

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER St Luke Lutheran Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Saint Luke Drive Spencer, IA 51301	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on clinical record review, staff interviews, and facility record review, the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals (DIA) within 24 hours for 1 of 1 residents reviewed for abuse (Resident #5). The facility reported a census of 75 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented diagnoses of diabetes mellitus, heart failure and arthritis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.</p> <p>Review of Progress Notes dated 3/29/24 at 10:46 p.m., revealed the following note: During the aide report nurse overhears aides talking about a physical altercation involving resident and aide. Aides state that at 2:00 p.m., the report for day shift stated the resident was swinging at the aide and giving her a hard time. Aide also states that it was reported by the resident that the aide hit her. Called the nursing supervisor on call phone and spoke with them regarding the situation. The aide is to work in the morning. On call supervisor states to speak to the aide tomorrow and anyone else who was present and let her know. When the resident was asked about what happened during the day she stated I don't remember we just didn't get along. When asked directly if there was an hitting resident stated no there was no hitting.</p> <p>Review of document titled Interview with Resident #5 dated 4/2/24 revealed feel no hitting of resident took place based on interview with Staff G, Certified Nursing Assistant and Resident #5 also the charting in the Nurses Notes on 3/29/24 support this.</p> <p>Review of facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 revealed the following:</p> <p>a. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting allegations of abuse to the administrator or designated designee.</p> <p>b. All allegations of resident abuse shall be reported to the State Agency no later than 2 hours after the allegation is made.</p> <p>(continued on next page)</p>

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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. All allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the State Agency, no later than 2 hours, if the events that cause the allegation result in serious bodily injury, or not later than 24 hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.</p> <p>Interview on 4/25/24 at 11:54 a.m., with the Administrator revealed he does not feel it should have been reported as the resident saying she was not hit when she was directly asked if anyone hit her.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on record review, resident and staff interviews, and facility policy review the facility failed to investigate allegations of abuse and separate resident from staff alleged of abuse during the investigation for 1 of 1 resident reviewed (Resident #5). The facility reported a census of 75 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented diagnoses of diabetes mellitus, heart failure and arthritis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.</p> <p>Review of Progress Notes revealed the following note:</p> <p>a. On 3/29/24 at 5:28 p.m., Resident was upset with Certified Nursing Assistant (CNA) as she was talking with her hands. Resident was yelling at staff member and made her upset. Nurse suggested that they use 2 aides while helping resident.</p> <p>b. On 3/29/24 at 10:46 p.m., During the aide report nurse overhears aides talking about a physical altercation involving resident and aide. Aides state that at 2:00 p.m., the report day shift stated that the resident was swinging at the aide and giving her a hard time. Aide also states that it was reported by the resident that the aide hit her. Called the nursing supervisor on-call phone and spoke with them regarding the situation. The aide is to work in the morning. On-call supervisor states to speak to the aide tomorrow and anyone else who was present and let her know. When the resident was asked about what happened during the day she stated I don't remember we just didn't get along. When asked directly if there was an hitting resident stated no there was no hitting.</p> <p>Interview on 4/24/24 at 2:25 p.m., with Staff G, CNA revealed she was assisting Resident #5 to the bathroom and when assisting her back into her wheelchair resident swung at Staff G. When Staff G asked why she swung at her she accused Staff G of hitting her when she was assisting her into the wheelchair. Staff G revealed she went and reported to Staff H, Registered Nurse (RN) that Resident #5 accused her of hitting her and Staff H told her not to go in there and if Staff G had to to make sure there were 2 staff present. Staff G further revealed she was never suspended or had disciplinary action in regards to this incident.</p> <p>Interview on 4/24/24 at 1:25 p.m., with Staff H, RN revealed no one had reported anything to her on her shift about Resident #5 accusing Staff G of hitting her. Staff H said Staff G talked a lot and used her hands when she talked and Resident #5 was upset with Staff G. Staff H told Staff G to make sure she had 2 people in the room with her as Resident #5 was upset with Staff G. She heard the next day during shift report from Staff I, Licensed Practical Nurse (LPN) that Resident #5 accused Staff G of hitting her.