

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2020
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NAME OF PROVIDER OR SUPPLIER DAUGHTRY FIELD ROAD GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365
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E 004	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.475(a)</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p>	E 004		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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E 004	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated every two years. The finding is: The facility's EP plan was not reviewed or updated every two years. Review on 12/1/2020 of the facility's EP plan revealed the date of their plan was 6/1/2018. Further review revealed there was not an updated plan located in the home. During an interview on 12/1/2020, the program director revealed she was not aware if the EP plan had been reviewed or updated every two years.	E 004			
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020			

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E 020	<p>Continued From page 2</p> <p>*[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.</p> <p>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.</p> <p>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuation locations based on a community and facility risk assessment. The finding is: The facility did not have an emergency plan which included evacuation locations.</p>	E 020			

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E 020	Continued From page 3 Review on 12/1/2020 of the facility's EP plan revealed the plan did not include information in regards to the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other emergencies. During an interview on 12/1/2020, Staff A reported they knew where to relocate with the clients if they needed to vacate the facility. Further interview revealed the clients would locate to North Drive Group Home. During an interview on 12/1/2020, the program director revealed she was unaware the EP plan did not include information pertaining to alternate evacuate locations. The program manager confirmed the clients would relocate to North Drive Group Home.	E 020			
E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at	E 030			

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E 030	<p>Continued From page 4</p> <p>§485.625(c)] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p>	E 030			

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E 030	<p>Continued From page 5</p> <ul style="list-style-type: none"> (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). <p>This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure an emergency preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is:</p> <p>The facility's EP plan did not include an updated face sheet.</p> <p>Review on 12/1/2020 of the facility's EP plan had the wrong contact information. Further review</p>	E 030			

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E 030	Continued From page 6 revealed the face sheet had the contact information for a client who no longer lived in the home. Additional review revealed a client who was admitted in July 2020 information was not included. Also, the EP plan included former staff and not the new staff.	E 030			
W 189	<p>During an interview on 12/1/2020, the program director confirmed the face sheet for the facility contained the incorrect information.</p> <p>STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained in the area of safety The findings are:</p> <p>A. Staff were not sufficiently trained in providing safety for the clients.</p> <p>1. During morning observations in the home on 12/2/2020 at 8:35am, Staff A handed the van keys to client #4 and told him to go ahead outside and start the van. Further observations revealed client #4 going outside alone, putting the key in the door lock of the van, opening the door, reaching in, putting the key in the ignition, turning the ignition, shutting the van door and coming back into the home. At no time did a staff person go outside with client #4.</p>	W 189			

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W 189	<p>Continued From page 7</p> <p>During an interview on 12/2/2020, Staff A revealed she has been trying to "integrate [Client #4] to do normal things." Further interview revealed Staff A had been working in the home for a year and client #4 has been starting the van by himself before that. Additional interview revealed Staff A did not see how client #4 starting the van alone was a safety concern.</p> <p>During an interview on 12/2/2020, the program director revealed client #4 should never had been allowed to start the van by himself.</p> <p>2. During morning observations in the home on 12/2/2020 at 8:41am, all six clients where observed getting into the van. Further observations revealed while the clients where getting on the van, it was idling in the driveway of the home. Additional observations revealed Staff A and Staff B did not come out of the house until 8:43am.</p> <p>During an immediate interview on 12/2/2020, Staff A did see anything wrong with the clients getting on the van alone. Staff A stated it was good they got on the van, while it was "warming up."</p> <p>During an interview on 12/2/2020, the program director stated the clients should never be left alone on the van. Further interview revealed the staff should have their eyes on the clients at all times.</p> <p>3. During morning observations on 12/1/2020 at 9:44am, the surveyor entered the day program and introduced themselves. Further observations revealed the staff who opened the door did not</p>	W 189			

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W 189	<p>Continued From page 8</p> <p>ask the surveyor any health questions or take their temperature.</p> <p>During afternoon observations on 12/1/2020 at 3:30pm, the surveyor entered the home. Further observations revealed the staff who told the surveyor to enter the home, did not ask the surveyor any health questions of take their temperature.</p> <p>During morning observations on 12/2/2020 at 6:18am, the surveyor entered the home and introduced themselves. Further observations revealed the staff who opened the door did not ask the surveyor any health questions or take their temperature.</p> <p>During morning observations on 12/2/2020 at 9:25am, the surveyor entered the day program and introduced themselves. Further observations revealed the staff who opened the door did not ask the surveyor any health questions or take their temperature.</p> <p>During an interview on 12/2/2020, the facility nurse #1 revealed all visitors temperature and health questions should be asked. Further interview revealed she was not sure if staff knew they had to do that.</p> <p>During an interview on 12/2/2020, the facility nurse #2 revealed with the pandemic going on, the surveyors' temperature should have been taken and health questions should have been asked. Additional interview revealed the facility does not have anything in writing pertaining to asking questions or taking the temperature of visitors.</p>	W 189			

