

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Glendale Care and Rehab Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6263 N Green Bay Ave Glendale, WI 53209	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013</p> <p>Based on staff interviews and record review, the facility failed to monitor the delivery of narcotic medication for one of three residents (Resident (R)1) reviewed for medications in a total sample of nine residents. On 03/04/24, R1 no longer had any Oxycodone at the facility, needed a new prescription from the Physician, and the medication was not available until 03/08/24. This practice has the potential to affect residents' pain management.</p> <p>Findings include:</p> <p>Review of the undated Face Sheet located in R1's electronic medical record (EMR), under the Profile tab, revealed R1 was admitted to the facility on [DATE] with diagnoses including history of a stroke, breast cancer, osteoarthritis, anxiety, and asthma.</p> <p>Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/24, located in R1's EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Per the MDS, R1 had pain and received as needed (prn) pain medication.</p> <p>Review of the care plan, located in R1's EMR under the Care Plan tab, dated 02/27/24, documented R1 had chronic low back pain related to bone disease and interventions included: pain assessments per facility policy, monitor for pain every shift, monitor/record/report to nurse any signs/symptoms of non-verbal pain, and medications and non-pharmacological interventions.</p> <p>Review of the Physician Orders, located in R1's EMR under the Orders tab and dated 02/27/24, documented: the narcotic pain medication Oxycodone hydrochloride (HCL) give 10 milligrams (mg) every eight hours prn for moderate to severe pain, Acetaminophen (APAP) tablet 500 mg give two tablets (1000 mg) every six hours prn for pain, and document non-pharmacological pain interventions every shift that included position change, massage, meditation, music, distraction, conversation, food/fluids, back rub etc. prn.</p> <p>Review of the March 2024 Medication Administration Record (MAR), located in R1's EMR under the Orders tab, documented the following pain medication administrations from 03/01/24 through 03/07/24.</p> <p>On 03/01/24 and 03/02/24, R1 received one dose of Oxycodone 10 mg for pain and no APAP.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/03/24, R1 received two doses of Oxycodone 10 mg for pain and received no APAP.</p> <p>On 03/04/24, R1 received 1000 mg APAP once for a pain rating of three on the day shift and once on the evening shift for a pain rating of seven with effect and R1 was repositioned.</p> <p>On 03/05/24, R1 had a pain rating of seven on the evening shift and received APAP 1000 mg with effect.</p> <p>On 03/06/24, R1 received APAP 1000 mg, repositioning, and conversation with effect for a pain rating of five.</p> <p>The MAR revealed no untreated pain.</p> <p>Review of the night shift Progress note, located in R1's EMR under the Progress note tab, dated 03/07/24 at 12:02 AM revealed Resident was in respiratory distress, oxygen saturation 88-87-86-90 percent via nasal cannula on two and one half liters, resident stated that she was not feeling well during nebulizer treatment and wanted to go to the hospital, BP [blood pressure] 172/89, respirations 20, and temperature 99.2. Resident sent to hospital via Ambulance.</p> <p>Review of the night shift Progress note, located in R1's EMR under the Progress note tab, dated 03/07/24 at 6:44 AM revealed the hospital called and gave report that resident will be returning to facility, all tests were negative, given Dilaudid [narcotic medication used to treat pain], respiratory issues were caused because resident needs dialysis and will return to facility by 8 o'clock .</p> <p>Review of the day shift Progress note dated 03/07/24 revealed R1 returned to the facility at 8:50 AM with no new orders.</p> <p>During an interview on 06/05/24 at 9:00 AM, R1 stated she was admitted to the facility with orders for Oxycodone and APAP as needed for pain. R1 said she usually took Oxycodone once a day and did not need the APAP. R1 said one day the nurse told her they did not have any Oxycodone; the nurse gave her APAP for pain and the pain relief was not as effective. She said the nurse told her the Pharmacy was waiting for the Physician to send over a prescription for Oxycodone. R1 said she went without any Oxycodone for seven days.