STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165186	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Indianola	708 South Jefferson Indianola, IA 50125

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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** 34817 Based on record review, staff interviews and policy review the facility failed to provide adequate nursing supervision for one of three residents reviewed who had high fall risk. The facility also failed to perform and document findings of root cause analysis after a resident had a fall to help determine the reasons for a resident's fall, and in order to prevent further falls for one of three residents reviewed for falls (Resident #7). The facility also failed to ensure fall interventions were added to the resident's Care Plan for one of three residents reviewed for falls. The facility reported a census of 78 residents. Findings include: The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had diagnoses of anemia, atrial fibrillation, cardiac pacemaker, muscle weakness and repeated falls. The MDS assessment revealed the resident had a Brief Interview for Mental Status score of 3, which indicated severely impaired cognition. The MDS recorded the resident required partial to moderate assistance for transfers and supervision for bed mobility. The MDS indicated the resident had a fall without injury since admission. The Care Plan initiated 12/6/24 revealed the resident had a risk for falls related to history of falls prior to admission. The Care Plan directed staff to educate the resident and family about causes of falls, safety reminders, and what to do if a fall occurs, consult physical therapy for strength and mobility, and review medications that could predispose him to falls. The Care Plan lacked fall interventions put in place after the resident had falls. The Fall Tools assessment dated [DATE] revealed the resident had a high risk for falls. The Progress Notes revealed the following: a. On 11/22/24 at 5:35 PM, resident admitted [DATE] post fall. Resident had more than four falls in the past year, and a history of anxiety. He is pleasantly confused but alert and oriented x 2 (person and place). Resident reoriented to room and call light system. He verbally stated he will use the call light with transfers. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 11/22/24 at 11:00 PM, nurse found the resident on the floor. He was kneeling to the left of his recliner facing the back wall. He had a skin tear to his scalp. He wasn't using his walker. This nurse had shown him how to use his call light an hour earlier but he didn't remember. He stated, Well I needed the bathroom. He also stated he hit his head. Neuro checks and range of motion (ROM) within normal limits (WNL'S). Immediate intervention will be to check on resident every two hours. c. On 12/4/24 at 1:00 PM, resident fell in his room. Staff heard loud sound and found resident on floor positioned on his left side, slightly on his abdomen. Feet facing recliner with top of head facing wall and back facing the dresser. Resident states he fell and hit his head on the wall while trying to walk himself. He complained of neck pain and upper back pain. The resident had no obvious sign of injury. Resident is on a blood thinner. Family requested resident to be evaluated at the hospital. Family notified the resident's shoes needed replaced. Rubber on bottom of right shoe was coming off. EMS transported resident to the hospital. d. On 12/4/24 at 11:04 PM, resident admitted to hospital for a head injury and on Coumadin. e. On 12/12/24 at 3:11 PM, resident admitted to the facility. Resident is a fall risk. Moved to a room closer to the nurse's station. f. On 12/13/24 at 9:15 PM, resident was transferring himself from the chair to the bed. The resident fell on the ground as the nurse ran to the room to assist. He did not hit his head. No new areas of injury noted. g. On 12/14/24 at 2:06 PM, resident slid out of bed to the floor with blankets wrapped around him. Bed lowered to the floor. Resident had no injuries. h. On 12/14/24 at 7:39 PM, resident was sliding off of the recliner when the nurse went to check on him. Resident assisted to the floor. Assisted resident into a wheelchair and sat him at the nurse's desk. Resident did not fall or try to get up while directly with staff. i. On 12/16/24 at 1:49 PM, housekeeping alerted the nurse the resident was lying on the floor. Resident lying on the floor in front of the bed. Resident stated he was trying to go to the bathroom. Resident reported hitting head on the mattress/bed. Neuro checks initiated. Family does not want resident sent out unless it's an emergency or resident is not stable. Resident is stable at this time. Will continue to monitor. j. On 12/16/24 at 9:50 PM, Certified Nursing