STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075439	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Home Infirmary/Pavilion	320 Colony Street Meriden, CT 06451

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for 1 of 1 resident (Resident #14) reviewed for choices, the facility failed to honor a resident's right to choose. The findings include: Resident #14 was admitted to the facility in September of 2024 with diagnoses that included dementia, chronic kidney disease, muscle weakness, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13), independent with eating, oral hygiene and toileting, required supervision or touching assistance for personal hygiene and was independent for bed mobility and transfers. The MDS identified that Resident #14 and his/her family participated in assessment and goal setting. The MDS did not identify Resident #14 with a swallowing disorder, coughing or choking during meals or when swallowing medications, or complaints of difficulty or pain with swallowing. The Resident Care Plan dated 1/2/25 identified Resident #14 was at risk for an alteration in nutrition related to changes in oral intake. Interventions included a no added salt diet, low cholesterol, soft and bite sized texture (level 6), mildly thick liquid (level 2) consistency, availing menu alternative, references at prescribed textures and monitoring and documenting oral intake. A Physicians order dated 2/20/25 directed a no added salt diet (NAS), low cholesterol, soft and bite sized texture (level 6), mildly thick liquid (level 2) consistency. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #14 on 3/5/25 at 11:45 AM identified that he/she was forced , by the facility, to drink thickened liquids and eat foods that were different from what his/her spouse ate. Resident #14 indicated that he/she was accompanied by his/her spouse for meals and had a difficult time enjoying meal times because of the diet he/she was served. Resident #14 identified that he/she had radiological and swallowing tests done in October of 2024 which identified he/she was at risk of aspiration and was subsequently started on thickened liquids. Resident #14 identified he/she developed diarrhea, due to the thickener, which caused frequent trips to the bathroom. Resident #14 indicated that he/she understood the consequences of not adhering to the recommended diet but preferred to not follow the recommendation. Resident #14 further indicated that the facility provided him/her thickened liquids and soft foods despite multiple discussions and requests to be placed on a regular diet and thin liquids. Resident #14 indicated that he/she is of advanced age and is most concerned about having a quality of life and would like his/her wishes to be honored by the facility. An Advanced Registered Nurse Practitioner's (APRN) note dated 2/4/25 by APRN #1 identified that Resident #14's spouse, who was also his/her first emergency contact person, had approached her requesting that Resident #14 be placed on palliative comfort measures only (CMO) to liberalize fluids. The note further indicated that the responsible party/power of attorney (POA) would need to be involved. The note identified that Resident #14 was readmitted to the facility due to cognitive and physical decline and he/she was being monitored for dysphagia and diarrhea possibly related to the thickener used in fluids. A Physician ' s order dated 12/11/24 directed to administer 2 milligrams of Loperamide Hydrochloride by mouth every 24 hours as needed for Diarrhea. Interview with Social Worker (SW) #1 on 3/5/25 at 12:20 PM identified that she was aware of Resident #14's food complaints. SW #1 identified that Resident #14 was started on thickened liquids due to choking concerns. SW #1 indicated that APRN #1 was responsible for addressing CMO requests and indicated she had no discussions with APRN #1 regarding Resident #14's food complaints. SW #1 identified there had been no meeting with the facility interdisciplinary team, Resident #14, or Resident #14 ' s family to discuss goals of care. Review of the clinical record failed to identify documentation of a meeting or collaboration between the facility interdisciplinary team, Resident #14, or Resident #14 ' s family to discuss goals of care Review of the clinical record identified Resident #14 was his/her own decision maker and did not have a named representative or POA. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 3/7/25 at 12:15 PM identified that she had a meeting with Resident #14 and his/her spouse to discuss the risks versus benefits of stopping the dysphagia diet and further discussed a CMO status. APRN #1 indicated that she did not think Resident #14, or his/her spouse were capable of making decisions because they lacked the insight to understand the benefit of the Speech and Language Pathologists (SLP) recommendations. APRN #1 identified that she thought Resident #14's daughter was Resident #14 ' s legal decision maker but indicated that she had not contacted or reached out to Resident #14's daughter to discuss goals of care. APRN #1 indicated that the facility did not want to cause harm to Resident #14 by advancing his/her diet per his/her request. APRN #1 identified that she informed