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/24/24 at 1:43 p.m., with Staff I, LPN revealed when she came onto her shift she had been told by Staff H, RN that Resident #5 didn't get along with Staff G. Staff I stated she didn't think much of it and went about her duties on her shift and at shift report at 10:00 p.m., overheard the CNA's reporting to the oncoming that Resident #5 had accused Staff G of hitting her. Staff I doubled checked with the CNA giving report and she revealed she had been told by the dayshift Resident #5 accused Staff G of hitting her. Staff I immediately called on-call nursing supervisor Staff J, Registered Nurse. Staff J asked Staff I if she had talked to the resident or the aides. Staff I was directed to talk to the aide when she came in for her morning shift. In the morning the aide told Staff I that she talked with her hands and Resident #5 thought she was swinging at her. Staff I told Staff G to stay away from Resident #5. Staff I reported information off to the dayshift nursing staff to tell Staff J when she came in. Staff I assumed Staff J was coming in to do an investigation into the situation.</p> <p>Interview on 4/24/24 at 3:26 p.m., with Staff J, RN revealed she was called by Staff I and stated that she had overheard the aides giving report and was told Resident #5 accused Staff G of hitting her. Staff J asked Staff I if she had talked to the aides or Resident #5. Staff J advised Staff I to talk to the aide in the morning when she came in. Staff J further revealed if something happened to Resident #5 she would have let everyone know and she had not heard anything about it so she wasn't too worried it happened. Staff J revealed she did not hear back from Staff I or anyone else from the building so she just left it at that. Staff J revealed Staff A, Assistant Director of Nursing had done an investigation on it either Monday or Tuesday after the report of the incident.</p> <p>Interview on 4/24/24 at 3:51 p.m., with the Administrator revealed he thought he knew about the incident but it didn't happen so they didn't do anything further but would check with nursing to see if there was an investigation.</p> <p>Review of document titled Interview with Resident #5 dated 4/2/24 revealed Staff A, ADON interviewed Resident #5. The document revealed feel no hitting of resident took place based on interview with Staff G, Certified Nursing Assistant and Resident #5 also the charting in the Nurses Notes on 3/29/24 support this.</p> <p>Review of document titled Interview of Staff G, CNA dated 4/2/24 revealed Staff A, ADON interviewed Staff G. Staff G talks with her hand and that upset Resident #5. Staff G states that Resident #5 swung at her and also that Resident #5 said she swung at Staff G because Resident #5 thought Staff G was swinging at her. Staff G stated there was no contact between Resident #5 and her other then when Staff G removed the EZ stand sling.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of untitled document and undated signed by Staff J, RN revealed she had received a call on the on-call nursing cell phone on 3/29/24 at 10:27 p.m., from Staff I, LPN stating she had overheard in CNA report that Staff G had hit Resident #5. She also stated she had overheard Resident #5 had swung at Staff G during cares. Staff J asked if Staff I had talked to the aides or nurses and she states she would talk to them the next morning as the ones that worked on 3/29/24 would be here the next day. Staff J also told Staff I that if Resident #5 would have gotten hit by a CNA she would have made sure the nurses knew it had happened. She is very vocal and in the past if anything happened she told staff right away. Staff I was going to talk with the staff in the morning and let the on-call nurse know. Staff J did not get any updates regarding this after that phone call. It is noted in Resident #5's chart during the day Staff G had taken Resident #5 to the toilet and Staff G talks with her hands and this upset Resident #5 in turn she was yelling at Staff G. Day shift nurse encouraged CNA's to use 2 staff. Staff I spoke with Resident #5 and she has stated that there was no hitting involved.</p> <p>Review of facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 revealed the following:</p> <p>Should an incident or suspected incident of resident abuse be reported or observed, the administrator or his designee will designate a member of management to investigate the alleged incident.</p> <p>The Administrator or designee will complete documentation of the allegation of resident abuse and collect any supporting documents relative to the alleged incident.</p> <ol style="list-style-type: none"> a. Review documentation in the resident record. b. Assess the resident for injury if the allegation involves physical or sexual abuse. c. Provide proper notification to primary care provider, responsible party, ect. d. Attempt to obtain witness statements (oral and or written) from all known witnesses. e. If there is physical evidence that can be preserved, attempt to do so, and maintain it in a safe location to minimize risk of evidence being tampered with. <p>Following investigation the Administrator or designated agent will be responsible for forwarding the results of the investigation to the State Agency. This written report shall be forwarded to the State Agency within 5 days of the initial report.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Initial and or immediate protection during facility investigation revealed upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment the facility shall immediately implement measure to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following if practicable: 1. Suspending the employee 2. Segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility and in rare instances 3. Separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with residents.</p> <p>Following completion of the facility investigation, if the facility concludes that the allegation of resident abuse are unfounded, the employee may return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the State Agency concludes its investigation and issues the written results of its investigation.