

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide protective oversight and a safe environment for one resident (Resident #1) who was assessed to be an elopement risk, had a history of a previous elopement from the facility, and resided on a secured behavioral unit. Staff allowed the resident into the exterior courtyard unsupervised, and failed to ensure the door was securely latched when the resident returned inside the facility. The resident went back out this unlatched door and left the premises without staff knowledge. Staff failed to complete hourly face checks on the resident from 7:30 P.M. until approximately 11:30 P.M. per facility policy. The resident was missing for over 12 hours before being located by staff. The facility census was 178.</p> <p>On 4/17/25 at 4:30 P.M., the administrator was notified of the immediate jeopardy (IJ) past non-compliance that occurred on 4/16/25. Corrective measures and an investigation began immediately. Resident #1's guardian, physician and law enforcement were notified of the elopement. The resident was assessed, placed under supervision of two staff members and transported to a acute psychiatric center for evaluation and treatment. Education was provided to staff and policies were reviewed on Protective Oversight, Face Checks, Code [NAME] Procedure, When to Notify, and Abuse and Neglect, to all staff. One on one education was provided to the staff directly involved and those staff members were suspended pending the investigation. All residents were audited for elopement risk and care plans updated. Maintenance staff completed door inspections to identify doors that did not latch and review of any outside areas that could be utilized to climb onto the building with. The door identified to the courtyard was marked as a fire exit only. The IJ was corrected on 4/17/25.</p> <p>Review of the facility policy, Intensive Monitoring/Visual Checks, revised 4/30/24, showed the following:</p> <ul style="list-style-type: none"> -To ensure a system is in place for residents who require increased monitoring for behavioral/psychiatric and medical issues; -Residents who require more intensive monitoring due to crisis, behavioral/psychiatric symptoms will be monitored by facility staff; -Intensive monitoring is defined as a periodic (hourly, every two hours or every shift) check by a facility staff member; <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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Residents may require more intensive monitoring based on their crisis, behavioral, psychiatric issues. The level of intensive monitoring shall be identified by the specific situation or resident assessment;</p> <p>-Residents who have poor impulse control including crisis, behavioral, psychiatric issues, such as, verbal/physical aggression, elopement ideations, suicidal/homicidal ideations and decompensation mentally or crisis may be placed on intensive monitoring or one to one or two to one (within eyesight of staff) monitoring at the discretion of the administrative staff or facility supervisor;</p> <p>-The facility staff will document the intensive monitoring in the residents' electronic medical record.</p> <p>Review of the facility policy, Elopements and Wandering Residents, revised on 6/12/24, showed the following:</p> <p>-The facility ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care, addressing the unique factors contributing to wandering or elopement risk;</p> <p>-The facility is equipped with door locks/alarms to help avoid elopements;</p> <p>-The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary;</p> <p>-Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team;</p> <p>-The interdisciplinary team will evaluate the unique factors contributing to risk to develop a person-centered care plan;</p> <p>-Interventions to increase staff awareness of the resident's risk, modify the residents' behavior, or to minimize risks associated with hazards will be added to the residents' care plan and communicated to appropriate staff;</p> <p>-Adequate supervision will be provided to help prevent accidents or elopements;</p> <p>-Staff will be educated on the reasons for the elopement and possible strategies for avoiding such behavior;</p> <p>-When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred to alternate placement in an appropriate facility.</p> <p>Review of Resident #1's undated, Face Sheet showed the following:</p> <p>-The resident was admitted to the facility on [DATE];</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident had a legal guardian.</p> <p>Review of the resident's Care Plan, revised 3/15/24, showed the following:</p> <p>-The resident was at risk of elopement due to a history of elopement from the facility and/or expresses a desire to elope from the facility;</p> <p>-Complete elopement assessment on admission, readmission, and quarterly;</p> <p>-Face Checks/Intensive Monitoring will be completed per facility policy;</p> <p>-Resident's photo and information will be kept in elopement book;</p> <p>-Maintenance will make improvement to fence to prevent residents from climbing over;</p> <p>-All non-bolted chairs are to be removed from all smoke areas;</p> <p>-Door code changed;</p> <p>-The resident had a guardian to assist in decision making due to mental illness.