

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  Spring Meadows Nursing, A Villa Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1125 Clarion Ave Holland, OH 43528	

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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815</b></p> <p>Based on record review, staff interview, review of email correspondence, and policy review, the facility failed to ensure resident representatives received copies of medical records in a timely manner. This affected two (#12 and #72) of two residents reviewed for medical record requests. The facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #12 revealed an admitted [DATE]. Resident #12 discharged to another long-term care facility on 02/26/25. Review of the discharge Minimum Data Set (MDS) assessment completed 02/06/25 revealed Resident #12 had impaired cognition.</p> <p>Review of Resident #12's emergency contact information revealed the Emergency Contact #1 was Resident #12's son.</p> <p>Review of an email dated 02/11/25 from Resident #12's son to Social Services Designee (SSD) #501 revealed a request for copies of medical records. Further review revealed multiple people were carbon copied (CC) on the email, including several people with the same surname as Resident #12.</p> <p>Review of an email dated 02/11/25 from SSD #501 to Medical Records (MR) #502 revealed a request for MR #502 to respond to Resident #12's son regarding his request for copies of the medical record. The email from SSD #501 to MR #502 included the forwarded email from Resident #12's son.</p> <p>Review of an email dated 02/12/25 revealed MR #502 sent a Records Request form to one of the people CC'd in the original email and did not email Resident #12's son who submitted the request.</p> <p>Review of an email dated 02/21/25 from Resident #12's son to SSD #501 revealed he was still awaiting a copy of the records from the facility.</p> <p>Review of an email dated 02/21/25 from MR #502 to Resident #12 revealed MR #502 sent a copy of a Medical Records Release form to Resident #12's email address.</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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/12/25 at 11:20 A.M. with MR #502 , along with a review of the email she sent on 02/12/25 revealed MR #502 did not know why she did not respond to Resident #12's son. Further interview confirmed she had not provided copies of the medical records to Resident #12's son at the time of the interview.</p> <p>2. Review of the medical record for Resident #72 revealed an admitted [DATE] with diagnoses of Parkinson's disease and type II diabetes mellitus. Review of the quarterly MDS assessment, dated 01/27/25, revealed Resident #72 had intact cognition.</p> <p>Review of Resident #72's emergency contact information revealed the healthcare Power of Attorney (POA) was Resident #72's daughter.</p> <p>Review of a nursing progress note dated 11/19/24 revealed a care conference was held and Resident #72's POA attended and requested a copy of Resident #72's medical records.</p> <p>Review of an email dated 11/20/24 from Resident #72's POA to SSD #501 revealed Resident #72's POA had a court hearing scheduled for 11/27/24 and requested copies of the medical record no later than 11/25/24.</p> <p>Review of an email dated 11/25/24 from SSD #501 to MR #502 revealed all required release of health information forms were attached and SSD #501 requested MR #502 to follow up with providing records to Resident #72's POA.</p> <p>Review of an email dated 01/29/25 from MR #502 to Resident #72's POA revealed she forwarded the request for copies of Resident #72's medical records to the corporate office.</p> <p>Interview on 03/13/25 at 1:22 P.M. with MR #502 stated she made copies of Resident #72's medical records and planned to provide them to Resident #72's POA when she was informed the request needed to be processed through the corporate office. MR #502 confirmed the first time she forwarded the request, initiated by Resident #72's POA in writing on 11/20/24, was on 01/29/25.</p> <p>Review of the undated policy titled Release of Information, revealed a resident may obtain photocopies of his or her records by providing the facility with at least 48-hour (excluding weekends and holidays) advance notice.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163096.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>44815</p> <p>Based on observation, staff interview, and review of the menu spreadsheet, revealed the facility failed to provide adequate portions of food. Additionally, the facility failed to ensure adequate food was prepared to provide all residents with an appropriate portion of food. This had the potential to affect all residents in the facility except Resident #92 who received no food by mouth. Finally, the facility failed to ensure residents on a pureed diet received all items on the menu. This affected five (#13, #24, #39, #42, and #94) residents on a pureed diet. The facility census was 90.