STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Andover	80 Andover Street Andover, MA 01810

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation and interview, the facility failed to provide a homelike environment in two resident rooms on the second floor. Specifically, the facility failed to 1. repair a broken overhead light and 2. failed to maintain hot water temperatures in a resident bathroom. Findings include: 1. During a family interview on 8/7/24 at 10:49 A.M., the family member said that the overhead bed light in room [ROOM NUMBER] was not working and that she has notified staff before. During an observation on 8/7/24 at 12:02 P.M., the surveyor attempted to turn on one of the overhead bed lights in room [ROOM NUMBER]. The light did not work. 2. During an interview on 8/6/24 at 8:15 A.M., one Resident said that his/her bathroom water was lukewarm and not getting hot. The Resident said that this has been an issue that the hot water has not been working for some time and he/she has notified staff. During an observation on 8/8/24 at 8:01 A.M., the surveyor obtained a hot water temperature of 68 degrees Fahrenheit from the sink in room [ROOM NUMBER]. During an interview on 8/8/24 at 8:15 A.M., the Maintenance Director was made aware of the broken light and the hot water temperature. The Maintenance Director said that staff are responsible for reporting broken equipment into their online reporting system and that he would input the repairs into the system and look at both issues. The Maintenance Director said he was not aware of the two issues.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded to reflect the status of one Resident (#70) out of a total sample of 19 residents. Specifically, two comprehensive MDS assessments failed to code Resident #70 with obvious or likely carious or broken natural teeth. Findings include: Resident #70 was admitted to the facility in November 2023 with diagnoses including chronic obstructive pulmonary disease, transient cerebral ischemic attack (stroke), anxiety and mood disorder. Review of the most recent MDS, dated [DATE], indicated Resident #70 scored a 13 out of 15 on the Brief Interview for Mental Status exam, indicating he/she is cognitively intact. During an observation and interview on 8/6/24 at 8:49 A.M., Resident #70 was observed to have missing lower teeth and some partial teeth. Resident #70 said his/her bottom teeth have been broken and missing since he/she came here. Review of Resident #70's medical record indicated the following: -A nursing assessment dated [DATE] indicated nursing staff assessed Resident #70 as having broken or carious (decayed) teeth. -An oral assessment dated [DATE] indicated nursing staff assessed Resident #70 with the presence of broken/missing teeth. Review of the MDS comprehensive assessments, dated 11/15/23 and 7/3/24, at Section L, oral/dental status, indicated Resident #70 as not having obvious or likely cavity or broken natural teeth. The two MDS assessments conflict with the nursing assessments of Resident #70's oral/dental status. During an interview on 8/7/24 at 4:09 P.M., the MDS nurse said Resident #70 is on a soft diet, is assisted with oral hygiene and does not have pain. The MDS nurse said the MDSs dated 11/11/23 and 7/3/24 do not match the nursing oral assessment for Resident #70 and need to be modified to reflect Resident #70's status.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview the facility failed to ensure for one Resident (#15), out of a total sample of 19 residents, was referred for a Preadmission Screening and Resident Review (PASARR) evaluation (an evaluation to determine if a resident needs specialized services to address his/her Serious Mental Illness (SMI) once it was identified the Resident had a new diagnosis of schizoaffective disorder. Findings include: Review of the MassHealth Nursing Facility Bulletin 186, dated June 2024 indicated the following: Definition: Level I Screening- A preliminary screening of all nursing facility applicants, regardless of payer source, conducted prior to their admission to a nursing facility, as required by federal PASARR regulations at 42 CFR 483.100 et seq. using the Level 1 Screening Form. A level 1 Screening identifies whether an applicant has, or is suspected of having, ID (intellectual Disability), DD (Developmental Disability), and/or SMI (Serious Mental Illness). C. Postadmission Level II Evaluations for Individuals with SMI. 1. A nursing facility must ensure an individual who has or is suspected of having an SMI is referred to DMH (Department of Mental Health) PASARR, accordance with Section 3. A for a post-admission Level II Evaluation (I.e. Resident Review) in the following instances: b. When an individual who resides in a nursing facility has experienced a significant change or the individual is newly identified as having a condition that may impact the individuals PASARR disability status, the appropriateness of the individual's nursing facility placement, or the individual's need for specialized services and/or Behavioral Health Services. Resident #15 was admitted to the facility in February 2020 with diagnoses that include, but are not limited to, chronic obstructive pulmonary disease, chronic pain syndrome and anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #15 