Assistant (CNA) called nurse because the resident had fallen and hit his head. Blood observed on the floor coming from the resident's arms and head. Family wanted resident sent to the hospital. k. On 12/17/24 at 3:35 AM, resident admitted to the hospital with a brain bleed. Incident Reports revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 11/22/24 at 8:15 PM, resident found on the floor kneeling to the left of his recliner facing the back wall. He had a skin tear to his scalp. He wasn't using his walker. Nurse had shown him how to use his call light an hour earlier but he didn't remember. He stated, Well I needed the bathroom. He also stated he hit his head. Immediate intervention included to check on the resident every two hours. b. 12/13/24 at 9:15 PM, heard a noise coming from the resident's room. Found resident transferring himself from the chair to the bed. Resident fell before the nurse could get to him. He did not hit his head. No additional injuries noted. Immediate action taken: Resident wearing traction socks. [NAME] across the room from him. Requested CNA to find a floor mat but unable to find a mat. Hourly rounding. Resident close to the nurse's station. Call light remains at bedside next to the resident. c. 12/16/24 at 1:54 PM, resident found lying on floor in front of recliner chair and the bed. He was trying to go to the bathroom. Immediate action taken included a body pillow placed in bed on the right side for barrier. A typed email dated 12/23/24 at 4:37 PM from Staff B, CNA, to the Administrator revealed the resident fell from sitting. He tried to get up, stood real fast, then fell sideways. He said he felt really dizzy and couldn't see good. The resident refused to use the call light. He said he didn't need it. Staff B placed the call light in reach. That night the resident wasn't getting up or down until that very moment. He was asleep or watching tv. His blood pressure was low. The nurse called family and 911. The ambulance took him to the hospital for trauma to the head. A Facility Investigation File revealed Resident #7 admitted to the facility and had a history of falls. The resident had a fall on 11/22/24 and 12/4/24. The fall on 12/4/24 was unwitnessed and he had no signs or symptoms of injury. He was sent back to the hospital related to Coumadin order. CT scan was negative and no fracture found. He returned to the facility on [DATE]. He had another fall on 12/13/24 and two falls on 12/14/24, and two falls on 12/16/24. Family refused transfer to the hospital for the falls reported to him on 12/13, 12/14 and 12/16 until the last fall. Staff report resident was very impulsive and would try to get out of bed. Resident could not be educated. BIMS was 0. Staff reported they would try to keep him at the nurse's station when possible. Resident #7 had a fall with injury on 12/16/24 at around 9:50 PM. On 12/17/24, the Administrator instructed the Director of Nursing (DON) to educate Staff A, Registered Nurse (RN), regarding creating a risk as staff had only entered a progress note regarding the fall with brain bleed. The Administrator approached the DON on 12/18/24 letting her know the nurse still did not enter the risk and if she wanted the Administrator to contact Staff A she would. The DON stated she would contact the nurse. The risk was still not created and the staff member had quit. Staff A's last day was 12/18/24. The DON never entered the risk as instructed by the administrator and then the DON quit on 12/19/24. On 12/16/24, CNA called Staff A because the resident had fallen and hit his head. Upon entering the room, Staff A saw the resident had blood on the floor coming from his arms and head. The resident fell twice before on 12/16 with no injuries. The son refused transport to the hospital after the other falls. Nurse called to get status of resident and was informed he was admitted with a brain bleed. Notes from the hospital revealed he was admitted with a subdural hematoma. During the investigation it was noted the resident care plan and root cause analysis were not completed timely. Education provided to staff nurses to complete an incident report for all falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/29/25 at 12:30 PM, the Director of Clinical Services (DCS) reported a PIP (Performance Improvement Plan) put in place for falls. She identified a concern because of the number of resident falls. The DCS reported some nurses entered a progress note but did not fill out an incident report. The DCS reported she was looking for incident reports but there may not be an incident report for each fall incident. In an interview 1/29/25 at 1:35 PM, Staff C, RN, reported the facility could use more staff. Staff C reported there had been too many resident falls. She thought when they didn't have enough staff to watch the residents, she