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/06/24 at 10:15 AM, Licensed Practical Nurse (LPN) 1 said R1 was alert and oriented and had orders for Oxycodone and APAP prn for pain. LPN1 said the nurses completed a pain assessment every shift and when a resident had pain and required a prn pain medication. LPN1 said on 03/04/24, R1 did not have any Oxycodone available. She said one of the nurses had called the pharmacy a few days prior and they said they would notify the Physician to renew the prescription. LPN1 said on 03/04/24, she called Pharmacy and told the pharmacy staff R1 used prn Oxycodone, did not have any more Oxycodone, and needed it sent to the facility as soon as possible. She said she told the pharmacy staff that at least one nurse had already contacted the pharmacy a few days prior. The person at the pharmacy told her she would notify the Physician to send a new prescription for Oxycodone and the medication would be sent to the facility. LPN1 said the pharmacy staff never asked her to call the Physician for the Oxycodone order. LPN1 said she explained this to R1, who was satisfied with the plan. LPN1 said during the day shift on 03/04/24, R1 had a pain rating of four, was repositioned and given APAP with effect. LPN1 said if R1 did not have effective pain relief from the APAP, she would have notified the Physician. LPN1 said she received no call back from the pharmacy and assumed there were no issues with the Oxycodone order.</p> <p>During an interview on 06/07/22 at 2:20 PM, the Director of Nurses (DON) stated when R1 was admitted to the facility, she did not have a lot of Oxycodone. On 03/05/24, the nurse told her they had contacted the pharmacy a few times prior to 03/05/24 requesting a refill of Oxycodone for R1. The DON stated the nurses told her the pharmacy staff said they would contact the Physician and they had not received Oxycodone for R1. The DON said she sent a text message to R1's Physician on 03/05/24 telling him R1 needed a new prescription for Oxycodone. The DON said the Physician texted her back that he would send the prescription to the pharmacy. The DON said the pharmacy usually notified the Physician when a new prescription was needed for a narcotic medication. The DON said the nurses did not report any further concerns with the Oxycodone, and she assumed the Oxycodone had been delivered. The DON said shortly after midnight on 03/07/24, R1 had shortness of breath, received the narcotic pain medication Dilaudid in the emergency department for her respiratory issues, had a negative cardiac work up, needed to receive dialysis and returned to the facility on [DATE]. The DON said when she saw R1 on 03/07/24, R1 was sleepy and voiced no concerns. The DON said she was not aware Oxycodone had not been sent from the pharmacy until 03/08/24. The DON stated she again texted the Physician, who said he had sent the new prescription for Oxycodone to the pharmacy on 03/05/24 and would immediately send another prescription. The DON said shortly afterward, the pharmacy called, gave the code, and the Oxycodone could be used if needed from the facility emergency box. The DON said when R1 complained of pain on 03/08/24, she received Oxycodone with effect and there have been no further concerns with her Oxycodone. The DON said she reviewed the incident with the Physician, who said he sent the Oxycodone prescription to the pharmacy on 03/05/24 and 03/08/24. The DON said she asked the Physician for a receipt of the 03/05/24 Oxycodone order sent to the Pharmacy and had not received any information. The DON said although the nurses said they spoke to the pharmacy staff on a few occasions, there was no documentation in the EMR to support the calls.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/07/24 at 12:35 PM, the Registered Pharmacist (RP) said R1 was admitted from the hospital with an order for Oxycodone. She said the Physician at the facility had to write a new prescription for Oxycodone for R1. The RP said as a courtesy, they sometimes sent a message to a physician reminding them when a resident needed a new prescription for narcotic pain medication. The RP said there was no documentation that the Pharmacy called or sent a message to the Physician regarding R1's Oxycodone. The RP said she spoke to the technician, who told her they received no prescription from the Physician prior to 03/08/24. The RP said the Pharmacy received two prescriptions for R1's Oxycodone from the Physician on 03/08/24 and immediately activated the order. The RP said the Pharmacy did not keep records of telephone calls from the nurses at the facility and she was not aware they called several times regarding R1's Oxycodone. The RP said she spoke to the technician, who had worked on R1's medications and the technician could not recall any telephone conversations with the nurses at the facility.</p> <p>During an interview on 06/05/24 at 4:18 PM, the Physician said R1 was admitted from the hospital with an order for Oxycodone. He said the pharmacy notified him when a resident needed a renewal or new prescription for a narcotic medication. He said he then sends them the form for renewal or a new prescription if indicated. The Physician said he received no notice from the pharmacy related to R1's need for a new prescription for Oxycodone or that she had no more Oxycodone at the facility. He said on 03/05/24, the DON texted him that the pharmacy needed a new prescription for R1's Oxycodone. He said he sent the prescription to the pharmacy, heard nothing back, and assumed the prescription was filled. The Physician said on 03/08/24, the DON texted him again that the pharmacy did not have the prescription for Oxycodone. He immediately sent the prescription to the pharmacy and the issue was resolved. The Physician said there was no consistency or protocol that the pharmacy followed.