scored a 9 out of 15 on the Brief Interview for Mental Status exam, indicating he/she had moderately intact cognition. Review of Resident #15's medical record indicated the following: -A Physician's order note dated 4/5/2022, NP (Nurse Practitioner) in today-new order to add dx (diagnosis) Schizoaffective disorder. Medical diagnosis list updated. The diagnosis of Schizoaffective disorder was added after Resident #15 was admitted to the facility. -A Social Services Note, dated 4/5/2022, note text: SW (social worker) offered supportive check-in to resident today. He/She presented with baseline paranoia but was redirectable with supportive discussion. He/she expressed concern that he/she may experience auditory hallucinations recently and confirmed plan to follow-up with Psych NP (Nurse Practitioner). SW will continue to follow. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documents provided by the facility Social Worker indicated a Level 1 PASRR dated 2/10/20 was incomplete. A second Level PASRR dated 12/3/20 indicated the Serious Mental Illness Screening indicated Resident #15 had a negative SMI screen. Review of the MDS dated [DATE] at Section I documented Resident #15 with psychotic disorder, other than schizophrenia. Review of the MDS dated [DATE] at Section I documented Resident #15 with Schizophrenia (e.g. schizoaffective, schizophreniform) Review of the clinical record failed to indicate a referral for a PASRR was completed with the onset of the diagnosis of Schizoaffective disorder. During an interview on 8/07/24 at 10:10 A.M. Social Worker (SW) #1 said a PASRR referral is triggered if a resident presents after admission with a change due to mental illness, has a new diagnosis that may impact them and create limitations. During a subsequent interview on 8/07/24 at 11:20 A.M., SW #1 said the PASRR dated 12/3/20 was negative for SMI. SW #1 said that Resident #15 is seen by the facility's psychological services provider for the diagnosis of schizoaffective disorder and symptoms of paranoia and delusions. SW #1 said they (she and SW #2) are working on a submitting a PASRR for Resident #15

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure for one Resident (#39), out of a total sample of 19 residents, that newly identified skin injuries, including an open skin area, was reported to the physician or the nurse practitioner, that the open area was measured, and that a treatment order was obtained to treat the open area. Findings include: Review of facility's policy titled: Wound Documentation effective 3/11/13 indicated Goal: To ensure appropriate wound documentation is recorded in the patient/resident medical record. Policy: 1. The facility will document notification of the physician, patient/resident and /or responsible party at the onset of a new wound or the deterioration of an existing wound. Procedure: 2. At the onset of a new wound, the nurse will initiate a weekly flow sheet (pressure or non-pressure) for each new wound. Policy titled Wound NTASureiment (sic) dated 3/11/13 indicate the patient/resident plan of care will be developed at the onset of each wound and will be revised as necessary. Policy: the facility will obtain measurements at the onset of a new wound. Resident #39 was admitted to the facility in February 2022 and has diagnoses that include, but are not limited to, venous insufficiency, adult failure to thrive, dementia, and moderate protein calorie malnutrition. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a score of 14 out of 15 on the Brief Interview for Mental Status exam indicating Resident #39 as cognitively intact and requires dependence on staff for bathing, toileting and dressing. Further review of the MDS indicated Resident #39 was at risk for developing pressure ulcers. Review of Resident #39's medical record indicated the following: -A care plan dated as initiated 2/10/2022, Resident has potential for skin breakdown r/t (related to) impaired mobility, has low weight, incontinence, has contractures to LE (lower extremities). Interventions included *Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration, etc. to MD (medical doctor) -A Norton Scale for Predicting Pressure Ulcer Risk dated 3/20/24 and 6/12/24 with scores of 10, which indicates a high risk for developing pressure ulcer. -A physician's order, weekly skin assessment due Friday on 7-3 shift, dated 2/10/24. Review of the weekly skin check dated 7/12/24 indicated Resident #39 had a right trochanter (hip) open area and the left trochanter (hip) redness. The document had the following questions: 3. If new areas noted what interventions were implemented? 4. Was the wound team notified? Both questions were left blank. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress notes failed to indicate the areas on Resident #39's right and left hip were reported to the physician, were measured, or that a treatment was implemented. During an interview on 8/8/24 at 8:34 A.M. and 9:39 A.M., Unit Manager (UM) #1 said if a resident is identified with any skin injuries including pressure injury, the nurse notifies the physician and gets orders for a treatment. UM #1 said they also will consult with the wound doctor and investigate the cause of the skin injury. UM #1 said he would also be notified on an open area. During an interview on 8/8/24 at approximately 9:50 A.M., the Assistant Director of Nursing (ADON) said when a nurse identifies a new skin injury or pressure area the nurse calls the doctor to get a treatment order, fills out an incident report packet, and she gets notified. The ADON said this was not done in the case of Resident #39. Review of the medical record failed to indicate the MD/NP was notified of Resident #39's right trochanter (hip) open area and the left trochanter (hip) redness when it was identified on 7/12/24.