had seen more residents with falls and residents sent to the hospital. In an interview 1/29/25 at 3:30 PM, the DCS reported no other incident reports found for Resident #7 besides the ones provided earlier on 1/29/25 (incident reports dated 11/22/24, 12/13/24, 12/16/24 at 1:54 PM). In an interview 1/29/25 at 4:00 PM, the DCS reported Staff D, RN, was frazzled and documented a note about Resident #7's fall twice on 12/16/24. The resident had a fall on 12/16/24 in the evening and went to the hospital. Staff A was called to come in and fill out a risk report the following day but Staff A said she quit. There was no incident report filled out for the fall on 12/16/24 at 9:50 PM. In an interview 1/30/25 at 9:00 AM, Staff F, CNA, reported Resident #7 had a risk for falls. He was close to the nurse's station and she did rounds every two hours. She would constantly check on him throughout her shift and made sure he had his call light. He would try to get up on his own especially if he was in the recliner. Staff F stated she would put him in a wheelchair by the nurse's station when she noticed he was getting anxious. The resident went to the hospital and had a head bleed. In an interview 1/30/25 at 9:10 AM, Staff E, RN, reported an incident report filled out whenever a resident had a fall. She filled out a neuro check assessment in the computer. Neuro checks completed every 30 minutes for two hours, then every eight hours for the next three days if the resident hit their head or had unwitnessed fall. A Change in Condition form also filled out on the computer. Interventions for falls are written down, and the care plans are updated by the nurses. In an interview 1/30/25 at 9:45 AM, Staff D, RN, reported a head to toe assessment done and an incident report filled out whenever a resident had a fall. An intervention entered on the incident report. Neuro checks completed every 1/2 hour after the initial fall, and then every 8 hours for the next 3 days. Neuro checks are signed off on paper with his initials, and he entered the vital signs in the computer. Staff D reported Resident #7 was confused but oriented to person and place. He had a lot of anxiety. He had falls. He was moved to a room closer to the nurse's station and he was working with therapy. Staff D stated he heard the resident get up and fall (on 12/16/24 afternoon). The CNA had just came out of his room [ROOM NUMBER]/2 hour before that. They changed out his gripper socks and put a body pillow in his bed for a boundary. Resident #7 would try to self transfer, and they frequently checked on him. Staff D reported Resident #7 was on the floor by the bed on 12/16/24. This was the first fall on 12/16/24. He was trying to go to the bathroom. The bruise on the side of his head was old. The family member touched the spot on his head and asked if it hurt and he said no that doesn't hurt. Family did not want him sent to the hospital at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 1/30/25 at 12:55 PM, the Director of Clinical Services (DCS) stated she was not at the facility when Resident #7 had a fall. He had a fall earlier in the day, and then fell after 9:00 PM and was sent to the hospital. Earlier in the day, the family did not want the resident sent to the hospital. After the second fall he was sent to the hospital. Resident #7 was admitted to the hospital for a brain bleed. There was no Risk Report filled out. The DCS stated she asked Staff A to come in and fill out the report. Staff A wouldn't come in. Then the Administrator told her Staff A was done. The DCS reported she knew they had issues with the number of resident falls. There was a period of time when they didn't have enough staff. She used a Fall tracker to check if a Risk Report was filled out and if fall interventions were put in place, She went through a root cause analysis for falls and tried to identify the times of day when falls had occurred. Resident #7 returned to the facility on hospice. He was close to the nurse's station so staff could keep an eye on him and watch him closely. The DCS reported she expected a Risk Report filled out on the computer for all resident falls. She had been training staff on filling out the Risk Report and attaching the progress note to the risk report. The Clinical Care Leader and the MDS nurse updated the Care Plans. The DCS reported resident falls reviewed in the AM meeting and the interdisciplinary team looked at the intervention implemented. She expected the MDS Coordinator check the intervention and add the intervention to the care plan. A Fall Prevention and Management policy reviewed 7/29/24 revealed a resident's fall risk factors reviewed upon admission and a Falls Tool UDA assessment completed for screening and identifying the resident's fall risk factors. The resident's care plan reviewed and updated with appropriate interventions. If the fall was not witnessed, neurological checks are required and must be documented in the medical record. Fall incidents documented in an incident report, and additional documentation recorded in a progress note if needed. A Nurse Risk and Care Planning Education on 12/16/24 revealed when an incident occurs, specifically after a fall, the charge nurse completed an incident by the end of the shift. An unwitnessed fall will include neuro checks for 72 hours, and the charge nurse working at the time of the fall will complete a head to toe along with the incident report.