the DNS and the nursing supervisor of Resident #14's and his/her family ' s requests for a transition to CMO and diet change. APRN #1 further indicated that it was the facility's responsibility to make decisions based on goals of care. Interview with the DNS on 3/7/25 at 1:00 PM, identified that the facility did not advance Resident #14's diet because a diet change would be unsafe. The DNS further identified that Resident #14's daughter requested a waiver in order for Resident #14 ' s diet to be changed but the facility did not provide any form of waiver. The DNS indicated that Resident #14 was not appropriate for a CMO status since he had not experienced a decline. Interview with SLP #1 on 3/10/25 at 9:20 AM identified that Resident #14 voiced concerns regarding the dysphagia diet recommendation. SLP #1 identified that Resident #14 received SLP services in October of 2024, was discharged in November of 2024, and no further referrals had been made after the November discharge. Facility's Residents [NAME] of Rights identified that residents have a right to refuse treatment . and residents rights would be honored. Review of facility policy titled, Palliative Care, identified, in part, that, the physician and staff will identify individuals who desire or are likely candidates for palliative care, for example, those with a known terminal illness or end-stage condition (that is, a condition that has resulted in substantial functional dependency, impairment and/or medical instability and continued decline anticipated, regardless of whether medical treatments are rendered.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for 1 of 3 residents (Resident #14) reviewed for elopement, the facility failed to develop a comprehensive care plan for a resident at risk of elopement. The findings include: Resident #14 was admitted to the facility in September of 2024 with diagnoses that included dementia, chronic kidney disease and hypertension. An Elopement Risk assessment dated [DATE] identified Resident #14 was at low risk for elopement. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6), required assistance for eating, supervision or touching assistance for personal hygiene and was independent for bed mobility and transfers. The MDS identified that Resident #14 ambulated with a walker. Resident Care Plan dated 10/9/24 identified Resident #14 had cognitive loss related to dementia. Interventions included reorienting and supervising as needed, giving choices regarding care, asking questions, rephrasing as needed for confusion or agitation and use of task segmentation to support short term memory deficits. A Nursing progress note by RN #1 on 10/15/24 at 7:00 PM identified that Resident #14 was exit seeking multiple times, was redirected by staff, and a new order for a Wander guard (monitoring device applied on residents who wander and are risk of elopement) to the walker was obtained for safety. An Advanced Practice Registered Nurse (APRN) progress note by APRN #1 dated 10/21/24 identified Resident #14 presented with periods of confusion, disorientation, exit-seeking and wandering behaviors. The note further identified that Resident #14 was often looking for his wife, who lived on the assisted living side of the facility, and that Resident #14 had a Wander guard in place. Review of the clinical record identified there was no repeat Elopement Risk assessment performed for Resident #14 until 12/31/24. An Elopement Risk assessment dated [DATE] identified Resident #14 was at risk for elopement. Observation of Resident #14 on 3/4/25 at 11:00cAM and 3/5/24 at 11:51 AM, identified a Wander guard attached to Resident #14's walker. Review of the RCP failed to identify a basic or comprehensive care plan with interventions directing care for Resident #14's elopement/wandering risk. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 (MDS Coordinator) on 3/6/25 at 12:31 PM identified that she was not notified in October of 2024 that a Wander guard was ordered for Resident #14 due to wandering behavior but was made aware in December of 2024 during Resident #14's quarterly MDS assessment. LPN #1 indicated that she forgot to develop an RCP with interventions directing care for Resident #14 ' s wandering behavior. Subsequent to surveyor inquiry, LPN #1 revised the RCP to identify Resident #14's Wander guard order with interventions to check placement every shift and for a Wandering assessment to be performed quarterly and with any change. Interview with the DNS on 3/7/25 at 9:16 AM identified that LPN #1 was responsible for updating RCPs and that RCPs are updated quarterly and with changes in condition. The DNS further identified that LPN #1 should have updated the RCP when the Wander guard was applied in October of 2024. Review of facility policy titled, Care Plans, identified, in part, that the care plan will be developed no later 7 days after the completion of the comprehensive MDS. The RCP of each resident is completed and reviewed by the 21st day after admission and quarterly thereafter at the Resident Care Conference. RCPs can also be revised, as needed at any time, on an interim basis. The MDS coordinator is responsible for ensuring that all new items, wounds, falls etc., are care-planned.

