STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21MM	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CEN	1300 MELODY LANE LEAKESVILLE, MS 39451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS #25056, at the facility from 05/06/24 through 05/09/24. The SA investigated CI MS #25056 related to verbal abuse and neglect and cited M500 related to the complaint investigation. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M610, M640 and M855.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or	M 500		6/21/24

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M 500	Continued From page 1	M 500		

nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on interviews, record review, and facility policy review the facility failed to ensure residents quality of life was maintained as evidenced by	M 500	1. Upon checking the site by the day shift nurse, resident#32 had his bandage and linen removed. New bandages and linen's were applied om 5.5.24.	

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M 500	Continued From page 4 the facility's failure to provide a clean and comfortable homelike environment, including clean, blood free linens for one (1) of 17 sampled residents. Resident # 32 Findings include: A record review of the facility's document "A Matter of Rights A Guide to Your Rights and Responsibilities as a Resident" with a copyright date of 2020, revealed " ... No Discrimination: You have the right to fair and equal treatment ... we will not treat residents differently based on ...their medical diagnosis ...We will meet all applicable rules requiring that we make available free communication aids and services, for example, by providing translation services or other language assistance ..." Resident #40 On 05/07/24 at 10:30 AM, Resident #40 attended the resident council meeting and the facility's Speech Therapist (ST) assisted her with communication during the meeting. Resident #40 complained she had missed medical and dental appointments because she did not have an interpreter to assist her with communicating with the providers at the clinics. She was unsure if the facility had rescheduled the appointments at this time. The ST reported that if she were made aware in advance, she would attend the appointments with the resident to assist in communicating with the providers. A record review of the "Departmental Notes" revealed Resident #40 had a "Nurse Notes" dated 4/18/24 at 8:39 PM for "(Proper Name) office from Gastroenterology ...called to reschedule a follow up appointment for resident. He was	M 500	2. Any resident who had this type of procedure could have been affected by the alleged deficient pracitice. 3. The facility conducted in-service training starting on 5.6.24 on how to check Peripherally Inserted Central Catheter(PICC)/Midline Catheter(MIDLINE) sites.The Director of Nursing(DON) or the Assistant Director of Nursing(ADON) conducted the in-services. An inservice was also conducted by the DON/ADON on changing bed linens on 5.29.24. 4. The DON, ADON, or Resident Care Manager(RCM) will check any resident who has had this procedure for 5 days a week for 4 weeks. Each PICC/MIDLINE inserted will be evaluated by a nurse for any blood on the bandage or linens. The DON, ADON, or RCM will check linens5 rooms 3 days a week for 4 weeks, after wards 3 rooms 2 days a week for 4 weeks, then 2 rooms for clean unsoiled linens for 2 months. These results will be reviewed by the DON or ADON in Quality Assurance Performance Improvement for 4 months. 1. Resident#40 had her appointments rescheduled to meet her need for an interpreter cardilogolist 6.14.24, dental 6.20.24, and gastroenterologist 6.10.24 scheduled by lpn.	

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M 500	Continued From page 5 unaware she is deaf and needs an interpreter. He stated he will call us back with a time once he has an interpreter scheduled...". A "Nurse Notes", dated 4/16/24, revealed, " ... Called for an update on referral sent to (Proper Name) for teeth extraction... This nurse informs ... that resident is deaf and will need an interpreter available ... will get in contact with that service and states that when an interpreter is required that the clinic is at the mercy of them...". A "Nurse Notes", dated 4/6/24, revealed, "... late entry 4/5/24: Resident left for cardiology appt (appointment) on 4/5/24 at 1100 (11:00 AM) and returned at 15:30 (3:30 PM). Resident was unable to see cardiologist D/T (due to) no interpreter for resident...New appt scheduled for 4/25/2 at 1300 (1:00 PM) ...A translator has been schedule for that appt ..."" At 11:50 AM on 05/09/24, during an interview with the facility's Nurse Practitioner (NP), she stated she was unaware Resident #40 had missed gastroenterology, dental, and cardiology appointments. She explained the appointments were very important for Resident #40's health and well-being and she should not have missed appointments due to not having an interpreter. At 12:00 PM on 05/09/24, during an interview with the Director of Nursing (DON), she explained she was unaware Resident #40 had missed appointments due to not having an interpreter and stated the facility's transportation driver knew sign language and could have assisted with communication during the appointments. The DON said she thought Resident #40 had an application (app) on her phone to help with interpretation and was unaware she could or would not use the phone app when she went to appointments. The DON also stated she thought the clinics provided their own interpreters for	M 500	2. All deaf residents could have been affected by the alleged deficient practice. 3. The facility will contract with an interpreter service to provide an interpreter for appropriate medical office visits. It was also confirmed that resident does have interpreter application on her cell phone.The transportation employees will be in-serviced on scheduling an interpreter for residents that use the service starting on 5.21.24 by the director of nursing. 4. The Director of Nursing(DON), Assistant Director of Nursing(ADON), or Resident Care Manager(RCM) will review appointments for use of an interpreter 5 times a week for 4 weeks, then monthly. This will begin 5.21.24. The results will be review in Quality Assurance Performance Improvement on 6.21.24 for 4 months.	

