STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145753	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Danville	1701 North Bowman Danville, IL 61832

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to return a credit balance and trust fund balance following discharge for one of three residents (R4) reviewed for billing in a sample list of 18. Findings include: The facility's Transactions Involving Resident Funds undated policy documents the Business Office Manager (BOM) is responsible for ensuring resident fund accounts are reconciled on a quarterly basis and statements will be provided in writing to the resident/resident's representative within 30 days after the end of the quarter. On 5/20/26 at 10:00 AM V28, R4's Family, stated the facility has at least two of R4's Social Security monthly benefits that were remitted following R4's discharge, first to the hospital and then to another skilled nursing facility, and the subsequent nursing facility has billed R4's estate. R4's census documents, stop billing on 10/20/25. This census and R4's electronic medical record profile documents Medicaid as R4's payor source.R4's Nursing Notes document R4 transferred to the hospital on [DATE] and on 10/27/25. V28 notified the facility of R4's transfer to another long-term care facility following hospitalization. R4's [NAME] Statements dated 12/20/25, 1/20/26, and 2/20/26 document a credit of $2120 after two payments of $1060 were made in November and December 2025.The Check Request Form dated 5/20/26 documents a request for a check in the amount of $2120 with payee as the long-term care facility that R4 resided in following hospitalization. This form documents the refund was for R4's November and December 2025 Social Security Administration Direct Deposit after R4 discharged on 10/20/25 while residing at another long-term care facility. R4's Resident Statement dated 3/2/26-5/1/26 documents a balance of $120.22 as of 5/1/26. There is no documentation that steps were taken to transfer this balance to V28 or R4's estate. On 5/26/26 at 9:53 AM V16 BOM reviewed R4's billing statements and trust fund statement. V16 stated R4's billing statement showed a credit balance of $2120 due to receiving two months of social security payments after R4 discharged from the facility. V16 stated V16 tries to catch this sooner and sends a check request form to the corporate office for reimbursement to the resident's family or to the facility the resident resides in. V16 confirmed R4 has an active trust fund balance. On 5/26/26 at 10:15 AM V16 stated R4 went to the hospital on [DATE] and V16 found out about a month and half later that R4 transferred to another long-term care facility. V16 confirmed R4's check request was submitted on 5/20/26, there were no prior check request forms submitted, and this would not be considered timely. V16 stated V16 tries to keep track of resident trust fund balances and sends the balance to the resident's current long-term care facility right away or if the resident dies, then the trust fund balance goes to the resident's Power of Attorney or advocate of estate. V16 confirmed V16 has not taken steps to release R4's remaining trust fund account balance to V28 or R4's estate.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide timely care for four (R8, R3, R13, R4) of four residents reviewed for change in condition in a sample list of 19. Findings include: 1. R8's progress notes dated 4/22/2026 at 7:30 PM document R8 was noted in the common area after an unwitnessed fall from R8's wheelchair with a bleeding cut to R8's forehead. R8 was sent to the emergency room and returned with sutures to R8's forehead on 4/23/2026 at 1:03 AM. R8's After Visit Summary dated 4/22/2026 from the local hospital documents to remove sutures in five days. R8's progress note dated 5/13/2026 at 09:08 AM documents R8's facial sutures were removed. On 5/20/2026 at 11:11 AM V2 verified R8's sutures were removed on 5/13/2026. Record review shows no documentation of physician or nurse practitioner notification, or an order to not remove the sutures until 5/13/2026. 