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49990 Based on resident interview, staff interview, and facility document review, the facility failed to provide sufficient staff to provide needed care. The facility reported a census of 78. Findings include: The Quarterly Minimum Data Set (MDS) for Resident #13, dated 12/14/2024, which documented her Brief Interview for Mental Status (BIMS) score as 15, which indicated intact cognition. An interview on 01/28/2025 at 08:15 PM with Resident #13 reporte she doesn't feel the facility had enough staff to provide care for all residents in a timely manner. She noted that she is ambulatory, and can transfer herself, but that her roommate can't and she has had to resort to leaving her room to track down staff members to assist her roommate. She further stated there are occasions in which staff answer the call light but don't provide assistance before leaving, requiring her to press her call button again and wait for someone to respond. The Annual MDS for Resident #10, dated 01/08/2025, which documented her BIMS score as 15, indicating intact cognition. An interview on 01/28/2025 at 07:36 PM with Resident #10 in which she stated cares take an extremely long time, with night time being the worst. She stated she does not feel the facility has enough staff members to care for everyone and stated she has had staff members tell her how overworked they are. She stated her call lights at night take in excess of 30 minutes at least once a week, with some weeks being worse than others. Resident #10 stated she remembered the survey team from the prior recertification visit, and stated that while staffing concerns got better for a while after the last survey, it had been getting worse since approximately November 2024. The Quarterly MDS for Resident #5, dated 12/18/2024, documented her BIMS as 15, indicating intact cognition. It documented Resident #5 is frequently incontinence, and that she requires partial or moderate assistance with toileting and personal hygiene. A direct observation on 01/27/2025 at 01:03 PM, revealed medicine cups containing what appeared to be barrier cream left on Resident #5's nightstand. The Care Plan for Resident #5, last revised on 01/05/2025, documented Resident #5 is at risk for skin breakdown due to incontinence and ordered staff to provide incontinence care as needed. An interview on 01/27/2025 at 01:03 PM with Resident #5 in which she stated the cream in the medicine cups was barrier cream and was dosed earlier in the day. She further stated despite multiple requests from staff to help her apply the cream she was told they did not have time to assist her, and the barrier cream was never applied. She stated she felt staffing had been better after the results of the last annual survey, but noted the facility was having trouble maintaining staff. She stated she is often not provided with incontinence care when requested, and noted she is unable to perform toileting hygiene on her own. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 01/27/2025 at 01:38 PM with Staff G, Registered Nurse (RN), in which she stated she does not believe the facility has the staff to adequately care for all of the residents in the facility. She stated falls and urinary tract infections (UTIs) had increased significantly as a result of not having the staff to adequately care for those in the facility, and told surveyors to ask about the performance improvement plans regarding both falls and UTIs. An interview on 01/29/2025 at 02:37 PM with Staff H, RN, in which she stated the facility did not have enough staff to care for everyone. She stated during a period of time from late November until mid December staff were being written up for failing to take meals, but there were not enough staff in the building for staff members to take breaks and still assist residents. She noted staff were burning out quickly, leading to a high turnover rate. An interview on 01/30/2025 at 08:27 AM with Staff I, Certified Nurses Aide (CNA), in which he stated he does not feel the facility has enough staff to care for everyone in the facility. He stated he had not felt that he was able to take a break while at work, and noted he had