</p> <p>Review of the resident's Elopement Evaluation, dated 3/5/25, showed the following:</p> <p>-History of elopement or an attempted elopement while at home: Yes;</p> <p>-History of elopement or attempted leaving the facility without informing staff: Yes;</p> <p>-Verbally expressed the desire to go home, packed belongings or stayed near an exit door: Yes;</p> <p>-Does the resident wander: Yes;</p> <p>-Wandering behavior a pattern, goal directed: Yes;</p> <p>-Risk for wandering/elopement identified.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 3/6/25, showed the following:</p> <p>-Cognitively intact;</p> <p>-Makes self-understood and understands others;</p> <p>-No signs or symptoms of delirium;</p> <p>-No behavioral symptoms exhibited;</p> <p>-No psychosis exhibited;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Video footage showed the resident left the facility at 7:45 P.M. after using a post to scale the side of the building;</p> <p>-Notified law enforcement and a missing person's report was sent out for the surrounding area;</p> <p>-Voicemail was left for the resident's guardian, will try to reach the guardian first thing in the morning.</p> <p>-All areas of building checked to ensure no objects are present that can be used to scale building.</p> <p>Review of recorded facility camera footage, dated 4/16/25, showed the following:</p> <p>-At 7:30 P.M., Resident #1 walked outside into the courtyard area, no staff members were observed in the courtyard. The resident walked around briefly in the courtyard and reentered the door to the facility;</p> <p>-At approximately 7:40 P.M., the resident exited the building again and walked around the courtyard area, no staff members were observed in the courtyard;</p> <p>-At 7:48 P.M., the resident climbed up the punching bag base onto the roof of the building.</p> <p>During an interview on 5/5/25 at 10:30 A.M. the Administrator said the following:</p> <p>-The resident was located by Certified Nurse Assistant (CNA) A when he/she was driving home from work. The resident was observed walking on a sidewalk approximately a mile from the facility;</p> <p>-CNA A was directed to wait until additional staff arrived on scene and to not approach the resident;</p> <p>-The Administrator, Social Service Director (SSD), and Assistant Administrator went immediately to the location where the resident was found;</p> <p>-The resident had turned onto a side street and was walking along the side of the street when the Administrator and the other staff arrived;</p> <p>-Staff got out of the vehicle and the resident ran approximately 100 feet and jokingly said, you found me, but got right into the vehicle when directed by staff;</p> <p>-The resident was wearing a sweatshirt and sweatpants, and no injury was noted.</p> <p>Observation on 4/17/25 at approximately 11:00 A.M., of the route the resident would have taken from the facility to where he/she was found, showed the following:</p> <p>-The resident would have walked approximately 1.3 miles from the facility, through a traffic light with a busy intersection, turned left where he/she would have crossed a four-lane intersection, with traffic speed of 35 miles per hour;</p> <p>-The street was well lit with sidewalks along the route and no curves or hills.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the [NAME].ground (a weather website service that lets you access real-time weather information) showed the lowest the temperature recorded from 4/16/25 at 7:45 P.M. until the morning of 4/17/25 at approximately 8:00 A.M. was 55 degrees Fahrenheit.</p> <p>During an interview on 4/23/25 at 9:30 A.M. the resident said he/she sustained no injuries from the elopement and did not want to discuss it any further. He/She was being transferred to another facility and was ready to go.</p> <p>Review of the resident's Progress Note, dated 4/23/25 at 10:17 A.M., showed the resident was discharged to another facility via facility transport.</p> <p>During an interview on 5/1/25 at 11:25 A.M. the resident's guardian said the following:</p> <ul style="list-style-type: none"> -The facility had reported the resident's elopement to him/her; -He/She had a meeting with the resident along with the Administrator a couple months ago; -At that time, the resident said he/she did not feel he/she had any mental health conditions; -The resident said he/she was not sure why he/she was in the facility and wanted to go home; -The resident became very upset during the conversation, cursed and abruptly left the room; -She agreed for the resident to be transferred to another facility after the elopement. The resident had eloped from the facility before. <p>During an interview on 4/21/25 at 1:45 P.M., Nurse Aide (NA) C said the following:</p> <ul style="list-style-type: none"> -He/She had worked at the facility for a few weeks. He/She was aware Resident #1 had eloped in the past; -Earlier