</p> <p>Review of the facility policy titled Ordering and Receiving Controlled Medications dated 2002 documented: . The Drug Enforcement Agency (DEA) requires that a pharmacy must have a valid prescriber signed prescription in order to dispense controlled substances . In an emergency situation, verbal authorization may be given by the prescriber to the pharmacist for a new orders as described by state law . If only one refill remains (CIII-Vs) or a partial fill quantity remains (CII), the pharmacy will simultaneously dispense the remaining fill, and if necessary proactively seek out a new, complete prescription from the prescriber for future us. The facility may be asked to contact the prescriber for a new prescription upon request for a medication with no remaining fills available.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013</p> <p>Based on observation, staff interview, and facility documentation review the facility failed to ensure food was served at palatable temperatures for two of nine sampled residents (Resident (R) 1 and R4) on one ([NAME] unit) of four units. This failure has the potential for decreased meal intake.</p> <p>Findings include:</p> <p>During an interview on 06/05/24 at 9:00 AM, Resident (R)1, who was alert and oriented, stated food was often cold when she received her tray, and the beverages were sometimes not cold enough. R1 stated she complained about the food several months ago and was told to ask the staff to reheat her food. R1 stated the staff would reheat her food when asked but some of the food did not taste good when reheated. R1 stated sometimes the food was still served cold.</p> <p>During an interview on 06/05/24 at 9:15 AM, R4, who was alert and oriented, stated sometimes the food was cold and the staff reheated the food in the microwave when asked. R4 said she did not like the taste of some foods when reheated.</p> <p>Review of the Facility Grievance Log, provided by the Director of Nurses (DON) and dated 03/06/24, documented R1 had concerns with cold food and was told to ask the staff to reheat her food when needed. The Log dated 03/26/24 documented R1 had concerns with cold food, egg options, and not receiving utensils. The Log revealed the Dietary Manager met with the resident on food preferences.</p> <p>During an interview on 06/07/24 at 10:47 AM, the Dietary Manager (DM) said since the purchase of two food carts with heating elements in January 2024, there were only a few complaints by residents of cold food. The DM stated he met with R1, discussed her concerns, reviewed food preferences with her, and told her he would educate the staff regarding utensils on her tray and monitor the food temperatures. He said follow-up test trays completed at the end of March 2024 revealed no food temperature issues. The DM said R1 had no further concerns with cold food since his March 2024 meeting. The DM said he was not aware R4 had concerns with cold food.</p> <p>Review of the "Cook Food Temperature Logs" provided by the DM, dated March 2024 and June 2024 lacked documentation that the staff tested the temperatures of milk and coffee before the beverages left the kitchen.</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 - Few</p>	<p>During an interview on 06/07/24 at 10:47 AM, the DM stated food was prepared in the kitchen located in the basement of the facility, placed in metal hotel style pans, and when finished being cooked was covered with tinfoil. The DM stated the steam table in the dining room on the first floor was turned on at approximately 4:20 PM. The DM stated the time the steam table was turned on was not recorded. He said food temperatures were taken of the hot food items and the dessert and recorded on the "Food Temperature Log" prior to transporting the food to the steam table in the dining room. The DM said at approximately 4:55 PM, the staff placed the food pans on carts and brought the food to the dining room above the kitchen. The DM said once the food was placed in the steam table, staff took the temperatures of the hot foods just before they began preparing the food trays and record the temperatures on the "Food Temperature Log." The DM said the facility has two food carts, where the prepared trays were placed that had heating units. He said they fill one food cart, the staff bring the food cart to the unit, and they immediately prepare the trays for the next food cart. The DM said when the first food cart was returned to the dining room, they began preparing trays for the next unit. The DM said prior to serving each unit, pitchers of juice and a gallon of milk in ice baths and the coffee container were brought to the nursing units. The DM said staff checked the temperature of the refrigerator where the milk and juice were stored prior to removing the gallon of milk from the refrigerator and they check the temperature of the coffee machine prior to filling the insulated coffee container. The DM stated there have never been issues with the temperatures on the coffee machine or refrigerators. The DM said the staff did not check the temperature of the milk. The DM said the temperature of hot food and hot beverages when served was to be 135 degrees Fahrenheit or hotter and cold food and milk were to be at 41 degrees Fahrenheit or lower.