2. A Minimum Data Set, dated [DATE] documents R3's Brief Interview for Mental Status score as 15, which reflects R3 is cognitively intact. On 5/13/2026 at approximately 10:00 AM R3 was lying in bed without a cover and did not have a splint present on R3's left leg. R3 had a black x marked on the top of R3's left foot. R3 had light purple bruising and swelling around R3's left ankle. R3 reported that the radiograph (x-ray) technician took it (the splint) off last night and no one else knew how to put it back on. On 5/13/2026 at 1:42 PM V19 (Certified Nursing Assistant) confirmed there was no splint on R3's leg. On 5/13/2026 at 1:45 PM V18 (Licensed Practical Nurse) stated R3 fell a few days ago and we (the staff) took preventative measures by wrapping it (R3's left lower leg). V18 does not know who took off R3's splint, but maybe it was V22 (Wound Nurse) earlier today. V18 stated V18 knows they have a lot of agency staff here (the facility) and they (the agency staff) don't know the policies, so they may have taken it (the splint) off. On 05/13/2026 at approximately 1:55PM V22 (Wound Nurse) confirmed V22 did not see R3 today during treatment rounds and V22 did not take off R3's splint. On 05/13/2026 at 2:05PM V2 (Director of Nursing) stated the facility has no policy in regard to splints, casts, braces, or other devices. When a resident returns from the hospital, the floor nurses are responsible for putting in orders and clarifying them (orders). Management checks to ensure this is done. V2 stated R3 had no orders other than to follow-up with orthopedics when R3 discharged from the hospital on [DATE]. V2 confirmed there were no physician orders for R3's splint in R3's electronic health record. Upon review of R3's After Visit Summary dated 05/10/2026 at 1:43PM, V2 confirmed that it documented the splint should be worn as instructed by the healthcare provider and taken off only if the healthcare provider says it is okay, but that it is unclear what specifically the order states. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V2 did not reach out to the hospital or physician to obtain or clarify orders for R3's splint because V2 was waiting for R3 to see orthopedics on 05/14/2026 and planned to consult with them at that time since they (orthopedics) are the expert. V2 stated there did not need to be any orders to monitor R3's circulation or skin. V2 confirmed there is a standing order set in their electronic health record system for monitoring when a resident has a cast. V2 stated staff are not expected to document if a resident's splint is in place or not. Staff would be aware of R3's splint being there from progress notes or shift-to-shift report. V2 would expect the staff to leave the splint in place until R3 went to the orthopedic appointment and received clarification and further instruction. V2 confirmed that if R3's splint was removed it could be harmful to R3, but if it is off, then it is from R3 manipulating it. V2 then went to R3's room. V2 confirmed R3's splint was not on. R3 reported to V2 that the x-ray technician removed it to complete R3's x-ray last night and that no one knew how to put it back on. On 05/20/2026 at 10:00 AM, V2 (Director of Nursing) stated the facility does not have a policy regarding physician's orders. R3's After Visit Summary from the hospital dated 05/10/2026 at 1:43PM documents the splint should be worn as directed by the healthcare provider and only removed with their approval. It documents the skin around the splint should be checked daily. R3's Nurses Note dated 5/10/2026 at 2:46 PM documents a verbal report was received from the hospital emergency room that R3 had a fracture. The hospital had placed a splint on R3 and that they are sending R3 back to the facility with instructions. R3's Radiology Results Report, dated 5/12/2026 at 10:17PM, documents R3's x-ray took place on 5/12/2026 at 7:00PM. On 5/12/2026 at 2:38PM, R3's Clinical Physician Orders were reviewed and did not include any orders for R3's splint or skin checks around the splint. R3's Nurses Note dated 5/12/2026 at 8:45AM, documents R3's Orthopedic appointment is scheduled for 5/14/2026 at 1:15PM. 3. On 5/19/2026 at 11:00AM R13 was sitting in R13's wheelchair watching television. R13 reported a lump in R13's left breast was noted while R13 was showering a couple months ago. R13 reports that sometimes this lump causes R13 pain. R13 stated a nurse practitioner had ordered an ultrasound and mammogram for it. Recently another nurse practitioner came and said the same thing as the last nurse practitioner. R13 reports R13 still has not had the ultrasound and mammogram done. R13 had a physician order dated 3/06/2026 at 9:35 AM for a STAT (immediate) diagnostic