in the evening, CNA A was joking around with another resident and Resident #1 took it as a threat towards the other resident and got upset; -Resident #1 got upset, face was red, and he/she was screaming at CNA A about the situation; -The resident was making comments about someone watching him/her, and wanted his/her bible; -Certified Medication Technician (CMT) B took Resident #1 outside to calm him/her down and Resident #1 apologized to CNA A; -It was his/her and CNA A's responsibility to do hourly face checks on each of the residents and document it; -It was a busy night and NA C and CNA A did not complete face checks like they were supposed to that night; -Around 11:30 P.M., he/she realized the resident was gone; <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She looked everywhere for the resident and when he/she could not find Resident #1, Licensed Practical Nurse (LPN) D was notified.</p> <p>During an interview on 4/21/25 at 3:35 P.M., CNA A said the following:</p> <p>-He/She had worked at the facility for a few weeks and wasn't very familiar with the residents;</p> <p>-On the evening of 4/16/25, he/she was joking around with another resident about their hat;</p> <p>-Resident #1 got upset and said, if you are going to fight him/her you will have to fight me. CMT B took Resident #1 outside to calm him/her down;</p> <p>-When Resident #1 came back inside, Resident #1 and CNA A apologized to each other about the situation and the misunderstanding;</p> <p>-CNA A felt bad about the situation, so he/she offered to take the resident outside to smoke;</p> <p>-CNA A opened the door to the outside courtyard area for the resident to go outside while CNA A went to get the resident a cigarette inside the facility;</p> <p>-The resident was already walking back inside before CNA A got back outside, and the resident decided to smoke inside instead;</p> <p>-He/She assumed the door latched, but did not check the door to assure it was latched;</p> <p>-He/She did not do face checks that night, he/she thought NA C was doing them;</p> <p>-He/She was not aware the resident was an elopement risk or had eloped before;</p> <p>-He/She and NA C could not locate the resident later in the night, CNA A and NA C searched for the resident and when they couldn't locate him/her they reported it to the charge nurse.</p> <p>During an interview on 4/17/25 at 12:00 P.M., CMT B said the following:</p> <p>-On 4/16/25 he/she worked the day shift (7:30 A.M. to 7:30 P.M.)</p> <p>-CNA A and another resident were talking and Resident #1 got upset about the situation and started yelling at CNA A;</p> <p>-CMT B took Resident #1 outside to calm him/her down;</p> <p>-He/She did not report the situation to LPN D because the resident had calmed down;</p> <p>-He/She left work around 8:00 P.M. that night.</p> <p>During an interview on 4/21/25 at 2:45 P.M., LPN D said the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-On 4/16/25 he/she was working 7:30 P.M. to 7:30 A.M. as the charge nurse and was responsible for four units, which included the unit where Resident #1 was;</p> <p>-He/She was not aware of any issues with Resident #1 during the evening on 4/16/25;</p> <p>-A little before 11:30 P.M. NA C called him/her and said that they could not locate Resident #1;</p> <p>-He/She called the other charge nurse in the building and told everyone to search for the resident;</p> <p>-About 10 to 15 minutes later, he/she talked to the Administer about the situation, a Code [NAME] was called and staff continued to search for the resident outside;</p> <p>-He/She was educated before he/she left that morning that as a charge nurse it was his/her responsibility to assure face checks were being done and he/she was responsible for the staff working on the units, also he/she should be checking in with staff routinely.</p> <p>During an interview on 4/17/25 at 10:00 A.M., the DON said the following:</p> <p>-The resident was very delusional on the evening of 4/16/25 and had an issue with a peer, but the peer was unaware of any issue between the two of them. Also, CNA A was joking around with another resident and Resident #1 got upset and thought the staff member was being disrespectful to the other resident. Resident #1 started yelling at CNA A;</p> <p>-CMT B took the resident outside to calm him/her down, the resident came back inside, was calm and apologized to CNA A about the situation;</p> <p>-CNA A felt bad about the situation and offered to take the resident out for a cigarette. CNA A opened the door to the outside courtyard and left the resident outside alone while CNA A went back inside of the facility to get the resident a cigarette. Before CNA A made it back outside, the resident was walking back inside the facility;</p> <p>-CNA A didn't check the door to assure it was latched after Resident #1 came back inside;</p> <p>-In the past there had been some issues with the door, staff or residents had propped the door open with a rock. The door could look like it was shut when it was not;</p> <p>-Later, the resident exited the unlatched door and eloped from the facility using the punching