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to implement the use of a hand splint in accordance with the rehabilitation plan of care for one Resident (#70), out of a total sample of 19 residents. Findings include: Review of the facility's policy with the subject Splints/Orthotics, dated February 2022, indicated Therapy will issue appropriate positioning splints/orthotic determined by patient needs. Purpose Splints or orthotic devices are those which are given to maintain range of motion, enable proper joint alignment, promote good skin integrity and hygiene, enhance functional ability and prevent further deformity. These include but are not limited to: splint, palm protectors, elbow and knee braces, ankle/foot orthotics etc. Procedure: 1: Order for OT (occupational therapy) or PT (physical therapy) evaluation and treatment will be obtained, and evaluation completed to determine the proper positioning device. 2: Splints or orthotics will be issued by an OT/PT or MD (medical doctor) and PT/OT will complete assessment and treatment to ensure proper plan of care is established. 3: Nursing staff will be in-serviced on proper application, wearing schedule, care and precautions related to the device being issued. The charge nurse will provide additional in-service to staff as needed. 4: The charge nurse will put the splint schedule on the CNA (certified nursing assistant) cardex and flow sheet. 5: The splint schedule will be put on the nursing cardex and monitored each day by nursing. 6: the splint schedule will be included on the resident plan of care. 7: If there is a problem with a device, the charge nurse or rehab department should notify of the specific problem. A screen form will be initiated by nursing and sent to the rehab department for follow up. Resident #70 was admitted to the facility in November 2023. Resident #70 has diagnoses that include, but are not limited to chronic obstructive pulmonary disease, transient cerebral ischemic attack, mood disorder, traumatic subarachnoid hemorrhage without loss of consciousness and hemiplegia unspecified affecting left nondominant side. Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #70 scored a 13 out of 15 on the Brief Interview for Mental Status exam, indicating he/she is cognitively intact. Further, the MDS indicated Resident #70 was dependent on staff for toileting, bathing and dressing. During an observation and interview on 8/6/24 at 8:49 A.M., Resident #70 was observed with his/her left arm and hand resting on a pillow. Resident #70 said he/she has a left-hand splint with Velcro and that some staff get frustrated putting on the left-hand splint. During an interview and observation on 8/6/24 at 4:44 P.M., Resident #70 was observed resting in bed. Resident #70's left arm/hand was resting on a pillow/wedge. A hand splint was on his/her bedside table. A sign above Resident #70's bed indicated hand splint on at evening and off in A.M. Review of Resident #70's medical record indicated the following: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*No physician's order for the donning or doffing or schedule for the use of a left-hand splint. *The Treatment Administration Record (TAR) and Medication Administration Record (MAR) dated for 6/2024, 7/2024 and 8/2024 did not indicate the use of a left-hand splint, including a donning and doffing schedule. *The Kardex (a document which details a summary of a resident's care needs) failed to indicate the use of a left-hand splint, or a schedule for the use of the splint. *The Care Plans dated prior to 8/8/24 did not indicate the use of a left-hand splint. During an interview on 8/7/24 at 8:50 A.M., the Assistant Director of Rehabilitation (ADOR) said Resident #70 uses a left-hand splint at night and is currently being trialed for left-hand splint use during the day and remains on skilled occupational therapy services. During further interview on 8/7/24 at 8:56 A.M., the ADOR said Resident #70 had a change of status in May and that Resident #70's left side including his/her upper extremity was impaired. The ADOR reviewed Resident #70's medical record and said there was no physician's order for the left-hand splint. The ADOR said an order is typically entered for the use of a device and that she was not sure if nursing staff document the donning or doffing of the left-hand splint. Review of the document the ADOR provided, titled Care Plan Updates, dated 6/26/24 and signed by the therapist and nurse, indicated the following: -A splint will be applied to L (left) Hand at bedtime and remove during A.M. care. Sleeping Splint. The education provided indicated: *please place isotoner glove on left hand at noc (night), followed by L hand splint. Remove both with A.M. care. The document was signed by five CNA (certified nursing assistant) staff. Review