bilateral mammogram and targeted breast ultrasound focused on the left breast indicated for left lateral breast mass. On 3/6/2026 at 12:37PM a Nurse Practitioner Subsequent Visit Note documents R13's chief complaint was a lump in R13's left breast. Upon examination, R13 had a golf-ball sized, mobile mass with associated tenderness. An order for a mammogram and targeted breast ultrasound focused if indicated on R13's left breast mass. The referral was sent to the scheduler, Director of Nursing, and Assistant Director of Nursing and they were aware. On 5/11/2026 at 8:30AM a Provider Note from infectious disease documents R13 notified them of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's left breast mass and the infectious disease nurse is going to notify R13's primary care provider for further evaluation of it. A Late Entry Provider Note on 5/13/2026 at 5:45PM documents R13 reported a lump in R13's breast had not yet been evaluated. It also documents there was no prior imaging done and plan to order a screening/diagnostic mammogram. On 5/19/2026 at 12:55PM V21 (Transportation Manager) stated V21 recalls sending two referrals for R13. The first one was sent and then V21 heard no response back, so V21 contacted them (local breast cancer center) and they said there was a prior authorization issue. V21 got it resolved and sent it again but did not hear back, so V21 called and they said they did not receive the referral so V21 sent them the referral again. On 5/19/2026 at approximately 1:07PM V2 (Director of Nursing) stated if there is a STAT order for imaging, they (the facility) try to get them (the residents) an appointment as soon as possible. If the facility is unable to get the residents in soon, then they will send the resident to the emergency room, but if the emergency room does not provide the type of test/imaging ordered, they will just keep trying to obtain the appointment. V2 confirmed there is no follow-up in regard to R13's referral documented in R13's electronic medical record. V2 stated V2 would not have any documentation of physician notification of delay of appointment scheduling for R13. V2 stated the provider is updated on any referral/appointment delays daily in morning meeting at which V21 (Transportation Manager) is present. On 5/20/2026 at 10:00 AM, V2 (Director of Nursing) stated the facility does not have a policy regarding physician's orders. 4. R4's Minimum Data Set, dated [DATE] documents R4 as moderately cognitively impaired. R4's progress note dated 10/20/25 at 10:43AM documents R4 experienced an unwitnessed fall. There were no injuries documented at that time. No neurological checks were initiated. R4's progress note dated 10/20/25 at 9:46PM documents R4 was found on the floor again. R4's temperature was documented as 101.6 degrees Fahrenheit. R4's family was notified of both falls. R4's Progress notes dated 10/20/26 at 10:24 PM documents R4's family member came to the facility and found R4 to be warm to touch and R4's speech was not clear. R4 was sent to the hospital at family member's request. R4's hospital note dated 10/20/25 documents R4 was admitted to the hospital with diagnoses of Urinary Tract Infection with Sepsis. On 5/18/26 at 11:00AM V1, Administrator and V2, Director of Nursing verified R4 should have had neuro checks following 10:43 AM fall and their expectation would be increased monitoring after a fall. V1 verified the responsible party should have been called after the first fall.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and maintain fall interventions following falls with injury, accurately assess and document falls, timely notify physician and family of falls, and complete neurological assessments following fall with a head injury for 4 residents (R3, R4, R10, R8) of 6 residents reviewed for falls on a sample list of 19. These failures resulted in R3 sustaining an acute nondisplaced fracture at the medial and posterior malleoli. Findings include: 1. R3's Minimum Data Set, dated [DATE] documents R3's Brief Interview for Mental Status score as 15 out of 15, which indicates R3 is cognitively intact. R3's Fall Risk Evaluation Note dated 5/9/26 at 1:25 PM documents R3 has a fall risk score of 16, which indicates R3 is at a high risk for falling. A Fall list provided by facility documents R3 fell on 5/5/2026, 5/8/2026, and 5/9/2026. R3's care plan with an initiation date of 11/23/24 and revised on 