bag base to climb up onto the roof and off the backside of the roof;</p> <p>-CNA A was driving home following his/her shift on 4/17/25 at approximately 8:00 to 8:30 A.M. and observed the resident walking on a sidewalk approximately a mile from the facility;</p> <p>-CNA A notified the facility and continued to follow the resident in his/her car until additional staff responded and transported the resident back to the facility, without any issues;</p> <p>-The resident said he/she tried to come back to the facility and got turned around and slept in the woods last night;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident made homicidal and suicidal comments when he/she got back to the facility and was sent out for a psychiatric evaluation. Two staff members accompanied the resident to the psychiatric facility due to the comments the resident made.</p> <p>During interviews on 4/17/25 at 11:35 A.M. and at 2:00 P.M., the Administrator said the following:</p> <p>-It was reported to him that earlier in the evening on 4/16/25 the resident was upset with CNA A who was joking around with another resident. Resident #1 thought the staff member was being serious, and being disrespectful to the other resident;</p> <p>-CNA A and Resident #1 apologized later after the incident. CNA A allowed the resident outside into the outside courtyard area while CNA A went back inside the facility to get the resident a cigarette;</p> <p>-The resident reentered the building and didn't latch the door behind him/her. CNA A didn't check to assure the door was closed after the resident entered the building;</p> <p>-There had been some issues with this door in the past and it not getting shut like it should when the residents came back inside the facility; -The resident exited the unlatched door at approximately 7:48 P.M. and climbed up the punching bag base onto the roof of the facility, jumped down onto the backside of the facility and left the premises per video footage obtained by the facility;</p> <p>-The punching bag and the base were not bolted down and it was positioned close to the building;</p> <p>-The night supervisor called around 11:45 P.M. and said they could not locate the resident and were looking for him/her;</p> <p>-At 11:48 P.M. LPN D called and said the resident was unable to be located and they were still searching rooms;</p> <p>-At 11:57 P.M. a text went out to all department heads, corporate and a Code [NAME] was issued;</p> <p>-The resident was to be on hourly face checks and upon review of the hourly face check documentation, hourly face checks were not completed on 4/16/25 from 7:30 P.M. through 11:30 P.M.</p> <p>-The resident was located by CNA A when he/she was driving home from work. The resident was observed walking on a sidewalk approximately a mile from the facility;</p> <p>-The resident said he/she slept under a tree throughout the night;</p> <p>-The resident was brought back to the facility and upon returning made comments regarding homicidal and suicidal, the resident was sent out for a Psychiatric Evaluation;</p> <p>-Staff should have notified the charge nurse Resident #1 had a change in his/her baseline during the evening of 4/16/25;</p> <p>-The resident should not have been allowed in the outside courtyard unsupervised. Staff should have checked to assure the door was latched when the resident reentered the building from the courtyard;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER North Village Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2041 Silva Lane Moberly, MO 65270	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He would expect staff to complete face checks hourly on all residents and documented.</p> <p>MO252874</p> <p>MO252991</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure food served to residents was palatable and served at a safe and appetizing temperature. The facility census was 178.</p> <p>Review of the undated facility policy, Food Temperatures, showed the following:</p> <ul style="list-style-type: none"> -Foods will be served at proper temperatures to ensure food safety; -Acceptable serving temperatures are: <ul style="list-style-type: none"> -Cereal, greater than 135 degrees but preferably 160 degrees to 175 degrees Fahrenheit; -Meat, entrees: greater than 135 degrees but preferably 160 degrees to 175 degrees Fahrenheit; -Potatoes, pasta and soup: greater than 135 degrees but preferably 160 degrees to 175 degrees Fahrenheit; -Hot vegetables, greater than 135 degrees but preferably 160 degrees to 175 degrees Fahrenheit; -Pastries, cakes, greater than 60 degrees Fahrenheit; -If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution and discard out of temperature range foods. <p>During an interview on 4/23/25 at 12:50 at 12:50 P.M., Resident #6 said the following:</p> <ul style="list-style-type: none"> -The facility stopped using the steam table because of cutbacks; -Hot food was not hot when served. <p>During an interview on 4/23/25 at 1:12 P.M., Resident #13 said the following:</p> <ul style="list-style-type: none"> -Hot food was not hot when served. -The facility stopped