</p> <p>Review of the facility's paper documents, labeled "Cook Food Temperature Log" provided by the DM dated 06/06/24, revealed the following documentation for the dinner meal, which included hamburger, French fries, and pineapples in the kitchen prior to bringing the food to the dining room:</p> <p>Meat: 177 degrees Fahrenheit</p> <p>Starch: 173 degrees Fahrenheit</p> <p>Dessert: 41 degrees Fahrenheit</p> <p>Review of the "Food Temperature Log" dated 06/06/24 revealed the following documentation for the dinner meal just before the Dietary Aide began preparing the food trays for residents.</p> <p>Meat: 165 degrees Fahrenheit</p> <p>Starch: 171 degrees Fahrenheit</p> <p>Dessert: no temperature recorded</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 - Few</p>	<p>During observation on 06/06/24 at 5:25 PM, the second food cart left the dining room. The first food cart had not been returned to the dining room. The hamburgers, French fries, ground and puree beef, and mashed potatoes were observed in pans in the steam table that were only partially covered with tinfoil. The pans that contained the hamburgers and French fries had one half of the tin foil peeled away, some of the food was not covered with tin foil and was exposed to the air. The sliced cheese was lying on an uncovered plate next to the steam table. At 5:34 PM, the first food cart returned, and staff began preparing trays for the [NAME] unit at 5:34 PM. A test tray, which was the last tray prepared, was placed on the food cart at 5:41 PM. The food cart was observed to arrive to the [NAME] unit at 5:42 PM and the last tray was delivered at 5:56 PM.</p> <p>The following were the temperatures that were taken with the Dietary Manager on the test tray on 06/06/24 at 5:57 PM.</p> <p>Cheeseburger: 106 degrees Fahrenheit:</p> <p>French Fries: 107 degrees Fahrenheit.</p> <p>Pineapples: 66 degrees Fahrenheit</p> <p>Milk: 57 degrees Fahrenheit</p> <p>Juice 45 degrees Fahrenheit</p> <p>Coffee: 135 degrees Fahrenheit</p> <p>The Surveyor and the Dietary Manager tasted the tray, and agreed the cheeseburger, French fries, pineapples, and milk were lukewarm and not palatable. The Surveyor tasted the coffee without milk, which was at an acceptable temperature. The DM stated if adding milk, the coffee could be a little hotter. The Dietary Manager stated the cheeseburger, French fries, pineapples, juice, and milk were not at acceptable temperatures per the facility policy. The DM said maybe the food cart was not plugged in a half hour before the food was placed in the steam table. The DM confirmed he did not retake food temperatures during the delay between when the second food cart left the dining room and the first food cart was returned to the dining room, which would have contributed to cooler food temperatures.</p> <p>During an interview on 06/06/24 at 6:04 PM, R1 stated the cheeseburger and French fries were cold, she did not want the food reheated, and was getting an alternate. R1 said she did not taste the milk. R1 said her coffee was delicious and hot.</p> <p>During an interview on 06/06/24 at 6:07 PM, R4 said the cheeseburger and French fries were cold, she did not want the food reheated as the cheeseburger would be too tough to eat. She said she declined the alternate and had her own food she was going to eat. She said she did not drink the milk.</p> <p>During an interview on 06/06/24 at 6:12 PM, the food and beverage temperatures were reviewed with the Director of Nurses (DON), and she confirmed the temperatures were not at acceptable temperatures.</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 - Few</p>	<p>Review of the policy titled "Record of Food Temperatures" provided by the DON documented: "Food temperatures will be checked on all items prepared in the dietary department. Hot foods will be held at 135 degrees Fahrenheit or greater . Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit . Measure and record the temperatures for each food product and milk at all meals. Record temperature on temperature log . Place cold menu items such as ham salad or egg salad over an ice bath in a pan and not beside a heated steam table."</p> <p>Review of the policy titled "Serving from The Steam Table" dated 2016 provided by the DON documented: "The temperature of the hot food will be taken and recorded on the hot food temperature log. The temperature of the hot food will be maintained at 135 degrees Fahrenheit as long as the food is on the steam table."</p>