4/22/2026 documents R3 is at high risk for falls related to Epilepsy, Tremor, Neuropathy, and Osteoarthritis. Interventions were not limited to but included: to ensure R3's wheelchair is locked and positioned next R3's bed to prompt R3 to utilize it for mobility rather than ambulating unassisted, a reacher to be supplied to R3, application of anti-rollbacks on R3's wheelchair, and ensuring the resident's call light is within reach. On 5/12/2026 at approximately noon R3 was sitting in R3's wheelchair with R3's right leg elevated on the bed. R3's right foot was bare, and left foot was in a splint and was on the floor. R3 was sitting on the edge of the wheelchair. The bed was not in the lowest position. R3 attempted to adjust R3's self in the wheelchair and it began to slip and roll back from under R3. R3 then engaged R3's wheelchair brakes and tried to readjust R3's position again, in which the chair did not roll back as much, but still rolled back while R3 was adjusting. R3's call light was hanging on the wall and was not in reach of R3. R3 did not have a reacher (device to grab items out of reach) within reach. R3 stated regarding the fall on 5/09/2026 that R3 had tried to get out of bed and R3's legs gave out. R3 stated that R3 had broken R3's left lower leg a couple of years ago and that the screws in R3's leg came out. R3 does have pain and has since that night and is on pain medication, but it only helps a little. On 5/12/2026 at approximately 3:15PM V2 (Director of Nursing) stated maintenance had looked at R3's wheelchair today and stated the anti-rollbacks were working correctly, however, confirmed they may be placed on the wheelchair too high up to be effective for R3's use. On 5/13/2026 at 10:00AM, 11:00 AM, and 11:38 AM, R3's wheelchair was in the hallway outside of R3's door and R3 was in R3's bed. On 5/13/2026 at 11:37AM V2 confirmed there is no documentation of R3's fall on 05/08/2026 and stated V2 was working on completing it. On 05/13/2026 at 12:56PM V17 (Licensed Practical Nurse) confirmed R3 fell on [DATE] at 11:45 PM. V17 was called into R3's room by a Certified Nursing Assistant and observed R3 sitting on the floor (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside the bathroom door in R3's room. R3 initially reported pain, but that was no worse than usual. V17 stated when R3 was moving R3's extremities R3 winced and R3 even winced when R3 moved R3's hands. R3 reported to the nurse that R3 was taking R3's self to the bathroom and R3's legs gave out. R3 did not want to go to the hospital. V17 said that the documentation was late because V17 thought V17 documented it that night, but it did not save, so V17 completed it on 05/11/2026. V17 confirmed that V17 did not call or text V25 (Medical Director) to notify V25 of R3's fall and assessment but instead faxed V25 because R3 did not appear injured based on V17's assessment. On 5/13/2026 at 1:05PM V2 stated the fax to V25 regarding R3's fall on 5/09/2026 could not be provided because the staff do not fax information to V25 but instead call V25 due to V25's schedule/multiple jobs. On 5/13/2026 at 1:42PM V19 (Certified Nursing Assistant) confirmed R3's wheelchair was out in hallway this morning. V19 stated it (R3's wheelchair) is back in there (R3's room) now. There is no documentation in R3's electronic health record addressing R3's fall on 5/8/2026. On 05/13/2026 at 2:05PM V2 (Director of Nursing) confirmed if a resident falls the documentation should be completed the same day of the fall and 72-hour monitoring should be completed. On 05/18/2026 at 9:32 AM V23 (Certified Nursing Assistant) stated V23 did recall R3's fall from 5/09/2026. V23 stated it was towards the beginning of V23's shift and V23 was on V23's way to answer call lights down the hallway because multiple lights were on. While walking down the hall V23 noticed R3 on the floor by the bathroom and R3's wheelchair was by R3 unlocked. V23 called for the nurse and the nurse came and assessed R3. V23 stated R3 was having pain and saying that R3's left ankle and foot hurt. The nurse asked R3 if R3 wanted to go to the hospital but R3 did not want to go. The nurse and V23 got R3 into R3's chair, but V23 cannot recall how R3 was transferred into R3's wheelchair from the floor. V23 then pushed R3 to R3's bed and R3 stood to transfer into R3's bed. On 5/18/2026 at 10:53 AM V24 (Nurse Practitioner) stated V24 R3's fall on 5/09/2026 