spoken to the Director of Nursing previously about this issue. He noted that he did not feel there was adequate training due to low staffing either, staff were just expected to figure it out. In an interview on 01/30/2025 at 09:27 AM with Staff C, RN, she stated staffing could be better. She had seen staff members struggle to take breaks because there were not enough staff members to relieve them. She noted she is often expected to cover two or more wings of the building for nursing services at a time. In an interview on 01/30/2025 at 10:01 AM with Staff J, CNA, she stated the facility does not have enough staff. She noted she struggles to take breaks because of lack of staffing and she has been written up within the last month for a failure to take breaks, which she didn't feel was fair. After being spoken to a second time about her breaks she started marking that she had taken her break, but then not actually taking a break because she felt it was unsafe to leave a unit unstaffed. She stated she felt she didn't have a choice because she had already been spoken to twice about not taking breaks. In an interview on 01/30/2025 at 10:20 AM with Staff K, CNA, she stated she believes the facility needs more CNAs and Nurses. She stated it felt like they just threw her into her role and hoped for the best because they needed staff so desperately, she does not feel that she was properly prepared for her role. She stated it was a 50/50 chance if she would get a break or not. In an interview on 01/30/2025 at 09:48 AM with the Advanced Registered Nurse Practitioner (ARNP), she stated she doesn't believe the facility has enough nurses to meet residents needs. She believed this had contributed to the increase in falls that residents had experienced, and noted the facility was now on a performance improvement plan (PIP) to decrease falls. She stated she does not believe the layout of the building allows two nurses to cover the four halls. In an interview on 01/28/2025 at 04:15 PM with the Staffing Coordinator, she stated minimum staffing in the facility requires two CNAs on each of the main hallways and 1 CNA on the smaller skilled care hallway. In addition, it required two nurses and two Certified Medication Aides (CMAs), with an additional aide from 2 pm-6 pm. She stated ideally, they would have three nurses on day shift. She noted the overnight she required fewer staff, with four total CNAs, one Medication Aide, and one Nurse required during the overnight shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility staffing sheets from 12/01/2024 to 12/26/2024 showed the facility worked short staffed on 13/26 days reviewed, and on at least one occasion during the review period had the Director of Nursing Services (DNS) working the floor to cover open nursing shifts. Review of facility staffing files revealed write-ups for failures to take breaks as assigned for 2 of the 6 staffing files reviewed.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49990 Based on staff interview, staffing file review, and facility document review the facility failed to have adequate nursing staff and had the Director of Nursing (DON) working the floor in a facility with a census greater than 60. The facility reported a census of 78. Findings include: Review of staffing files dated 12/01/2024 to 12/26/2024 revealed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) scheduled to work the nursing floor on 10 occasions during the reviewed period. In an interview on 01/29/2025 at 02:37 PM with the former Director of Nursing (DON), she noted she was working the floor three times a week or more from a period of time lasting from November 2024 until December 2024 when she quit. She cited working full time as a PM nurse as the reason she ultimately left the facility. She noted she experienced burnout due to the high demands placed on her, and began to worry about her license. She originally gave notice but left early after the facility continued to ask she work as a full time PM nurse in addition to her DON duties. She was unaware that the facility had agency staffing available during the month of December. She stated she was unsure it was even allowable under code to have the DON work the floor as a charge nurse for a facility of this size. She noted staff members were being written up for not taking breaks, but she felt it was unfair to staff to write them up when it was the facilities fault for not having enough staff. In an interview on 01/29/2025 at 12:30 PM with the Regional Director of Clinical Services and the current assistant Director of Nursing, they stated administrative issues in December lead to a failure in staffing that frequently required the DON and ADON to work the floor. They noted they did have a staffing contract with Grapetree, which the facility failed to utilize to ensure staffing levels. They acknowledged the DON should not have been working the floor in a facility with a census above 60. Review of a facility provided job description for the Director of Nursing, with a last revised date of 09/11/2024, states the DON should perform care to residents on an as needed basis, but did not clarify how much floor work could be expected of the DON. Review of Federal regulation 483.35(b)(3) states the director of nursing may only serve as a charge nurse when the facility had an average daily occupancy of 60 or fewer residents.