STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525330	A. Building B. Wing	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not assure bowel elimination and implement interventions to prevent constipation and fecal impaction for 4 of 4 residents (R1, R2, R3, and R4). The facility does not have a bowel and bladder policy, did not monitor or assess bowel movements, did not develop and implement a care plan related to constipation, R1 did not have documentation of a bowel movement for 5 days (5/11-5/15/21) and was taking narcotics. R1 was hospitalized on [DATE] for treatment of fecal impaction that caused significant pain. R1did not return to the facility. R2 experienced a fecal impaction requiring intervention and the facility did not have a record for her bowel movements for 10 days prior. R3 did not have documentation of bowel movements for 8 days and R3 did not have documentation of bowel movements for 8 days. R4 did not have documentation of a bowel movement multiple days in May. Findings Include: Example 1 Surveyor requested a copy of the facility Bowel and Bladder Policy and Bowel Training Policy. The facility was unable to provide Surveyor with copy of policies prior to leaving the facility. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual for the definition of constipation reads, If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). Surveyor reviewed R1's medical record. R1 was admitted to the facility 5/11/21 with diagnoses that included Rheumatoid Arthritis, Diverticulitis of small intestine without perforation or abscess without bleeding, muscle weakness, chronic pain, and history of bariatric surgery. (continued on next page)

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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F 0690 Level of Harm - Actual harm Residents Affected - Few	Discharge MDS (Minimum Data Set) dated 5/16/21 indicates that R1 is frequently incontinent of bowel and bladder. A staff assessment of cognition indicates R1 is independent - decisions consistent/reasonable. R1 requires limited assistance with bed mobility and transfers, is independent with eating and requires extensive assistance with toileting. MDS assessments under H0600 Constipation present state, No. Note: An admission MDS was not completed as R1 was not in the facility long enough for one to be completed. Surveyor reviewed R1's Admission record which did not indicate a date for R1's last bowel movement. Surveyor reviewed Certified Nursing Assistant (CNA) bowel charting from 5/11/21 to 5/16/21. There are no Bowel Movements charted from 5/11/21 to 5/15/21. On 5/16/21, AM (Morning), NOC (Night) and PM (Evening) shifts all charted M (Medium), 3 (Constipated/Hard). There is no documentation that a nurse was updated. Surveyor reviewed Nurse's Notes for R1 for entire stay in the facility. Daily Skilled Notes do not show that bowel or GI (Gastrointestinal) assessments were documented or completed between 5/11/21 and 5/16/21. Surveyor reviewed Physician orders from admission. Surveyor noted Oxycodone tablet 10 mg (Milligrams). Give 1 tablet by mouth every 4 hours as needed for pain. No more than 6 in a day, Sennosides tablet 8.6 mg. Give 2 tablets by mouth as needed for constipation. Take two tablets PO (by mouth) BID (twice a day) PRN (as needed) for constipation. Note: Surveyor requested a copy of the facility's standing orders. DON (Director of Nursing) indicates that the facility does not have standing orders. Surveyor reviewed Medication Administration Record (MAR) from 5/11/21 to 5/16/21. Sennosides are not documented as being given. Oxycodone was taken as follows: 5/11/21: None 5/12/21: taken at 4:22 PM for pain 5/10 and taken at 8:54 PM for pain 6/10. 5/13/21: taken at 4:06 PM for pain 5/10 and taken at 8:54 PM for pain 5/10. 5/14/21: taken at 4:50 AM for pain 5/10 and taken at 7:05 PM for pain 5/10. 5/15/21: taken at 7:37 AM for pain 9/10, taken at 11:38 AM for pain 8/10, and taken at 5:41 PM for pain 5/10. 5/16/21: taken at 8:50 AM for pain 9/10. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R1's Controlled Drug Use Record for Oxycodone 10 mg. Log indicates R1 took Oxycodone on the following occasions . 5/12/21: 4:16 PM and 9:00 PM 5/13/21: 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM (The 8:00 AM dose and the 12:00 PM dose are not noted in the Nurse's Notes and there is no pain rating for these times.) 5/14/21: 4:45 AM, 9:00 AM, 1:00 PM, 7:00 PM (The 9:00 AM and the 1:00 PM doses are not noted in the Nurse's Notes and there is no pain rating for these times.) 