probably resulted in R3's fracture to R3's left ankle. R3's Nurses Note dated 5/10/2026 at 1:08 PM documents R3 reported pain in R3's left lower leg. R3's left lower leg was sensitive to touch and when a blanket touched R3's leg R3 would cry out in pain. R3's left ankle was swollen in comparison to R3's right ankle. V25 was notified and ordered to send R3 to the hospital to be evaluated. R3's Nurses Note dated 5/10/25 at 2:46 PM documents a verbal report was received from the emergency room that R3 had a fracture. The hospital had placed a splint on R3 and that they are sending R3 back to the facility with instructions. R3's Radiology report dated 5/12/2026 at 10:16PM documents, Impression: Acute nondisplaced fracture at the medial and posterior malleoli. A Hospital After Visit Summary dated 5/10/2026 documents R3's reason for visit was a fall with ankle injury and R3 had a fracture. The facility's Incidents and Accidents Policy, revised in 2026, documents the nurse will contact and inform the residents' practitioner of the incident/accident, report any injuries or other findings, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtain orders. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. The documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. The facility's Fall Prevention Program Policy, revised in 2026, documents when any resident experiences a fall, the facility will assess the resident, complete a post-fall assessment, complete an incident report, and notify the physician and family. It documents when any resident experiences a fall, the facility will review the resident's care plan and update it as indicated. 2. A Minimum Data Set, dated [DATE] documents R10's Brief Interview for Mental Status scored a 12, which reflects R10 is moderately cognitively impaired. A care plan last revised on 5/08/2026 documented R10 is at high risk for falls related to unawareness of safety needs and pain. Interventions were not limited to but included placing a scoop mattress on R10's bed and applying bolsters to the bed. On 5/18/2026 at 1:00PM R10 recalled R10's fall on 5/02/2026. R10 reported R10 went to pick up something off the floor and fell out of R10's wheelchair. R10 stated, They (the staff) didn't get me up off the floor. They called 911 and I went to the hospital. R10 was wearing non-skid footwear, and the call light was within reach. No bolsters or scoop mattress were present on R10's bed. On 5/18/2026 at 2:27PM V2 (Director of Nursing) confirmed R10's mattress was not a scoop mattress and there were no bolsters on R10's bed. V2 stated when R10 returned from the hospital R10 changed rooms, so the staff may have forgotten to take R10's bed to R10's room. 3. R8's progress notes dated 4/22/2026 at 7:30 PM documented R8 was noted in the common area after an unwitnessed fall from R8's wheelchair with a bleeding cut to R8's forehead. R8 was sent to the emergency room and returned with sutures to R8's forehead on 4/23/2026 at 1:03 AM. On 4/23/2026 at 2:44 PM, V20, former Director of Nursing documented, as R8 approached the side near the south hall entrance, R8 stopped and leaned forward falling forward out of R8's wheelchair. On 5/18/2026 at 11:20 AM, R8 was sitting in a wheelchair in the dining room. No anti-roll back device was noted to R8's wheelchair. R8's Care Plan documents the anti-roll back device was added as a fall prevention intervention on 1/5/26. On 5/18/2026 at 11:30 AM, V2, Director of Nursing, verified the anti-roll back device was not on R8's wheelchair. On 5/19/2026 at 12:40 PM, V2, Director of Nursing, confirmed neurological checks were not completed on R8 since R8 came back from the emergency room with a negative computed tomography (CT) scan. The facility Head Injury policy dated 2026 documents staff are to perform neuro checks as indicated or as specified by the physician. R8's medical record contained no documentation of physician notification or an order for neurological checks. 