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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** 50179 51183 Based on observations, review of the clinical record, facility policy and interviews for 1 of 2 residents (Resident #10) reviewed for skin conditions and 1 of 1 residents (Resident #11) reviewed for Urinary Tract Infections (UTI), the facility failed to revise resident care plans (RCP) after changes in condition occurred. The findings include: 1. Resident #10 was admitted to the facility in August of 2023 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), hypoosmolality and hyponatremia (excess water in the body and low sodium levels) and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), required set up assistance for eating, supervision for bed mobility, and partial/moderate assistance for toileting and transfers. The RCP dated 1/16/25 identified Resident #10 was at risk for impaired skin integrity. Interventions included ensuring properly fitting shoes, observing feet for redness or skin breakdown with care, treatments as ordered, observing for edema, warmth, induration, redness, drainage, updating the physician as needed, observing skin for breakdown with care, redness, excessive moisture, raised areas, open areas and drainage. A nurse's note dated 2/25/25 at 10:27 PM by RN #6 identified an area of purpura to Resident #10's left lower shin opened with a scant amount of bleeding and a dressing was applied. A progress note dated 2/28/25 at 10:15 AM by Advanced Practice Registered Nurse (APRN) #1 identified a new wound to the left shin which was suspected of having a traumatic etiology as it was located on the extensor surface. Review of the clinical record identified there were no revisions to the RCP to include the new wound to the left lower shin or protective/preventative interventions. 2. Resident #11 was admitted to the facility in June of 2022 with diagnoses that included Dementia, falls and UTI. The Quarterly MDS assessment dated [DATE] identified Resident #11 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 4), was independent with bed mobility, required supervision for transfers, and required partial/moderate assistance for toileting. The RCP dated 1/30/25 identified potential for activities of daily living/self-care deficit related to weakness and confusion. Interventions included vital signs as needed, labs as ordered, observing for changes in mental status and observing for UTI: abdominal/flank/back pain/discomfort, fever, changes in urine color, clarity or odor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 2/24/25 at 3:00 PM by APRN #1 identified dark concentrated urine with a history of UTI and that urinary frequency had subsided significantly with medication. A Physicians order dated 2/24/25 directed 72-hour monitoring for UTI and monitoring for dysuria for 3 days. A urine culture dated 2/25/25 identified greater than 100,000 colonies per milliliter of Klebsiella Pneumoniae in the urine. A physician's order dated 2/27/25 directed to administer Sulfamethoxazole -Trimethoprim (antibiotic) tablet 800-160 milligrams twice a day for a UTI for 7 days. Review of the clinical record identified the RCP was not revised to include the confirmed UTI, monitoring or treatment. Subsequent to surveyor inquiry, the RCP was revised to include an actual UTI and antibiotic treatment. Interventions included to encourage fluids, provide peri care, intake and output as needed, medication as ordered, labs as ordered, observe for signs and symptoms of UTI: mental status changes, fever, dysuria, frequency, urgency, increased incontinence, abdominal/flank/back pain/discomfort, toilet every 2 hours and as needed, prompt incontinent care. Interview with LPN #1 on 3/6/25 at 12:44 PM identified the facility interdisciplinary team (IDT) should update RCPs. Interview with the Director of Nursing Services (DNS) on 3/7/25 at 9:20 AM identified LPN #1 (MDS Coordinator) is responsible for updating RCPs and that RCPs should be updated after clinical meetings, risk meetings, after changes in condition and quarterly by the IDT. Review of the Care Plan policy dated 6/23, directed, in part, care plans will be updated at a minimum of quarterly when the resident has an MDS to be completed. The MDS Coordinator is responsible for ensuring all new items, wounds, falls, etc. are care planned.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for 1 of 1 resident (Resident #14) reviewed for choices, the facility failed to identify and promote individualized care for a resident who voiced goals of care requests. The findings include: Resident #14 was admitted to the facility in September of 2024 with diagnoses that included dementia, chronic kidney disease, muscle weakness, and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13), independent with eating, oral hygiene and toileting, required supervision or touching assistance for personal hygiene and was independent for bed mobility and transfers. The MDS identified that Resident #14 and his/her family participated in assessment and goal setting. The MDS did not identify Resident #14 with a swallowing disorder, coughing or choking during meals or when swallowing medications, or complaints of difficulty or pain with swallowing. The Resident Care Plan dated 1/2/25 identified Resident #14 was at risk for an alteration in nutrition related to changes in oral