</p> <p>Findings include:</p> <p>1. Observations and interviews on 03/12/25 beginning at 11:37 A.M. revealed [NAME] #301 serving the noon meal. [NAME] #301 stated the meal was chili, cornbread, salad, and pumpkin pie. [NAME] #301 stated residents on a regular texture diet and a mechanical soft texture diet received the same chili and cornbread. [NAME] #301 prepared pureed chili and pureed cornbread for residents on a pureed diet. [NAME] #301 used a serving spoon to serve chili to approximately ten residents who received either regular or mechanical soft textured chili.</p> <p>Observation on 03/12/25 at 11:55 A.M. revealed [NAME] #301 preparing Resident #94's pureed meal tray. [NAME] #301 scooped two scoops of pureed chili into the bowl, and one scoop of cornbread onto the plate.</p> <p>Observation on 03/12/25 at 11:59 A.M. revealed [NAME] #301 replaced the serving spoon with a spoodle utensil (a serving spoon with a defined measurement). Concurrent interview with [NAME] #301 confirmed she used a serving spoon used during preparation of the chili to serve chili portions to approximately the first eight resident trays.</p> <p>Interview and observation on 03/12/25 at 12:50 P.M. with [NAME] #301 revealed she was preparing Resident #39's pureed tray. [NAME] #301 scooped one scoop of chili, and then approximately half of a second scoop of chili into the bowl. [NAME] #301 stated she added some of a second scoop because the single scoop didn't look like enough.</p> <p>Observation on 03/12/25 at approximately 12:54 P.M. revealed one meal ticket remained with a request for two bowls of chili. [NAME] #301 scraped the last of the chili from the pan and produced one scoop. Dietary Manager (DM) #503 went to the attached Assisted Living Facility kitchen to obtain a second bowl of chili for the final meal ticket.</p> <p>Interview and observation on 03/12/25 at 12:55 P.M. revealed the spoodle used to serve chili to residents on regular and mechanical soft diets was 4 ounces. Additionally, the scoops used to serve both the pureed chili and the pureed cornbread were 1 and 5/8 ounces.</p> <p>Interview on 03/12/25 at approximately 12:57 P.M. with DM #503 and review of the menu spreadsheet revealed residents on a regular and mechanical soft diet should have received an 8 ounce portion of chili. Further review revealed residents on a pureed diet should have received 8 ounces of chili and 3 ounces of cornbread.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/12/25 at 1:21 P.M. with DM #503 confirmed the facility did not prepare enough chili to provide the appropriate portions to residents on regular and mechanical soft diets.</p> <p>2. Observations on 03/12/25 beginning at 11:37 A.M. revealed [NAME] #301 prepared pureed chili and pureed cornbread for residents on a pureed diet.</p> <p>Observation on 03/12/25 at 11:55 A.M. revealed [NAME] #301 preparing Resident #94's pureed meal tray. [NAME] #301 scooped two scoops of pureed chili into the bowl, and one scoop of cornbread onto the plate.</p> <p>Observation on 03/12/25 at 12:42 P.M. revealed Certified Nursing Assistant (CNA) #101 assisting Resident #24 in the dining room while he ate a pureed meal. CNA #101 confirmed she mixed the pureed cornbread into the pureed chili. No vegetable was observed with Resident #24's meal.</p> <p>Interview on 03/12/25 at 12:49 P.M. with [NAME] #301 confirmed she served residents on a pureed diet only chili and cornbread.</p> <p>Interview and observation on 03/12/25 at 12:50 P.M. with DM #503 revealed residents on a pureed diet received applesauce instead of a vegetable, and gelatin dessert instead of pumpkin pie because the pie was too frozen to scoop prior to meal service.</p> <p>Interview and observation on 03/12/25 at 1:08 P.M. with CNA #101 confirmed Resident #24 received cornbread, chili, a nutrition supplement drink, and a nutrition supplement ice cream. No vegetable, applesauce, or gelatin dessert were observed or provided.</p> <p>Interview with DM #503 on 03/13/25 at approximately 2:00 P.M. and concurrent review of the pureed menu for the noon meal on 03/12/25 confirmed residents on a pureed diet should have received a pureed cook vegetable and pureed pumpkin pie.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163287.