using a steam table on his/her unit. -It made him/her angry and upset residents had to eat cold food every day. <p>During an interview on 4/23/25 at 1:15 P.M., Resident #20 said the following:</p> <ul style="list-style-type: none"> -The facility had been without the steam table for a couple weeks now. -Staff consistently served the food cold that should be hot. <p>Observation on 4/24/25 at 7:38 A.M. showed the following:</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Dietary staff pushed an insulated cart onto the hall which contained each of the residents plated breakfast on trays inside the cart. Each meal was on a plastic plate covered with a plastic cover;</p> <p>-Eleven bowls of oatmeal were on top of the cart with one large piece of plastic wrap across the top of the bowls;</p> <p>-The meal consisted of waffles, sausage, and oatmeal;</p> <p>-Staff opened and shut the cart various times before starting to serve residents;</p> <p>-At 7:43 A.M., the first tray was passed;</p> <p>-At 7:46 A.M., Certified Nurse Aide (CNA) F said to Nurse Aide (NA) E to get all the other residents up, out of bed;</p> <p>-The oatmeal and milk ran out during serving and staff went to the kitchen to get more;</p> <p>-Staff continued to pass trays to the residents in the dining room;</p> <p>-At 7:56 A.M., the test tray was removed from the cart, with 12 residents still needing hall trays delivered (12 trays remained in the cart for the residents). Staff reported those residents were not awake yet;</p> <p>-At 7:56 A.M., temperatures of the test tray showed: the sausage patty was 85 degrees Fahrenheit, the waffle was 78 degrees Fahrenheit; the oatmeal was 120 degrees Fahrenheit (hot foods should be served at 120 degrees Fahrenheit or higher), bland in flavor, and no condiments were provided with the test tray.</p> <p>Observation on 4/24/25 at 8:08 A.M. showed the following:</p> <p>-Resident #18 propelled his/her wheelchair into the dining room for breakfast;</p> <p>-Staff served him/her tray from off the cart. Staff did not heat up the resident's tray;</p> <p>-The resident said the food was cold. The food was always cold.</p> <p>During an interview on 4/24/25 at 8:15 A.M. Resident #19 said the following:</p> <p>-Typically, all the hot foods he/she was served at the facility were room temperature or cold.</p> <p>-Staff never offered to heat up his/her meals.</p> <p>-Ice cream was warm when it was served.</p> <p>During an interview on 5/5/25 at 12:55 P.M., NA E said the following:</p> <p>-The kitchen stopped using the steam cart a couple weeks ago;</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-A lot of residents had complaints about hot foods being served cold.</p> <p>During an interview on 4/23/25 at 3:40 P.M., CNA F said the following:</p> <p>-The facility stopped using a steam cart to bring meals to the unit;</p> <p>-Staff on the hall served the meals to residents;</p> <p>-His/her shift started at 7:30 A.M., the breakfast cart was brought to the floor shortly after he/she arrived. A lot of the residents were not even out of bed yet and the food was cold by the time the residents made it to the dining room;</p> <p>-There were lots of complaints about hot food being served cold.</p> <p>During an interview on 4/24/25 at 8:00 A.M. and 1:00 P.M. Environmental Services Manager/Unit Manager G said the following:</p> <p>-There had been a lot of complaints on hot food being served cold;</p> <p>-Staff could microwave the residents food if the residents asked for it to be reheated;</p> <p>-The facility made budget cuts, and the steam cart was cut out on the unit. Dietary staff brought a cart to the unit with prepared trays, staff on the hall were responsible for passing out each tray;</p> <p>-Staff had to run back and forth to the kitchen a lot for additional milk, cereal and other items, because there was not enough sent to the floor to serve each resident;</p> <p>-Staff would open and shut the cart multiple times so the food was often served cold;</p> <p>-The cart was brought to the hall before a lot of the residents were even out of bed.</p> <p>During interviews on 4/24/25 at 11:10 A.M. and 5/5/25 at 11:12 A.M., the Dietary Manager said the following:</p> <p>-Meals were plated in the kitchen and transported to the hall on an insulated cart. The cart kept the food hot/warm for approximately 20-30 minutes depending on how often staff opened and shut the cart door;</p> <p>-Hot foods should be kept inside the insulated cart until served to the residents, oatmeal should not be transported to the unit on top of the cart with a piece of plastic wrap over the top;</p> <p>-She would expect hot food be served at least 135 degrees Fahrenheit to the residents on the floor.</p> <p>During an interview on 4/24/25 at 11:00 A.M., the administrator said the following:</p> <p>-The food was plated in the kitchen and brought down on an insulated cart and left for staff working on the hall to serve;</p> <p>(continued on next page)</p>		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hot food should be served per facility policy. MO252991 MO253175 MO253179 MO253367