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appointments and was not aware it was the facility's responsibility. The DON reviewed the departmental notes that were documented by the nurses in the medical record and confirmed she was not aware Resident #40 had missed appointments for gastroenterology, dental, and cardiology due to not having an interpreter. The DON commented that she had not thought about the resident needing an interpreter for appointments.

At 12:15 PM on 05/09/24, during an interview with Licensed Practical Nurse (LPN) #3, she explained she was not aware it was the facility's responsibility to provide an interpreter for appointments. LPN #3 stated Resident #40 had mouth pain, was treated for an abscessed tooth, completed antibiotics, and went to the dentist for a tooth extraction. However, the provider could not communicate with the resident and the tooth was not extracted. She said Resident #40's daughter was notified that the resident needed an interpreter before she could have the tooth extracted. LPN #3 confirmed Resident #40 had a dental appointment rescheduled for a tooth extraction on 5/30/24 and there was indication that appointments had been rescheduled for cardiology and gastroenterology.

At 01:00 PM on 05/09/24, during an interview with Certified Nurse Aide (CNA) #2, she explained she was the transportation aide and assisted with driving and attending appointments. CNA #2 confirmed Resident#40 had not been seen at appointments because there was no interpreter available. She explained she had not been asked to perform sign language for the resident and stated that although she knew a little sign language, she did not feel she knew it well enough to communicate with providers at

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M 500	Continued From page 7	M 500		

appointments. She stated Resident #30 had not used her phone app while at appointments.

At 03:30 PM on 05/09/24, during an interview with the Administrator, he explained he expected residents to attend scheduled appointments and the staff to ensure residents had everything in place prior to the appointment.

Record review of the "Face Sheet" revealed the facility admitted Resident #40 on 5/3/22 with current diagnoses including Deaf Nonspeaking.

A record review of the Annual Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 4/25/24 revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

Review of the medical record revealed there was no documentation that Resident #40 attended the rescheduled appointment for the cardiologist on 4/25/2 at 1:00 PM.

Resident #32

A record review of the facility's policy "Safe and Homelike Environment", revised 2/12/2023 revealed " ... In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and homelike environment ...Policy Explanation and Compliance Guidelines ...4. The facility will provide and maintain bed and bath linens that are clean and in good condition ..."

On 5/6/24 at 11:30 AM, in an interview, Resident #32 complained he had gotten blood on his bed sheets and gown when he had a procedure for an intravenous (IV) line. He said he had to sleep on sheets and in a gown that had blood on them.

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M 500	Continued From page 8 On 5/6/24 at 12:40 PM, during an interview with Licensed Practical Nurse (LPN)#1, she explained she did not remember Resident #32's sheets and gown having blood on them, but she only took off the black compression wrap and did not go back into the resident's room that evening. On 5/6/24 at 3:20 PM, during an interview with Certified Nurse Aide (CNA) #4, she reported she did not remember what time it was, but when she went to obtain Resident #32's vital signs, she saw some blood on his bed sheet and gown. She stated she was not assigned to care for Resident #32 that evening and she forgot to tell his aide or nurse about the blood on the sheets. She said she thought someone would see it. On 5/7/24 at 1:00 PM, during an interview with the Ombudsman, she explained Resident #32 complained to her today that he had to lay in a bloody gown and bloody sheets overnight this past weekend until a nurse came in to change the midline dressing and changed his sheets and gown. On 5/8/24 at 9:00 AM, during an interview with Registered Nurse (RN) #2, she explained she worked on 5/4/24 and 5/5/24 as the weekend supervisor the past weekend. She reported on 5/4/24, Resident #32 had a line inserted around 3:00 PM. She left at 3:30 PM and did not observe the resident after the procedure was completed. She stated on the morning of 5/5/24, she observed Resident #32 and changed the dressing for the line. She confirmed the resident's draw sheet and gown had dried blood and she had to change his sheets and his gown. She explained his sheets and gown should have been changed when they became soiled with blood. Resident	M 500		