of the Occupational Therapy OT Recert Progress Report and Updated Therapy Plan, with a certification period of 7/23/24-8/23/24 indicated Goal #6.0-continue Pt/caregiver will demonstrate 100% competency of proper donning/doffing splint, splinting PM schedule, and skin checks in order to maintain joint/skin integrity to improve QoL (Quality of Life) During an interview on 8/7/24 at 3:20 P.M., CNA #1 said Resident #70 wears a leg and hand splint at night and that he was educated on how to put it on and that he only works to 7:00 P.M. CNA #1 said when he comes back to work the next morning the hand splint is sometimes off. CNA #1 said he did not know where the use of the splint is documented. During an interview on 8/7/24 at 3:24 P.M., Nurse #1 said Resident #70 has worked with OT and PT and has made some gains after he/she suffered a stroke. Nurse #1 said devices used are put in as physician orders, the CNAs put on the device and the nursing staff document the use on the TAR. Nurse #1 said there was no order that she could see for the use of a left-hand splint for night use. During an interview on 8/7/24 at 3:33 P.M., Unit Manager #1 said Resident #70 was to use a left-hand splint at night and that it never got on the orders and therefore there was no documentation to ensure it was being completed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24 3:49 P.M. Occupational therapist #2 said that she began treating Resident #70 a few weeks ago when the other treating OT left. OT #2 said she has treated the Resident three for four times. OT #2 said she is trialing the use of a day splint, that there were occasions that the Resident removed the splint him/herself. OT#2 said she did not discontinue the night splint during the trials because he/she did not want the Resident to have nothing and would benefit from using the splint. OT #2 said CNA staff can don and doff the splint once there is an order and education is provided. OT #2 said the Resident said that staff do not always put on the splint.

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F 0690 Level of Harm - Minimal harm or potential for 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** 36431 Based on observation, record review, and interview, the facility failed to ensure the catheter bag for one Resident (#14) was off the floor to prevent potential contamination, out of a total sample of 19 residents. Findings include: Review of the facility's policy titled Foley Catheter Care, Date May 1, 2022, reviewed 2023 indicated the following: - A foley catheter is a closed urinary drainage system consisting of a Foley catheter with a balloon at the distal end to secure it in place inside of the bladder. - The Foley catheter is attached to a collection bag making it a closed system. The system should not be broken unless there is a specific reason such as changing the collection bag. - The following policy provides guidance related to MD orders necessary for the care and maintenance of a Foley Catheter. The MD may write additional orders if there is a specific resident need. Policy: It is the policy of this facility to maintain MD orders for the care and maintenance of a foley catheter. The MD orders will include: 1. When the foley is to be inserted. 2. The size of the foley lumen. 3. The size of the foley balloon. 4. Catheter care once each shift including: Checking the foley for patency * Checking the foley position * Checking the condition of the urine noting presence of sediment and urine color. * Perineal care * Wash perineum with warm soapy water, rinse well and dry well. 5. MD order will indicate if the foley may be irrigated with 50cc of normal saline if there are signs of blockage. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* This would include be increase in sediment and decrease in urine being collected. 6. MD order will indicate if the foley may be changed if a clog is not relieved with irrigation. 7. MD order will indicate when to change the collection bag. * Note: there is no specific timeframe for changing the collection bag. It should be changed when it has become soiled inside with sediment or outside from another source. 8. Foley collection bags should be emptied once each shift. The amount emptied should be recorded in the resident's clinical record. Resident #14 was admitted to the facility in November 2020 with diagnoses that include but are not limited to hemiplegia and hemiparesis following a cerebral infarction affecting left non-dominant side, benign prostatic hyperplasia with lower urinary tract symptoms. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #14 scored a 15 out of 15 on the Brief Interview for Mental Status which indicates he/she is cognitively intact, require substantial/maximal assistance from staff for dressing, is dependent for toileting and did have behaviors. Further the MDS indicated Resident #14 has an indwelling catheter for urinary output. During the survey the following observations were made by the surveyor. On 8/06/24 at 9:04 A.M. Resident #14's was in his/her bed. The urinary drainage bag was on the floor on his/her right side of the bed. The drainage bag was opaque, not covered, and was bulged. Resident #14 said staff empty around it 5 in the morning and that he/she did not place it on the floor and could not physically place it on the floor. On 8/6/24 at 9:56 A.M., Resident #14 was in his/her bed and the urinary drainage bag was on the floor. On 8/7/24 at 8:19 A.M., Resident #14 was in bed. The bottom of the urinary drainage bag was resting on the floor. On 8/08/24 at 6:51 A.M., Resident #14 was in bed. The urinary drainage bag was on the floor on the right side of his/her bed. At this time Certified Nursing Assistant (CNA) #2 came in the room and observed the urinary drainage bag on the floor and said the bag should not be on the floor and should be hung higher on the side of the bed. CNA #2 said the bag may have moved when the bed was moved. During an interview on 8/08/24 at 8:47 A.M., Unit Manager (UM) #1 said the urinary collection bag should not be on the floor, that the Resident does use the bed control and moves his/her bed and that could be why the urinary collection bag was on the floor. UM #1 staff should monitor the position of the urinary collection bag.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41019 Based on observation and interview, the facility failed to serve food that is palatable and at a safe and appetizing temperature. Findings include: Review of the facility's policy titled, Palatability dated effective 6/29/20 indicated Purpose: -Ensure food has an appetizing aroma and appearance. -Food is served at a preferable temperature (hot foods served hot and cold foods served cold). During the resident group meeting on 8/7/24 at 10:02 A.M., 4 out of 6 participating residents said that the food served is always cold and bland. During a test tray conducted on 8/7/24 at 12:12 P.M., the following was observed: - The milk temperature was 50 degrees Fahrenheit. - The sweet potato was 100 degrees Fahrenheit and tasted lukewarm, and was sitting in water on the plate. - The ham was 90 degrees Fahrenheit, tasted lukewarm, and was sitting in water. - The zucchini squash was 100 degrees Fahrenheit and was very soft, not strained, and in liquid. 46339 A test tray was completed on 8/7/24 at 1:00 P.M., of the 1st floor unit the following temperatures were recorded: -Ham was 115 degrees Fahrenheit and tasted lukewarm and watery. -Sweet potato was 130 degrees Fahrenheit and tasted watery. -Zucchini was 127 degrees Fahrenheit and tasted bland and watery. -Yogurt was 53 degrees Fahrenheit. -Chocolate cake was 74 degree Fahrenheit. During an interview on 8/7/24 at 4:37 P.M., the findings of the test trays was shared with the Food Service Director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225558	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Andover	80 Andover Street Andover, MA 01810

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36431 Based on observation, record review and interview the facility failed to ensure proper food handling practices to prevent cross contamination during the meal distribution service in the kitchen. Findings include: Review of the facility's policy titled Handwashing-Glove, manual Dietary Services, dated 9/14/20 indicated the following: Purpose Guidelines for hand washing and glove use to promote safe and sanitary conditions throughout the department. Hand washing procedure- 1. Hand washing is a priority for infection control. 2. Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food substances. raw chicken to fresh fruit, following contact with any unsanitary surface i.e. touching hair sneezing opening door etc. Gloves 1 Gloves will be worn/changed when: a) handling raw meats poultry, and fish/seafood. b) handling ready-to-eat foods. C) transitioning from one task to another including raw to ready-to eat food prep, leaving the work area and returning, using rest room and returning, potentially touching a contaminated surface and returning to work duties. 2) When gloves are used, hand washing must occur per above procedures prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed, see above. Gloves may be used for one task only. During the lunch meal distribution in the kitchen on 8/7/24 at 11:41 A.M., the following was observed: After recording the temperature of the food [NAME] #1 removed her gloves from both hands and, without hand hygiene, placed new gloves on both hands and proceeded to gather utensils for the food. [NAME] #1 touched the top of the cover to the pan on the back stove, potentially contaminating the gloves, then using her gloved hands, directly removed green salad mix and placed it on a plate. -At 12:00 P.M., [NAME] #1 used her gloved hands to pick up salad greens and placed them directly on the plate. -At 12:08 P.M., [NAME] #1 used her gloved hands to pick up salad greens and place directly on the plate. [NAME] #1 then touched the pan cover on the back oven with her gloved hands. -At 12:17 P.M. [NAME] #1 placed her gloved hand inside a bag of rolls and removed a roll and placed it on a plate. -At 12:19 P.M., [NAME] #1 used her gloved hands to place salad greens on a plate then used the same gloved hand to reach into a bag of rolls and removed a roll and placed it directly on the plate. During an interview on 8/7/24 at 2:13 P.M., the surveyor told the Food Service Director (FSD) the observation that were made during the meal distribution. The FSD said hand washing should occur before putting on gloves and food should not be touched directly to prevent cross contamination.