5/15/21: 7:37 AM, 11:38 AM, and 5:35 PM 5/16/21: 8:50 AM Surveyor reviewed Nurse's Notes from 5/11/21 to 5/16/21. There are no notes related to bowel assessments completed, bowel movements charted, PRN medications administered, physician notification of lack of bowel movement, medication effectiveness assessments or interventions completed. R1 called 911 on her own behalf on 5/16/21. Nurse's Note from 5/16/21 at 7:01 PM, states Resident called 911, she was having bowel impaction, though she had medium formed bowel movement on AM and PM shift today. Resident's PCP (Primary Care Provider) was called and updated. Voice message left for her N/P (Nurse Practitioner) and DON was also updated. Surveyor reviewed the comprehensive plan of care for R1 dated 5/11/21. There is no focus area related to constipation, bowel management or monitoring. On 6/01/21 at 11:18 AM, Surveyor interviewed R1. Surveyor asked R1 to tell her about her recent hospitalization from the facility. R1 stated, I reported to numerous CNAs (Certified Nursing Assistance) and I also spoke with a Nurse who did not speak very good English that I was constipated and having pain related to constipation. On the day I was hospitalized staff kept telling me I had a bowel movement but I didn't. I was in so much pain that I started picking the bowel movement out myself. I told the CNA and Nurse I thought I needed to go to the hospital but no one did anything, so I called them myself. I ended up in the hospital for a week due to a fecal impaction. I am currently no longer in the hospital and back at an Assisted Living Facility. I refused to go back to the facility after my hospitalization . On 5/17/21 at 12:30 PM, DON B conducted an interview with CNA C. Surveyor reviewed CNA C's statement which states the following, I took care of R1 on 5/16/21 on both shifts. R1 slept most of both shifts. Call light put on but I answered (sic) (she) the resident requested pain medication. I informed the Nurse, Nurse went right in. The resident did have 2 medium bowel movements one on day shift and one right before she left. Before 911 came I was in the room cleaning up R1 because she had a BM (bowel movement). I had the water running and resident turned on her side. I let her know I was going to get a gown and I would be right back. When I came back I seen 911 coming towards door and a co-worker and I cleaned her up. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 6/01/21 at 12:09 PM, Surveyor interviewed CNA C. CNA C stated, I worked with R1 on 5/16/21. R1 refused both her morning and afternoon meals and stated she was impacted and thought she needed to go to the hospital, which I reported to both the day shift and PM shift Nurses. R1 complained of being constipated but I told her she had a bowel movement. R1 had stool on her hands and fingers and I thought she was playing with her stool. I told the Nurse R1 stated she was constipated but she had a bowel movement. Surveyor asked if it was possible R1 was trying to digitally remove stool and didn't actually have a bowel movement. CNA C stated, Yes, I just thought she was a digger. She told me she was in pain and wanted to go to the hospital and I reported that to the Nurse. Note: CNA reported to the Nurse on both the day shift and PM shift that R1 thought she needed to go to the hospital for what she believed to be a fecal impaction. On 6/01/21 at 2:32 PM, Surveyor interviewed DON B. DON B stated, I am aware of the concerns with R1 and R2 that is why I started a QA (Quality Assurance) and educated staff on documentation of bowel movements. I completed interviews with staff working at the time. I am not aware of any current noncompliance. Audits are randomly being done to monitor documentation. Surveyor asked DON B if it is an expectation that bowel movements are documented daily and reviewed by the Nurses. DON B stated, Yes, that is why I started the QA. On 5/17/21 at 3:00 PM, DON B conducted an interview with LPN D. Surveyor reviewed LPN D's statement which states the following, Resident informed nurse she had a medium BM and she felt as if it should have been more. Nurse went to med (medication) cart and CNA went to her room, before I can make it back around the next thing I knew 911 was in his (sic) room. During the shift resident only requested pain medication never stated or informed nurse she wanted to go to the hospital. On 6/01/21 at 2:40 PM, Surveyor interviewed LPN D. Surveyor asked LPN D about R1 and her hospitalization . LPN D stated, I didn't fill out the interview. I informed the DON of what happened and she wrote it and I signed it. I did review what she wrote prior to signing and it was accurate. R1 called and said she needed me. She stated she felt she should have more of a bowel movement. I informed R1 I would come and assess her but before I could do that CNA C reported R1 had another medium bowel movement that was formed. The person that gave me report also stated stool was formed. The person giving me report did not indicate stool was constipated or hard. R1 did not report pain for that day to me. LPN D also states staff are to report bowel movements to the next shift, sometimes it is missed and then we should look in the charting. Surveyor asked LPN D if CNA C reported R1 had stool on her hands and fingers. LPN D stated, No. I offered R1 a stool softener but the EMS (Emergency Medical Service) was already here and she refused and wanted to go to the hospital. The CNA should have let me know R1 had stool on her hands and fingers as that would be new for this resident and indicate something was wrong. Surveyor asked if CNA C reported R1 wanted to go to the hospital. LPN D stated, No, she never told me that. On 6/01/21 at 3:39 PM, Surveyor conducted an interview with NHA A. Surveyor asked NHA A who was in charge of QA (Quality Assurance) and if aware of QA done for R1 and R2. NHA A stated, I think there was just constipation stuff not impaction. The QA Plan will be ongoing without an end date but we would like to see improvement within a month. Last week we had an in-service on documentation in POC (point click care). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 6/01/21 at 4:45 PM Surveyor interviewed MDS Coordinator (MDS Coor) F. Surveyor asked MDS Coor F where the information is gathered from that is entered into the MDS, and specifically Section H: Bowel and Bladder, question H0600, if constipation was present. MDS Coor F stated he would use the 7 day look back period. The assessment date of 5/16/21 would mean information would be gathered from 5/11/21 to 5/16/21 otherwise known as the rule of 7. Information is gathered from ECS including nursing notes and assessments. Surveyor asked what other methods would are used to gather information to make this assessment. There was no documentation provided to support H0600 marked No for constipation present. MDS Coor F also stated that she was hospitalized herself during this time and was completing the MDS from the hospital. Note: R1 was only in the facility for 6 days so a true 7 day look back period was not available to MDS Coor F. Note: Surveyor called hospital on 12 separate occasions to request R1's records but was unable to reach anyone and a return call was never received. Surveyor also attempted to call EMS (Emergency Medical Services) and a call was also not received back from them. The DON also attempted to get records for Surveyors without success. On 5/17/21 an in-service was completed and 23 CNA's and Nurses attended. The in-service form indicates the following Topic: Understanding the importance of reporting and recording residents Bowel Movement. Nurses should view the dash board Q (every) shift to ensure alerts are noted and documented. CNA's should document in the POC and report any abnormal findings to the nurse. Describe Information Provided: Understanding constipation and Fecal Impaction. See attached. Regular monitoring with stool charting prevents constipation, urinary retention and delirium in elderly patients. Note: There are no forms that would have been provided during this in-service in the facility QA folder. Note: There are 52 CNA's and Nurses listed on the facility staff listing. DON B provided Surveyor with a copy of what she indicates staff were educated on 5/17/21. This document states in part . Alerts are intended to show when they are truly important to resident well-being and care. Too often we see them due to inaccurate documentation or lack of documentation. Do's: 1. Document on all scheduled or times tasks every shift. PRN bricks are only to be documented on if that task was completed. They should remain white if not utilized. 2. Check with each resident toward the end of shift that you did not already chart on to ensure if they had a BM. 3. Document Resident Not Available only at end of shift if the resident was truly not available for your entire shift and therefore the only answer you could give. DON'T: 1. Do not document on PRN (as needed) task brick unless you did the task and need to chart it - these DO NOT have to 'go-green.' Staying white will not affect your compliance and is the correct thing to do so you do not trigger alerts. 2. Do not use N/A (not applicable) unless that is truly the answer. Very rarely would that be the correct answer. 3. Do not document 'Resident Not Available' or 'Activity did not occur' at the beginning of a shift as the proper time to indicate these is (sic) at the end of a shift if not able to observe or complete that task. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The facility has audits dated 5/18, 5/19 and 5/25/21. These audits indicate the following: 5/18/21, Clinical Dashboard Reviewed, No. Any resident's alerts triggering for NO BM'S, NO. QA/QI review completed by: (Surveyor unable to read initials or what initials are written). 5/19/21, Clinical Dashboard Reviewed, Yes. Any resident's alerts triggering for NO BM'S, yes. FB flagged on 5/19 but had to BM. QA/QI review completed by . (Surveyor unable to read initials or what initials are written). 5/25/21, Clinical Dashboard Reviewed, Yes. Any resident's alerts triggering for NO BM'S, yes. FB flagged on 5/25 but had BM 5/25. QA/QI review completed by . (Surveyor unable to read initials or what initials are written). 36253 Example 2 R2 was admitted to the facility on [DATE]. A physician progress note, dated 5/4/21 following a video visit, stated R2 was having issues with constipation and had been taking Miralax three times per week and Senna daily to assist with relief since her admission. R2's MAR (Medication Administration Record) shows R2 was given the Miralax and Senna as ordered since her admission to the facility. Surveyors attempted to speak with R2 on 6/1/21, but she was unable to provide any information regarding her bowel regimen or history of constipation. Facility documents resident bowel movements on both its POC (Point of Care) system and the MAR. R2 was documented as having no bowel movements on both the POC and MAR between 5/4/21 and 5/14/21. A facility progress note, dated 5/14/21, states Therapy approached stating that the resident isn't