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44815</p> <p>Based on observation, staff interview, record review, menu review, and recipe review, the facility failed to ensure residents on a mechanical soft diet received appropriately textured food. This had the potential to affect 12 (#11, #15, #28, #29, #38, #44, #48, #55, #68, #69, #82 and #97) residents on a mechanical soft diet. Additionally, the facility failed to ensure residents received appropriate food textures and thickened beverages with their meals. This affected two (#24 and #42) residents on a pureed diet observed during meal service. The facility census was 90.</p> <p>Findings include:</p> <p>1. Observations and interviews on 03/12/25 beginning at 11:37 A.M. revealed [NAME] #301 serving the noon meal. [NAME] #301 stated the meal was chili, cornbread, salad, and pumpkin pie. [NAME] #301 stated residents on a regular texture diet and a mechanical soft texture diet received the same chili and cornbread.</p> <p>Review of the facility's mechanical soft menu revealed residents should receive ground beef &amp; bean chili.</p> <p>Interview on 03/12/25 at approximately 12:55 P.M. with Dietary Manager (DM) #503 and concurrent review of the mechanical soft menu revealed residents should receive ground beef &amp; bean chili. DM #503 stated the meat they used was ground beef and she instructed staff to break it down into small pieces. DM #503 stated the facility did not prepare a different version of the chili for residents on a mechanical soft diet.</p> <p>Interview on 03/12/25 at 1:21 P.M. with DM #503 confirmed whole kidney beans were used in the chili provided to residents on a regular diet and residents on a mechanical soft diet.</p> <p>Follow-up interview on 03/12/25 at 2:23 P.M. with DM #503 revealed she could find no recipe for ground beef &amp; bean chili.</p> <p>Interview on 03/13/25 at 12:20 P.M. with Regional Director of Dietary (RDD) #403, and concurrent review of a recipe for ground beef &amp; bean chili revealed the recipe used pinto beans. Additional review of the regular beef &amp; bean chili recipe revealed an alternative to use kidney beans. RDD #403 confirmed the ground beef &amp; bean chili recipe did not list kidney beans as an alternative.</p> <p>2. Review of the medical record for Resident #24 revealed an admitted [DATE] with a diagnosis of type II diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had impaired cognition.</p> <p>Review of the current physician order dated 02/13/25 revealed Resident #24 received a pureed diet with honey-thick liquids.</p> <p>Observation on 03/12/25 at 12:42 P.M. revealed Certified Nursing Assistant (CNA) #101 providing assistance to Resident #24 in the dining room while he consumed the noon meal.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/12/25 at 1:08 P.M. revealed CNA #101 remaining by Resident #24's side in the dining room. Resident #24 consumed all of his meal, including chili, cornbread, a nutrition supplement drink, and a thickened ice cream nutrition supplement. Attempted interview with Resident #24 at that time revealed Resident #24 was hard of hearing and could not express whether he was still hungry after the meal.</p> <p>Observation on 03/12/25 at approximately 1:30 P.M. revealed CNA #101 feeding Resident #24 a white substance out of a small pre-packaged cup.</p> <p>Interview on 03/13/25 at 11:50 A.M. with CNA #101 confirmed she provided regular vanilla ice cream, not a thickened nutrition supplement, to Resident #24 during the noon meal on 03/12/25. CNA #101 could not verify Resident #24's diet order included thickened liquids. CNA #101 stated the ice cream was still frozen, and had not melted, when she fed Resident #24.</p> <p>Interview on 03/13/25 at approximately 4:00 P.M. with RDD #403 confirmed residents with orders for thickened liquids should not receive regular ice cream because ice cream melted to a thin liquid.</p> <p>3. Review of the medical record for Resident #42 revealed an admitted [DATE] with a diagnosis of dysphagia (difficulty swallowing). Review of the Nursing Admission Evaluation dated 03/10/25 revealed Resident #42 was confused and had unclear speech.</p> <p>Review of the current physician order dated 03/10/25 revealed Resident #42 was on a pureed diet with nectar-thick liquids.</p> <p>Observation on 03/13/25 at approximately 12:40 P.M. revealed Resident #42's meal tray inside the meal cart in the hallway waiting to be served to Resident #42.</p> <p>Upon Surveyor request, observation on 03/13/25 at 12:44 P.M. revealed RDD #403 removing Resident #42's meal tray from the cart and carrying it to the conference room.</p> <p>Interview and observation on 03/13/25 at 12:46 P.M. with RDD #403 confirmed Resident #42 was on a pureed diet with nectar-thick liquids. Observation of the meal tray revealed a pureed bowl of soup, pureed cornbread, and pureed sweet potatoes. In a separate bowl was green gelatin dessert. Also on the tray was a glass of lemonade. RDD #403 confirmed the lemonade on Resident #42's cart was not thickened. Additionally, RDD #403 confirmed gelatin dessert was not appropriate for residents on thickened liquids and the gelatin liquefies (melts) in the mouth and becomes a thin liquid. RDD #403 subsequently ensured Resident #42 received an appropriate replacement meal tray.