intake. Interventions included a no added salt diet, low cholesterol, soft and bite sized texture (level 6), mildly thick liquid (level 2) consistency, availing menu alternative, references at prescribed textures and monitoring and documenting oral intake. Interview with Resident #14 on 3/5/25 at 11:45 AM identified that he/she was forced , by the facility, to drink thickened liquids and eat foods that were different from what his/her spouse ate. Resident #14 indicated that he/she was accompanied by his/her spouse for meals and had a difficult time enjoying meal times because of the diet he/she was served. Resident #14 identified that he/she had radiological and swallowing tests done in October of 2024 which identified he/she was at risk of aspiration and was subsequently started on thickened liquids. Resident #14 identified he/she developed diarrhea, due to the thickener, which caused frequent trips to the bathroom. Resident #14 indicated that he/she understood the consequences of not adhering to the recommended diet but preferred to not follow the recommendation. Resident #14 further indicated that the facility provided him/her thickened liquids and soft foods despite multiple discussions and requests to be placed on a regular diet and thin liquids. Resident #14 indicated that he/she is of advanced age and is most concerned about having a quality of life and would like his/her wishes to be honored by the facility. An Advanced Registered Nurse Practitioner's (APRN) note dated 2/4/25 by APRN #1 identified that Resident #14's spouse, who was also his/her first emergency contact person, had approached her requesting that Resident #14 be placed on palliative comfort measures only (CMO) to liberalize fluids. The note further indicated that the responsible party/power of attorney (POA) would need to be involved. The note identified that Resident #14 was readmitted to the facility due to cognitive and physical decline and he/she was being monitored for dysphagia and diarrhea possibly related to the thickener used in fluids. A Physician ' s order dated 12/11/24 directed to administer 2 milligrams of Loperamide Hydrochloride by mouth every 24 hours as needed for Diarrhea. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Worker (SW) #1 on 3/5/25 at 12:20 PM identified that she was aware of Resident #14's food complaints. SW #1 identified that Resident #14 was started on thickened liquids due to choking concerns. SW #1 indicated that APRN #1 was responsible for addressing CMO requests and indicated she had no discussions with APRN #1 regarding Resident #14's food complaints. SW #1 identified there had been no meeting with the facility interdisciplinary team, Resident #14, or Resident #14 ' s family to discuss goals of care. Review of the clinical record failed to identify documentation of a meeting or collaboration between the facility interdisciplinary team, Resident #14, or Resident #14 ' s family to discuss goals of care. Review of the clinical record identified Resident #14 was his/her own decision maker and did not have a named representative or POA. Interview with APRN #1 on 3/7/25 at 12:15 PM identified that she had a meeting with Resident #14 and his/her spouse to discuss the risks versus benefits of stopping the dysphagia diet and further discussed a CMO status. APRN #1 indicated that she did not think Resident #14, or his/her spouse were capable of making decisions because they lacked the insight to understand the benefit of the Speech and Language Pathologists (SLP) recommendations. APRN #1 identified that she thought Resident #14's daughter was Resident #14 ' s legal decision maker but indicated that she had not contacted or reached out to Resident #14's daughter to discuss goals of care. APRN #1 indicated that the facility did not want to cause harm to Resident #14 by advancing his/her diet per his/her request. APRN #1 identified that she informed the DNS and the nursing supervisor of Resident #14's and his/her family ' s requests for a transition to CMO and diet change. APRN #1 further indicated that it was the facility's responsibility to make decisions based on goals of care. Interview with the DNS on 3/7/25 at 1:00 PM, identified that the facility did not advance Resident #14's diet because a diet change would be unsafe. The DNS further identified that Resident #14's daughter requested a waiver in order for Resident #14 ' s diet to be changed but the facility did not provide any form of waiver. The DNS indicated that Resident #14 was not appropriate for a CMO status since he had not experienced a decline. Although requested, a policy on the provision of social services was not provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51183 Based on the tour of the Dietary Department, observations, facility documentation, facility policy, and interviews, the facility failed to ensure the Dietary Department served food at temperatures outside of the danger zone and failed to ensure foods reheated by nursing staff were served at safe temperatures. The findings included: 1. Observation of the tray line on 3/6/2025 at 11:42 AM identified a test tray was placed on the only Pavilion meal delivery cart at 12:02 PM and the cart was brought through the dining room onto the nursing unit. The meal delivery cart was observed to be a Bunn rack and was covered with a zippered clear plastic cover that went over the top of the Bunn rack