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M 500	Continued From page 9 #32 reported to her that he had asked a LPN and CNA to change his sheets and gown because of the blood, but no one changed them. At 1:00 PM on 5/9/24, during an interview with the Director of Nursing (DON), she explained she expected staff to change resident's sheets and gown and to not allow a resident to lay in soiled linens overnight. At 4:00 PM on 5/9/24, during an interview with the Administrator, he explained he expected all linens to be clean for residents. A record review of the "Face Sheet" revealed the facility admitted Resident #32 on 12/3/19 with current diagnoses including Hemiplegia Following Cerebral Infarction Affecting Left Nondominant Side. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 2/22/24 revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of the "Departmental Notes" revealed Resident #32 had a "Nurse Notes", dated 5/5/24 10:58 AM for " ... Resident had midline insertion done as ordered on 05/04/24 ... Dressing to midline insertion site soiled with blood due to procedure ...Dressing changed per sterile technique ..."	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate	M 640		6/21/24

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M 640	Continued From page 10 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on resident and staff interviews, record review, and the facility policy review, the facility failed to secure a resident in the facility van during transport for one (1) of two (2) residents reviewed for accidents. (Resident #43) Findings Include: Review of the facility's policy, "Incident and Accidents", dated 5/13/2023, revealed, " ...It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur ..." Review of the facility's "Fall Prevention Policy", dated 2/20/23, revealed, " ...Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls..." Review of the "Resident Incident Report" for Resident #43, dated 10/4/23, revealed the facility investigated the incident and the "Narrative of incident and description of injuries" indicated "the transporter stated that resident was strap in place in wheelchair and upon taking off in the van the resident chair flipped over backwards and resident stated he hit his head no injuries noted except where resident stated he hit his head but no ap-preat (sic) injury noted on head ..." An interview with Resident #43 on 5/6/24 at 12:41	M 640	1. Resident #43 was assessed by the nursing staff with no complaints of pain on 10.4.23. The following day he complained of pain and was sent to the hospital for evaluation returned with no injury. The assistant maintenance director checked the straps for defects. No defects found. 2. All residents who uses a wheelchair and uses the facility transportation could have been affected by the alleged deficient practice. 3. The driver will report any problems with securing the residents immediately to administration. They will suspend the transport until the problem has been remediated.Facility employees who drive the van were in-serviced for proper use of straps in securing residents in wheelchairs by the director of nursing starting on 5.10.24. Facility employees that drives the vans will be in-serviced quarterly.The maintenance staff was in-serviced on proper application of the securing straps starting on 5.21.24. 4. The vans will be inspected by the maintenance director, assistant maintenance director, or the	

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M 640	Continued From page 11 PM, revealed his wheelchair had overturned in the facility's transportation van on the return trip from a doctor's office visit last year. Resident #43 stated he must not have been strapped down properly because his wheelchair turned over backwards as the driver put her feet on the gas. He said that he did not touch the straps. He explained the van driver had connected the strap to the wheelchair wheels, but he was unable to see exactly what was going on at the bottom of the wheelchair. He stated that he did not want to go to appointments in the van since the fall occurred, so the facility took him to appointments in the company car with a different driver. During an interview on 5/7/24 at 11:30 AM, with Certified Nursing Aide (CNA) #2, she stated that on 10/4/23, she had strapped Resident #43 into the facility's van and had checked to ensure he was secure. CNA #2 said she had accelerated the gas and the resident's wheelchair overturned and he fell backward onto the floor of the van. CNA #2 explained that she immediately stopped the van to check on the resident and noted the front right belt and the seat belt were not connected. CNA #2 was unsure how the belts could have come apart unless the resident had released them. CNA #2 stated that she notified the facility immediately, assisted the resident back in the wheelchair, and made sure the straps were connected. When the resident arrived at the facility, he was checked by the nurses. During an interview on 5/8/24 at 12:45 PM, with the Director of Nursing (DON), she confirmed Resident #43 had a fall in the transportation van in October 2023. The DON confirmed she had completed the investigation and had interviewed CNA #2 who indicated that she had checked the straps in the van to ensure the resident was	M 640	administrator for any issues with the straps. This will take place 2 times a week for 4 weeks starting 5.21.24. Then weekly for 4 weeks followed by monthly inspections. Any issues will be reported to the administrator for further review. The results will be review in Quality Assurance Performance Improvement by the maintenance director on 6.21.24 for 4 months.	

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M 640	Continued From page 12 secured prior to leaving the doctor's office. The DON stated CNA #2 said the wheelchair overturned when she accelerated the gas to leave the doctor's office. CNA #2 brought the resident back to the facility where he was assessed and found to have no injuries. During the investigation, the DON interviewed Resident #43 and he stated he had hit his head, but he was fine and the resident confirmed the CNA had secured the straps to his wheelchair. The DON and the Maintenance Tech checked the straps on the van to ensure they were working properly, and they found no issues. The DON explained that she and the previous Administrator did not suspect negligence regarding securing the straps to the wheelchair and she believed Resident #43 may have removed the seat belt and the right front strap from the wheelchair himself. During an interview on 5/09/24 at 02:32 PM, with the Maintenance Tech, he confirmed he had checked the straps on the transportation van when the resident returned after he had fallen in October and did not find any faulty equipment. A record review of the "Face Sheet' revealed the facility admitted Resident #43 on 7/25/23 with current diagnoses including Cerebral Palsy. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/17/24 revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively Intact	M 640		
M 855	45.30.7 Food Preparation Food Preparation. Foods shall be prepared by methods that conserve optimum nutritive value,	M 855		6/21/24