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163287.</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>44815</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure staff practiced proper hand hygiene during meal service. Additionally, the facility failed to ensure food was covered during delivery to resident rooms. This had the potential to affect all residents in the facility except Resident #92 who received no food from the kitchen. Additionally, the facility failed to ensure staff practiced proper sanitation practices when handling resident meal trays. This affected one (Resident #101) resident's tray observed during meal service. The facility census was 90.</p> <p>Findings include:</p> <p>Observations during noon meal preparation and service on 03/12/25 beginning at 11:32 A.M. revealed [NAME] #301 wearing disposable gloves, opening the reach-in refrigerator and picking up a bag previously opened and re-sealed shredded lettuce. [NAME] #301 proceeded to open the bag of lettuce while touching the outside of the bag with both gloved hands, then reached into the bag with her right hand and served portions of shredded lettuce into bowls.</p> <p>Interview on 03/12/25 at 11:36 A.M. with [NAME] #301 confirmed she did not change her gloves after opening the reach-in cooler and touching the exterior of the lettuce bag before reaching inside the bag to portion lettuce into bowls.</p> <p>Observations on 03/12/25 at 11:37 A.M., 11:39 A.M., and 11:43 A.M. revealed [NAME] #301 removing soiled gloves and putting on new gloves without washing her hands.</p> <p>Observation on 03/12/25 at 11:53 A.M. revealed [NAME] #301 wearing disposable gloves and leaving the serving line. [NAME] #101 returned wearing disposable gloves and carrying a slice of cheese. [NAME] #301 proceeded to prepare a cheeseburger by placing the cheese on a hamburger bun, then picking up a burger and tearing it into bite-size pieces, placing the burger on the bun and using both hands to put the cheese burger together and place on a plate. Concurrent interview with [NAME] #301 confirmed she did not wash her hands between glove changes and confirmed she retrieved the slice of cheese from the reach-in cooler and did not change her gloves between opening the cooler and preparing the cheeseburger.</p> <p>Continued observation on 03/12/25 at approximately 11:56 A.M. revealed the staff had prepared and loaded approximately six meal trays and loaded them into the tray cart when the staff realized no salads were on the trays. Observation on 03/12/25 at 11:58 A.M. revealed Dietary Aide #302 setting a resident's tray on the ground in order to view the tray behind it and add a salad. Concurrent interview with Dietary Aide #302 confirmed she set Resident #101's tray on the ground.</p> <p>Continued observations during the noon meal service on 03/12/25 at 12:00 P.M. revealed residents received pumpkin pie. Observation of the pie revealed it was plated but not covered by a lid or plastic wrap.</p> <p>(continued on next page)</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>Observations on 03/12/25 beginning at 12:15 P.M., during the passing of meal trays to resident rooms on the 300 hall, revealed resident trays with pumpkin pie. Further observation revealed the pumpkin pie was uncovered in the tray cart. Concurrent interview with Certified Nursing Assistant (CNA) #104 confirmed the pumpkin pie was uncovered on each tray.</p> <p>Observation and interview on 03/12/25 at 12:40 P.M. with CNA #102 on the 200 hall confirmed the pumpkin pie on residents trays inside the tray cart were uncovered.</p> <p>Interview on 03/12/25 at 12:54 P.M. with DM #503 confirmed the pies were sent on the tray carts without being covered because they were frozen and she left them uncovered to thaw.</p> <p>Review of the policy Food Preparation and Handling, dated 09/01/21, revealed staff were responsible for food preparation procedures that avoid contamination by potential harmful physical, biological, and chemical contamination.</p> <p>Review of the policy Hand Washing, dated 09/01/21, revealed staff should wash their hands before putting on gloves and as often as needed during food preparation and when changing tasks.</p> <p>Review of the policy Meal Distribution, dated 09/01/21, revealed all foods that are transported to dining areas that are not adjacent to the kitchen will be covered.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163287.</p>		