and zipped along the front corners of the rack. The meal plates on the trays inside the rack were covered with clear hard plastic covers that did not contain warming pellets. All meal trays were delivered to the residents by Nurse Aide (NA) #2. Interview with the Assistant Food Service Director (Asst Food Service Dir) on 3/6/2025 at 12:05 PM identified that for breakfast meal service, all residents ate in their rooms, and the Cambro meal delivery cart (insulated meal delivery cart) was used because it had room to hold all trays. The Asst Food Service Dir indicated that for the lunch meal service, some residents ate in their room, but most ate in the dining room, so there wasn't a need for the Cambro meal delivery cart for delivering the meals. On 3/6/2025 at 12:15 PM the test tray was the last tray served on the nursing unit, was brought to the nursing unit kitchenette, and the following temperatures were obtained: Sweet potatoes: surveyor- 107.6 degrees Fahrenheit, Asst Food Service Dir- 105 degrees Fahrenheit Chopped spinach: surveyor- 114.5 degrees Fahrenheit, Asst Food Service Dir- 114 degrees Fahrenheit Pork: surveyor- 97.2 degrees Fahrenheit, Asst Food Service Dir- 95.6 degrees Fahrenheit Interview with the Asst Food Service Dir on 3/6/2025 at 12:16 PM identified the food temperatures were low. Observation on 3/7/2025 at 11:48 AM identified a test tray was placed on the only Pavilion meal delivery cart and the cart was brought through the hallway of the Residential Care Home (RCH), through the double doors into the hallway of the Pavilion and delivered to the nursing unit. The meal delivery cart was a Cambro meal delivery cart with a door that closed and latched in the front. The meal plates on the trays inside the cart were within a blue, hard plastic, heated pellet thermal container which fully enclosed the meal plate. The Asst Food Service Dir and Registered Nurse #1 assisted the NAs in delivering the meal trays. The test tray was the last tray served on the nursing unit. On 3/7/2025 at 11:52 AM the test tray was brought to the nursing unit kitchenette on the unit and the surveyor observed the Asst Food Service Dir obtain temperatures of the test tray food which identified safe food temperatures. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Food Service Director and Asst Food Service Dir on 3/7/2025 at 12:00 PM identified after the low temperature food readings of the test tray on 3/6/25, they decided to initiate the blue heated pellet thermal system for the meal plates and to use the Cambro meal delivery cart rather than the Bunn rack with zippered cover for delivery of meal trays during lunch. Review of the Food Transportation policy identified food would be maintained at a temperature outside the food safety danger zone of 41 to 135 degrees Fahrenheit. Plates and bowls would be covered by foil, plastic wrap, snap-on covers or domes during transportation and holding, and trays would be placed into covered carts for delivery. 2. Observation on 3/6/2025 at 12:11 PM identified NA #2 brought Resident #24's tray into the kitchenette to reheat the food per Resident #24's request. Interview with NA #2 on 3/6/2025 at 2:00 PM identified she asked residents if they needed any items or their food reheated when delivering meal trays, and if a resident requested food to be reheated, she would use the microwave in the kitchenette to heat the food for 40 to 50 seconds. NA #2 identified there was not a thermometer in the kitchenette to check food temperatures, instead, she tried not to overheat food. NA #2 further identified that she reheated food less during breakfast when meal trays were delivered in the Cambro meal delivery cart, and more often for meals delivered on the Bunn rack. Observation of the kitchenette on 3/7/2025 at 9:15 AM identified a thermometer with alcohol wipes for cleaning was located in the drawer furthest from the door on the left side of the room. Interview with NA #5 on 3/7/2025 at 9:30 AM identified she reheated food as requested by residents and tried not to overheat food to prevent residents from burning their mouth. She indicated she reheated food for 25-30 seconds at a time, or longer, as requested. NA #5 identified she did not have a thermometer for checking the temperature of the food but instead would place her hand above the food to gauge how warm the food was. Interview with the Food Service Director on 3/7/2025 at 11:47 AM identified that nursing staff were permitted to reheat food for residents. She identified the food was reheated in the microwave in the kitchenette, food was to be heated until the temperature was 165 degrees Fahrenheit and verified by the thermometer in the kitchenette, and after reheating the food, the food was to sit for at least 1 minute before being served. The Food Service Director further identified she provided the DNS with a new thermometer the previous day. Review of the On-Unit Food Reheating policy, identified, foods may be reheated by facility staff only using the nourishment kitchen's microwave and provided thermometer. Further identified was reheated foods must reach an internal temperature of 165 degrees Fahrenheit for 15 seconds, microwaved food must be let to rest for at least 1 minute, and to prevent injury reheated foods must be retested to ensure the temperature has reduced to approximately 135 degrees Fahrenheit prior to serving to the resident.