4. R4's Minimum Data Set, dated [DATE] documents R4 as moderately cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's progress note dated 10/20/25 at 10:43AM documents R4 experienced an unwitnessed fall. There were no injuries documented at that time. No neurological checks were initiated. R4's progress note dated 10/20/25 at 9:46PM documents R4 was found on the floor again. R4's temperature was documented as 101.6. This progress note documents R4's family was notified of both falls. R4's Progress notes dated 10/20/26 at 10:24 PM documents R4's family member came to the facility and found R4 to be warm to touch and speech was not clear. This note documents R4 was sent to the hospital at family member's request. R4's hospital note dated 10/20/25 documents R4 was admitted to the hospital with diagnoses of Urinary Tract Infection with Sepsis. On 5/18/26 at 11:00AM V1, Administrator and V2, Director of Nursing verified R4 should have had neuro checks following 10:43 AM fall and their expectation would be increased monitoring after a fall. V1 verified the responsible party should have been called after the first fall.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that is palatable, attractive, and at an appetizing temperature for two (R1, R14) of 3 residents reviewed for Dietary Services. This failure has the potential to affect all 150 residents currently residing in the facility.Findings include:On 5/12/26 at 12:05PM dietary staff were plating food from the steam table in kitchen. Plate service was observed from 12:05PM to 12:20PM. During this time dietary staff was not observed checking food holding temperatures.Facility Week at a Glance Menu dated Week 3 lists lunch meal for 5/12/26 as Ranch Baked Chicken with potato wedges, buttered carrots, dinner roll, and mixed fruit dump cake.On 5/12/26 at 12:42PM R14 was in bed with a lunch tray untouched on bedside table. R14 stated R14 did not like the taste of the food and it was cold when it was placed on R14's bedside table. R14 stated R14 generally likes the flavor of the food but it's always cold so R14 can't eat it, the eggs taste like they came straight out of the fridge.On 5/13/26 at 11:33AM, test tray was plated on a regular plate with cover. The plate was placed on a serving tray. No warming element was observed to be used. Food temperatures were taken after the last hall tray was served to R14 at 12:05PM. The hamburger meat temped at 115 degrees Fahrenheit (F). Pasta noodles temped at 97.5 degrees F., Peas at 96 degrees F, and pineapple at 50 degrees F. Hamburger was not palatable, pasta noodles were cold and slimy, peas did not have butter taste as listed on menu and pineapple chunks were hard and not chewable. Aroma of the meal was not appetizing.Facility Week at a Glance Menu dated Week 3 lists the breakfast meal for 5/13/26 as choice of cereal, bacon, and cinnamon toast, and lunch meal for 5/13/26 as Hamburger Stroganoff, Buttered Peas, Pineapple, and Beverage.Kitchen Food Temp Log documented several meals that were not temped at cook time, hold time, and service time. Food is served from a steam table. 5/12/26 Lunch service temperatures (temps) were documented as follows: Meat 180 degrees F, Starch 185 degrees F, and Vegetable 180 degrees F. This Log does not document a temperature for cold food items. 5/13/26 breakfast meal has no food temperatures documented. 5/13/26 Lunch service temps were documented as follows: Meat 185 degrees F, Starch 180 degrees F, and Vegetable 175 degrees F. The log does not document temperature for cold food items.On 5/13/26 at 2:15PM V12, Assistant Dietary Manager stated that V12 has only had one complaint made to V12 about the food and that complainant was R1. The complaint was that the kitchen staff doesn't know how to cook. V12 stated that R1 often orders R1's own meals in. V12 stated all meals are served from the steam table and confirmed the kitchen food temp log had several missing cooked temperatures and holding temperatures.On 5/13/26 at 3:33PM, V2, Director of Nursing, confirmed the hall trays do not have any element to keep food warm, and trays are passed on an open shelf cart.Facility Policy entitled Food Preparation and Service dated 11/2022 documents food temperatures need to be taken to ensure cooked food is not in the danger zone of above 41 degrees F and below 135 degrees F where the potential for food borne illness growth occurs rapidly which includes potentially hazardous foods as meats, poultry, eggs, yogurt, cottage cheese and milk. Policy also documents proper hot and cold temperatures are maintained during food distribution and service, and all foods held in danger zone are discarded after 4 hours. All foods held in steam tables are to be monitored throughout meal service by dietary staff.The facility's Midnight Census Report dated 5/12/26 documents 150 residents reside in the facility.