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W 249 W 249	Continued From page 9 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of dining and self help skills. This affected 3 of 6 audit clients (#1, #2 and #5). The findings are: A. Clients #1 and #5 were not prompted to use a knife during dining. 1. During lunch observations at the day program on 12/1/2020 at 11:27am, client #1 was presented with a whole bologna sandwich. Further observations revealed client #1 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #1 prompted to cut his sandwich. Further observations revealed client #1 only had a spoon at his place setting. During dinner observations at the home on 12/1/2020 at 5:03pm, client #1 served himself one whole piece of a chicken breast. Further	W 249 W 249			

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W 249	<p>Continued From page 10</p> <p>observations revealed client #1 picking up the whole chicken breast and eating pieces larger than 1/2 inch. At no time was client #1 prompted to cut his chicken breast. Further observations revealed client #1 only had a spoon at his place setting.</p> <p>During breakfast observations at the home on 12/2/2020 at 7:35am, client #1 served himself one whole piece of french toast. Further observations revealed client #1 pulled the french toast apart into 2 pieces and ate them. At no time was client #1 prompted to cut his french toast. Further observations revealed client #1 only had a spoon at his place setting.</p> <p>Review on 12/2/2020 of client #1's comprehensive functional assessment dated 4/21/2020 revealed he requires "verbal, gestures and modeling" for his dining skills.</p> <p>2. During lunch observations at the day program on 12/1/2020 at 11:27am, client #5 was presented with a whole bologna sandwich. Further observations revealed client #5 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his sandwich. Further observations revealed client #5 only had a spoon at his place setting.</p> <p>During dinner observations at the home on 12/1/2020 at 5:06pm, client #5 served himself one whole piece of a chicken breast. Further observations revealed client #5 picking up the whole chicken breast and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his chicken breast. Further observations revealed client #5 only had a spoon at his place setting.</p>	W 249			

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W 249	<p>Continued From page 11</p> <p>During breakfast observations at the home on 12/2/2020 at 7:40am, client #5 served himself one whole piece of french toast. Further observations revealed client #5 picking up the whole piece of french toast and eating pieces larger than 1/2/ inch. At no time was client #5 prompted to cut his french toast. Further observations revealed client #5 only had a spoon at his place setting.</p> <p>Review on 12/2/2020 of client #5's comprehensive functional assessment dated 3/17/2020 revealed he requires "verbal, gestures and modeling" for his dining skills.</p> <p>During an interview on 12/2/2020, Staff A revealed how all the forks and knives in the home are located in an unlocked box, which is located on the counter in the kitchen. Staff A stated the forks and knives were kept locked because of a former client who resided in the home. Further interview revealed Staff A reported no one had told her to remove the forks and knives and place them in a drawer in the kitchen.</p> <p>During an interview on 12/2/2020, the program director revealed staff should be giving some type of prompts to clients #1 and #5 to cut their food. The program director stated she was not aware the forks and knives were not assessable to the clients.</p> <p>B. During observations in the home on 12/2/2020 at 6:18am, client #2 was observed wearing the same yellow colored sweat shirt which he wore on 12/1/2020. Additional observations revealed the shirt had a large stain on the front.</p>	W 249			

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W 249	Continued From page 12 Review on 12/2/2020 of client #2's comprehensive functional assessment dated 12/23/2019 revealed client #2 "demonstrates adequate dressing skills although verbal prompts and cues may be necessary at times." During an interview on 12/2/2020, Staff A revealed client #2 can independently "pick out his own clothes and dresses himself." During an interview on 12/2/2020, the program director stated staff should have ensured client #2 wore a clean shirt.	W 249			
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure recommended equipment specifically eyeglasses were furnished for 1 of 6 audit clients (#2). The finding is: Client #2 was not prompted to wear his eyeglasses. During observations at the home on 12/2/2020, from 6:18am until 8:53am, client #2 was not prompted to wear his eyeglasses.	W 436			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2020
NAME OF PROVIDER OR SUPPLIER DAUGHTRY FIELD ROAD GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365		
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W 436	Continued From page 13 Review on 12/2/2020 of client #2's visual examination dated 6/29/2020 revealed, "Eyeglasses: Full time." Review on 12/2/2020 of client #2's comprehensive functional assessment dated 12/23/2019 stated, "[Client #2] has prescription glasses which he wears full-time."	W 436			
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills on first shift were not conducted at varied times. Review of fire drill reports on 12/1/2020 revealed the following: Five fire drills were conducted on third shift: 3:30pm, 3:30pm, 3:00pm, 3:00pm and 3:55pm. During an interview on 12/1/2020, Staff A revealed first shift hours are 6:15am until 6:30pm.	W 441			