</p> <p>Interview on 4/25/24 at 11:54 a.m., with the Administrator revealed he does not feel the staff should have been separated pending investigation since the resident denied being hit by the staff member.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>44474</p> <p>Based on interviews, record review, and policy review, the facility failed to ensure call lights were answered in under 15 minutes for 4 out of 4 residents reviewed (Resident #2, #5, #6 and #7). The facility reported a census of 75 residents.</p> <p>Findings include:</p> <p>1. Interview on 4/24/24 at 12:42 with Resident #2 revealed she waits a long time when she uses her call light and has waited over 2 hours for her call light to be answered. When Resident #2 told the facility about the long call light wait time, they went back and looked at the call light times and told her she was right about waiting so long. Resident #2 revealed she has had incontinent episodes of bowel movement and it makes her feel terrible. Resident #2 further revealed she has a catheter but there are times she has even been wet because staff does not come in and empty the bag enough so the urine backs up and her clothing gets wet with urine.</p> <p>Review of the facility provided document titled Device Activity Report dated 4/24/24 with report dates from 4/22/24- 4/24/24 revealed the following:</p> <p>a. On 4/22/24 the call light turned on at 7:05 a.m., and was on for 64 minutes.</p> <p>b. On 4/22/24 the call light turned on at 4:27 p.m., and was on for 24 minutes.</p> <p>c. On 4/23/24 the call light turned on at 6:14 p.m., and was on for 44 minutes.</p> <p>2. Interview on 4/24/24 at 11:41 a.m., with Resident #5 revealed she has to wait a long time for her call light to be answered. Resident #5 further revealed she doesn't feel there is enough staff here to take care of all the residents and when she uses her call light sometimes no one ever comes. Resident #5 revealed she worries at times if she will make it to the bathroom when she has to wait so long for the staff to answer her call light.</p> <p>Review of the facility provided document titled Device Activity Report dated 4/24/24 with report dates from 4/22/24- 4/24/24 revealed the following:</p> <p>a. On 4/23/24 the call light turned on at 1:40 p.m., and was on for 15 minutes.</p> <p>3. Review of the facility provided document titled Device Activity Report for Resident #6 dated 4/24/24 with report dates from 4/22/24- 4/24/24 revealed the following:</p> <p>a. On 4/22/24 the call light turned on at 1:56 p.m., and was on for 15 minutes.</p> <p>b. On 4/23/24 the call light turned on at 7:20 p.m., and was on for 39 minutes.</p> <p>c. On 4/23/24 the call light turned on at 8:10 p.m., and was on for 24 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. On 4/23/24 the call light turned on at 9:27 p.m., and was on for 23 minutes.</p> <p>e. On 4/24/24 the call light turned on at 8:45 a.m., and was on for 27 minutes.</p> <p>4. Interview on 4/24/24 at 9:50 a.m., with Resident #7 revealed she has to wait a long time for her call light to be answered. Resident #7 further revealed she feels there is not enough staff here to take care of her.</p> <p>Review of the facility provided document titled Device Activity Report dated 4/24/24 with report dates from 4/22/24- 4/24/24 revealed the following:</p> <p>a. On 4/22/24 the call light turned on at 8:40 a.m., and was on for 16 minutes.</p> <p>b. On 4/22/24 the call light turned on at 9:03 a.m., and was on for 16 minutes.</p> <p>c. On 4/23/24 the call light turned on at 6:22 p.m., and was on for 20 minutes.</p> <p>d. On 4/24/24 the call light turned on at 7:05 a.m., and was on for 35 minutes.</p> <p>Review of Licensed Nurse Orientation Checklist provided by the facility dated 5/17/23 revealed no call light should go beyond 15 minutes.</p> <p>Interview on 4/25/24 at 10:27 a.m., with Staff A, Assistant Director of Nursing (ADON) revealed she expected call light to be answered in less then 15 minutes.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44474</p> <p>Based on observations, staff interviews, and facility policy reviews the facility failed to ensure food was covered before leaving the dining area and served to residents in their rooms. The facility identified a census of 75 residents.</p> <p>Findings include:</p> <p>During an ongoing observation on 4/24/24 at 12:04 p.m., in the dining room revealed the following:</p> <p>a. Staff D, Certified Nursing Assistant (CNA) took Resident #10 ' s meal tray to their room. The meal tray left the dining area with the cake and drinks uncovered and exposed as the tray went to Resident #10 ' s room.</p> <p>b. Staff D took Resident #11 ' s meal tray to their room. The meal tray left the dining area with the cake, a cup of ranch dressing and drinks uncovered and exposed as the tray went to Resident #11 ' s room.</p> <p>c. Staff E, CNA took Resident #12 ' s meal tray to their room. The meal tray left the dining area with the juice and coffee uncovered and exposed as the tray went to Resident #12 ' s room.</p> <p>d. Staff F, CNA took Resident #13 ' s meal tray to their room. The meal tray left the dining area with cake, ice water and coffee uncovered and exposed as the tray went to Resident #13 ' s room.</p> <p>e. Staff D took Resident #14 ' s meal tray to their room. The meal tray left the dining area with the cake, juice and milk uncovered and exposed as the tray went to Resident #14 ' s room.</p> <p>Review of the facility provided policy titled Resident Nutrition Services with a revision date of November 2009 revealed if a resident is receiving a room tray, all food and beverages must be covered before transport.</p> <p>Interview on 4/24/24 at 12:17 with Staff B, Dietary Manager revealed she expected all staff to cover all items leaving the dining room area.</p>		