs of the residents read: The department will follow policies and procedures developed in accordance with local, state and federal regulations and will plan, organize, and evaluate all aspects of food and nutrition services. Guidelines: 2. To provide food and drink that is nutritious, palatable, attractive, and at a safe and appetizing temperature to meet individual needs.