feeling well. She is having weakness and unable to stand and also altered mental status change. Resident states she is tired and would like to go home. The facility notified R2's physician who gave the facility orders to send to the hospital for evaluation. R2 was admitted to the hospital on 5/14/21 and was discharged on [DATE]. The discharge summary report from the ED (Emergency Department) states, Abdominal CT revealed large colonic/rectal stool burden and very distended urinary bladder with possible bladder outlet obstruction. Patient was manually disimpacted (removal of stool from the rectum) in ED and a Foley catheter was inserted. Upon return to the facility on [DATE], the facility incorporated a bowel regimen as prescribed by the hospital and bowel movements have been tracked indicating R2 has had a bowel movement at least every other day through 6/1/21. On 6/1/21 at 4:30 PM, Surveyor interviewed DON B (Director of Nursing). DON B stated the bowel movements for R2 would only appear in the MAR and POC and there is no other record of bowel movements. DON B also stated the facility had identified concerns with charting bowel movements and conducted in-service training with nursing staff on 5/17/21. DON B stated she had no way of verifying if, in fact, bowel movements were taking place prior to 5/17/21 and not being documented or if residents were truly constipated for long periods of time. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Example 1 and Example 2 deficiences are being cited at Actual Harm. Example 3 R4 was admitted to the facility on [DATE] with diagnoses in part . Anxiety disorder, muscle weakness, limitation of activities due to disability, and dizziness and giddiness. 5-day MDS (Minimum Data Set) dated 5/11/21 indicates that R4 has a BIMS (Brief Interview of Mental Status) score of 10, indicating that R4 has moderate cognitive impairment. R4 is occasionally incontinent of bladder and always continent of bowel. R4 requires extensive assistance of one with bed mobility, limited assistance of two staff for transfers and toileting and independent after set-up for eating. MDS assessments under H0600 Constipation present is not completed. Surveyor reviewed Certified Nursing Assistant (CNA) bowel charting from 5/22/21 to 5/31/21. There is no Bowel Movements charted from 5/22/21 to 5/26/21 and 5/29/21 to 5/31/21. On 5/28/21 it is charted that R4 had M (Medium), 1 (Formed/Normal). There is no other documentation indicating that a Nurse was notified on any occasion that R4 had went multiple days without having a BM or without BM charting. Surveyor reviewed R4's eMAR (Electronic Medication Administration Record). Surveyor noted Senna Tablet 8.6 mg (Sennosides), Give 1 tablet by mouth one time a day for constipation, ordered 5/05/21. Surveyor reviewed the comprehensive plan of care for R4 dated 3/17/21. There is no focus area related to constipation, bowel management or monitoring. 42482 Example 4 R3 was admitted on [DATE] with diagnoses of diabetes, cellulitis of the right lower extremity, left below the knee amputation, congestive heart failure and generalized muscle weakness. R3's MDS (Minimum Data Set), a comprehensive assessment of R3's functional status and capabilities completed on April 2, 2021 indicates he was continent of bowel and bladder and had a BIMS (Brief Interview of Mental Status) score of 15. BIMS scores of 13-15 indicate an intact cognitive response. R3's health record indicates in the documentation form entitled, 'Survey report for bowel and bladder care' that during the period of May 23-May 31, 2021 (9 days), R3 did not have a bowel movement (BM). Per the instructions on this recording tool, which was initiated on 11/25/15, staff are supposed to record every shift (shift being 8 hours) whether a resident had a BM or not. Staff are also supposed to document size, consistency and number of BM's every shift. Of the 93 opportunities in May to record this information, staff failed to document anything 21 times or 21.4% of the time for R3. On 6/1/21 at 1:30 PM, Surveyor asked DON B, for the facility policy regarding bowel regimes, standards of care and/or standing orders for constipation? DON B replied, We don't have a policy on bowel regimes or standing orders for constipation. Surveyor asked DON B, how do you know when someone is developing constipation? DON B answered, It comes up as an alert on our electronic health record (EHR). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Surveyor was unable to locate the 'alert' indicating R3 had not had a BM in R3's health record. On 6/2/21 at 3:15 PM, Surveyor asked DON B, regarding the facility process that alerts the nurses a resident has not had a BM? DON B indicated, The CNA's (certified nursing assistants) record the BM's. If it has been more than three days, the EHR sends an alert to the nurse. The nurse should then follow up. Surveyor stated an alert on R3's record was not found and R3 has went 10 days without a BM. Surveyor showed DON B the BM tracking record within R3's record. DON B replied, Sometimes, R3 transfers himself to the toilet and has a BM, therefore, nothing is charted. Surveyor asked DON B, what the expectation is for CNA's regarding BM documentation. DON