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49990 Based on observations, food temperatures during food services, resident interview, and facility policy review, the facility failed to serve food within appropriate temperature ranges during 1 of 1 meal observed. The facility reported a census of 78. Findings include: In an interview on 01/28/2025 at 08:15 PM with Resident #13, she stated that while she typically enjoys the food it is often served to her cold and she has to microwave it to make it warm. She stated that while she is ambulatory and can heat food herself, she worries that it is not as easy for other residents in the facility. She typically requests a room tray. Her brief interview for mental status (BIMS) is noted as 15, indicating intact cognition. In an interview on 01/28/2025 at 07:36 PM with Resident #10, she stated the food is often cold and not to her liking. As a result, she has requested her husband take her home for dinner during most evenings. Her BIMS score is noted as 15, indicating intact cognition. In an interview on 01/27/2025 at 12:40 PM with Resident #16 she stated the food is often bland and not always hot. She noted she usually eats in the dining hall. In an interview on 01/28/2025 at 02:00 PM with Resident #12 he stated that his pork patty during meal service for the day was not hot. He noted at the time he had gotten a room tray. In an interview on 01/28/2025 at 11:13 AM with Staff F, Dietary Cook, she stated they have had trouble with their steam table that has been reported within the last month to the maintenance department as well as her supervisor, the Certified Dietary Aide who runs the kitchen. She stated the steam table has been having trouble maintaining food temperatures. A direct observation on 01/28/2025 at 10:28 AM of the initial kitchen prep documented temperatures at the time of transfer to the steam table as 173 degrees Fahrenheit for the main dish, a BBQ pork patty. It also documented temperature for the mixed vegetables as 199 degrees, and the temperature for the Potato salad as 38 degrees. During the continuous kitchen observation, the steam table could be seen only weakly emitting steam during food service, with all steaming of the main dish station ceasing to steam at 11:22 AM. The plate warmer was cold, and not emitting any heat while the kitchen prepared room trays to residents. At the end of at 12:27 PM on 01/28/2025 the main dish temperature on the steam table was 149.8 degrees Fahrenheit, with the mixed vegetables not having enough remaining to take an accurate end temperature with. The potato salad continued to read 38 degrees. A sample tray was prepared and sent to surveyors, with temperatures at the time of service to the surveyor being only 113.8 degrees. The mixed vegetables read 136.7 degrees, and the potato salad read 38 degrees. The BBQ pork patty felt lukewarm to the touch, and the plate was cool to the touch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165186	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Indianola	708 South Jefferson Indianola, IA 50125

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/29/2025 at 09:15 AM with the Certified Dietary Manager (CDM), she stated she was unaware the plate warmer was not properly warming plates. She confirmed she had been previously advised the steam table was having trouble holding temperatures, losing significant heat over the course of service. She showed documentation that confirmed the steam table had been reported for failure to maintain temperatures on December 13th, 2024, and had been looked at by maintenance. She noted the steam table should maintain foods at 160 degrees Fahrenheit at least, and confirmed that foods such as meat and warm dairy should be served to residents at no less than 135 degrees Fahrenheit. In an interview on 01/30/2025 at 12:21 PM with the Regional Dietary Director, she acknowledged that food temps were low and confirmed the plate warmer was not operational. Review of a facility provided document titled Food Temperature Monitoring, last revised 12/16/2024, documents that a proper serving temperature is one that minimizes the risk of scalding but remains appetizing to residents. It did not specify a target temperature for service to residents.