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M 855	Continued From page 13 flavor, and appearance. Also, the food shall be acceptable to the individuals served. A file of tested recipes shall be maintained to assure uniform quantity and quality of products. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to provide resident meals at an appetizing temperature for two (2) of two residents reviewed for food. Resident #32 and Resident #109. This had the potential to affect all residents who receive meals from the kitchen. Findings include: A record review of the facility's policy, "Food and Nutrition Services", revised 10/2017, revealed " ... Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs ...Policy Interpretation and Implementation: ... 7. Food and nutrition services staff will inspect food trays to ensure ...the food ...is served at a safe and appetizing temperature ..." Resident #32 On 05/06/24 at 11:35 AM, during an interview with Resident #32, he complained the food was served cold daily at all meals. On 5/07/24 at 12:15 PM, during an observation, the facility staff were in the dining room with the meal tray carts and were reviewing trays. One (1) cart had six (6) trays and one (1) cart and nine (9) trays. The carts were open carts and the trays had insulated plate covers used on the plates.	M 855	1. Resident#32 had his food re warmed on 5.7.24 and Resident#109 was offered another tray on 5.8.24. 2. All residents who receive meals from the kitchen could have been affected by the alleged deficient practice. 3. The facility will work to assure meals are ready, palatable and served on time.The RD in-serviced the dietary staff on proper food temperture delivery on 5.22.24. 4. The food temperatures will be taken on trays 2 meals a day 5 times per week for 4 weeks starting 5.27.24. After 4 weeks the temperature will be taken 4 meals per week for 3 months. The dietary manager, registered dietition(RD) or the administrator will take the tempertures. The results will be reviewed in Quality Assurance Performance Improvement on 6.21.24 for 4 months.	

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M 855	Continued From page 14	M 855		

The first cart with nine (9) trays went to the floor at 12:19 PM for the A and B hall. A cart with three (3) trays went to the floor at 12:20 PM for E hall. A cart with six (6) trays went to A and B hall at 12:22 PM and the last tray was removed at 12:27 PM. At 12:29 PM Resident #32 received his lunch tray and he had a fork in his silverware. He asked Certified Nurse Aide (CNA) #6 to bring him a spoon and since she was still delivering trays, she asked a nurse to provide him with a spoon. Resident #32 received a spoon at 12:35 PM, and complained the food was cold and requested staff to take the food back and warm it up. Resident #32's meal included chopped meat, green beans, and a baked potato on his meal tray.

On 5/07/24 at 2:00 PM, during an interview with CNA #6, she explained residents had complained about cold food for several months and some residents had requested food to be rewarmed. She confirmed Resident #32 had asked for his food to be rewarmed.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 2/22/24 revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

Resident #109

During an interview on 5/6/24 at 10:36 AM, Resident #109 complained the food was cold and explained that she often had to ask the staff to warm it up.

In an interview on 5/6/24 at 11:00 AM, with CNA #1, she stated the residents complain most of the time about the food being cold. She said she explained to the residents that the kitchen only

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M 855	Continued From page 15	M 855		

had one person working several times a week.

An observation of a test tray and interview with the Dietary Manager (DM) on 5/7/24 at 1:00 PM, revealed temperature of the baked potato was 118, the meat was 103, and the green beans were 101, and the food was lukewarm when tasted. The DM reported she had problems with residents complaining the food was cold and explained it took the staff a long time to get the food to the residents. She confirmed she currently had staffing challenges in the kitchen, and she was training a new cook. She also confirmed she had attended resident council meetings where there had been complaints about cold food, and she was working to correct the situation.

On 5/8/24, in an observation, the meal trays arrived on F-hall at 6:30 PM. The residents complained the food was cold. Resident #109 complained the Mexican rice was cold and the hamburger meat to go on the taco salad was cold. Resident #109 said she does not like cold hamburger meat or cold rice.

During an interview on 5/09/24 at 10:51 AM, with the DM she confirmed the food that was served for dinner on 5/8/24 was cold because the new cook in training, Dietary #1, had placed the hamburger meat in with the lettuce and tomato and put it into the refrigerator because she thought the salad and meat should be cold.

On 5/9/24 at 3:30 PM, during an interview with the Administrator, he confirmed residents had complained about cold food and on 5/07/24 it had taken a long time for staff to get the trays on the floor and he confirmed he heard about the cold taco salad served on 5/08/24 for dinner. He

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M 855	Continued From page 16 expected residents to be served food that is palatable, attractive, and at a safe and appetizing temperature.	M 855		