B answered Part of the education I am providing is to document BM's but it is hard to get everyone on board. Surveyor asked DON B, do you expect staff to chart per the instructions on the documentation form that includes size, number and consistency of BM every shift? DON B replied, Yes. Surveyor asked DON B, regarding the alert for R3's record that there has not been a BM. DON B indicated, she did not see the alert for R3. Surveyor asked, can indicate in R3's health record where the nurses interviewed the resident to determine if R3 had a BM in the last 9 days? DON B answered, No. Surveyor asked DON B, per the facility's tracking, should an alert have been generated in the EHR? DON B answered, Yes. Surveyor asked, if R3 did or did not have a BM, should this have been charted? DON B replied, Yes. Surveyor asked DON B, if the resident did not have a BM, should the nurses have followed up, interviewed, assessed the resident and informed the physician? DON B, indicated Yes. Surveyor asked DON B, what policy or standard of care does the facility use if a resident hasn't had a BM or is developing constipation? DON B replied, We don't have a standard of care or policy, we use the alert on the EHR. The CNA is supposed to ask the resident and chart, not just leave it blank. R3 takes himself to the bathroom so I know he is not constipated. Surveyor asked DON B, what about nonverbal residents, how would you determine they are constipated or impacted without accurate charting, without the resident's self-report, without a facility process for follow up, assessment or physician notification? DON B replied, I am doing education so there is better charting. Surveyor asked DON B, if the record was accurate, what standard of care or process would a nurse follow to assist R3 who hasn't had a BM in 9 days? DON B answered, We don't have a standard of practice or policy regarding this; we have the alert in the EHR. On 6/1/21 at 3:30 PM, Surveyor interviewed R3 if he is bothered with constipation. Surveyor asked R3, has constipation been an issue for you? R3 replied, I don't have constipation. I use Miralax (an osmotic laxative which pulls water into the colon to make stools softer and easier to pass) about every third day and don't have any trouble at all. Surveyor asked R3, have you had any periods of time when you didn't have a BM for 5-8 days? R3 stated, Never, never gone that long without a BM. Surveyor asked R3, about his medications in particular the narcotics ordered for pain and they can cause constipation; do the narcotics control your pain? R3 answered, I rarely have pain, and I don't use the narcotics. Surveyor asked R3, but you do use the Miralax? R3 replied, Yes, about every 3 days, I'm on water pills and not moving around as much as I should, it slows me down in that department. Of note, Surveyor reviewed R3's medication administration record (MAR) for May 2021. Miralax was recorded as given one time, on 5/3/21 at 07:49 AM. R3 had an order for Miralax and Senna-Docusate (laxative-stool softener combination medication) initiated on 2/9/21 for constipation.

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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)
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 36253 Based on observation and interview, the facility did not provide meals at regular times comparable to normal mealtimes in the community. This has the potential to affect all 71 residents. Residents received their lunch meal two hours late. On 6/1/21 at 2:30 PM, Surveyors observed facility CNAs (Certified Nursing Assistants) passing out meals down a resident hall. At 2:30 PM, Surveyor interviewed CNA G who stated he just arrived at the building for his PM shift and saw the cart of fluids and the meal cart and he and CNA H just began passing out meal trays. CNA G stated he did not know how long the carts had been sitting in the hall. Surveyor then interviewed CNA H who stated she primarily works PM shift, and she has had to pass out lunch trays to start her shift around 3 or 4 times in the past month. Surveyors interviewed multiple residents while trays were being passed out: At 2:31 PM, R5 stated he had just got his food, it was cold and the lunch meal is late half of the time. At 2:32 PM, R6 stated he had just gotten his tray and it was cold. At 2:34 PM, R7 stated she just received her meal, but lunch is usually served before 1:00 PM. At 2:36 PM, R8 and R9 stated they had received their meals in the last 5 minutes, but on most days lunch is received at around 12:30 PM. On 6/1/21 at 3:00 PM, Surveyor interviewed DM F (Dietary Manager). DM F stated the trays had just left the kitchen for the wing just before 2:30. DM F stated the kitchen was struggling to keep up with staffing. Although she had staff, she did not feel the kitchen had enough well-trained staff to complete certain tasks. DM F stated the turkey that was on the lunch menu had not been pulled from the freezer the night before in order to thaw. DM F noticed it had not been pulled earlier that morning when she arrived and, therefore, was unable to get meal trays out in time due to the delay in thawing. DM F stated the goal is to get lunch meals out to the resident wings by 12:30 PM.