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W 441	Continued From page 14 During an interview on 12/1/2020, the program director confirmed the fire drills conducted on first shift were not varied.	W 441			
W 460	<p>FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure clients #1, #5 and #6 diets were provided as prescribed. This affected 3 of 6 clients. The findings are:</p> <p>A. Clients #1, #5 and #6 diets were consistently followed.</p> <p>1. During lunch observations at the day program on 12/1/2020 at 11:27am, client #1 was presented with a whole bologna sandwich. Further observations revealed client #1 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #1 prompted to cut his sandwich.</p> <p>During dinner observations at the home on 12/1/2020 at 5:03pm, client #1 served himself one whole piece of a chicken breast. Further observations revealed client #1 picking up the whole chicken breast and eating pieces larger than 1/2 inch. At no time was client #1 prompted to cut his chicken breast.</p> <p>During breakfast observations at the home on 12/2/2020 at 7:35am, client #1 served himself</p>	W 460			

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W 460	<p>Continued From page 15</p> <p>one whole piece of french toast. Further observations revealed client #1 pulled the french toast apart into 2 pieces and ate them. At no time was client #1 prompted to cut his french toast.</p> <p>Review on 12/1/2020 of client #1's nursing evaluation dated 4/6/2020 stated, "Diet: All foods to be cut into 1/4 - 1/2 bite size pieces."</p> <p>Review on 12/1/2020 of client #1's nutritional evaluation dated 1/10/2020 stated, "...all food cut into 1/4 - 1/2 bite size pieces."</p> <p>Review on 12/2/2020 of client #1's physician orders signed on 11/30/2020 stated, "Diet: All food to be cut into 1/4 - 1/2 inch bite size pieces."</p> <p>2. During lunch observations at the day program on 12/1/2020 at 11:27am, client #5 was presented with a whole bologna sandwich. Further observations revealed client #5 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his sandwich.</p> <p>During dinner observations at the home on 12/1/2020 at 5:06pm, client #5 served himself one whole piece of a chicken breast. Further observations revealed client #5 picking up the whole chicken breast and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his chicken breast.</p> <p>During breakfast observations at the home on 12/2/2020 at 7:40am, client #5 served himself one whole piece of french toast. Further observations revealed client #5 picking up the whole piece of french toast and eating pieces larger than 1/2/ inch. At no time was client #5</p>	W 460			

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W 460	Continued From page 16 prompted to cut his french toast. Review on 12/1/2020 of client #5's nursing evaluation dated 2/28/2020 stated, " Cut all food into 1/4 - 1/2 pieces." Review on 12/1/2020 of client #5's nutritional evaluation (no date) stated, "Cut all food into 1/4 - 1/2 pieces." Review on 12/2/2020 of client #5's physician orders signed on 11/30/2020 stated, "Diet: Cut all food into approx 1/4 - 1/2 inch pieces." 3. During lunch observations on 12/1/2020, client #6 consumed a microwave bowl of spaghetti. Review on 12/2/2020 of client #6's nursing evaluation dated 1/21/2020 stated, "Diet: Avoid...tomato based sauces." Review on 12/2/2020 of client #6's nutritional evaluation dated 11/8/2019 stated, "Diet: Avoid...tomato based sauce." Review on 12/2/2020 of client #6's physician order signed on 11/30/2020 stated, "Avoid...tomato based sauces." During an interview on 12/2/2020, the facility nurse #1 confirmed clients #1, #5 and #6 diets should have been followed as written.	W 460			
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature.	W 473			

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W 473	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all foods were served at an appropriate temperature. This affected all clients residing in the home. The findings are:</p> <p>Food was not served at an appropriate temperature.</p> <p>During morning observations in the home on 12/2/2020 at 6:57am, Staff B scooped the scrambled eggs into a serving dish, covered them a placed the serving dish onto the kitchen counter. At 7:02am, the serving dish with the eggs where placed on the table. At 7:12am, the serving dish with the french toast was observed on the table. Further observations revealed the clients began eating at 7:35am. At no time where the clients prompted to reheat their food.</p> <p>During an interview on 12/2/2020, Staff B revealed food is allowed to sit out for 30 minutes before it needs to be reheated. Further interview revealed Staff B has never reheated any food for the clients.</p> <p>During an interview on 12/2/2020, Staff A was able to show the surveyor a thermometer which was located in a drawer in the kitchen. Staff A stated food can sit out for 10 minutes before it needs to be reheated.</p> <p>During an interview on 12/2/2020, the program director revealed the food should have been reheated before the clients began eating.</p>	W 473			