STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045442	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cavalier Healthcare of England	400 Stuttgart Highway England, AR 72046

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on record review and interview, the facility failed to ensure a resident’s family member serving as Power of Attorney was invited to participate in a care plan meeting for one (Resident #13) of three residents reviewed for care plans. The findings include: A review of Resident #13’s admission Record indicated the facility admitted the resident on 10/20/2023, with diagnoses which included Alzheimer’s and dementia. The admission Record indicated the resident had a designated Power of Attorney (POA) when admitted . A review of Resident #13’s quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 04/28/2025 revealed the resident had a Brief Interview for Mental Status score of 04, which indicated severe cognitive impairment. A review of Resident #13's Care Plan, initiated on 11/27/2023, revealed the resident had impaired cognitive function, dementia or impaired thought processes. The Care Plan also revealed Resident #13 had impaired nutrition, with an intervention to include family in their nutritional evaluation. During an interview on 07/02/2025 at 3:23 PM, Resident #13's POA stated they had not heard of, or been invited to participate in, a Care Plan meeting since the resident was admitted (10/20/2023). During an interview on 07/02/2025 at 3:26 PM, the Nurse Manager indicated there was no one to conduct Care Plan meetings, and the facility was currently hiring. During an interview on 07/02/2025 at 3:33 PM, the MDS Coordinator indicated Care Plan meetings were scheduled quarterly. She stated the POA, or whoever the resident wanted to be involved in their Care Plan meeting, was contacted. During an interview on 07/03/2025 at 8:29 AM, the MDS Coordinator revealed Resident #13 had not had a Care Plan meeting since being admitted . During an interview on 07/03/2025 at 10:04 AM, the Administrator stated the Care Plan meetings were conducted quarterly, upon admission, and with a change of condition. He verified Resident #13 had not had a Care Plan meeting because two of the resident’s family members worked at the facility. The Administrator stated he was not sure if Resident #13’s POA had been contacted for a Care Plan meeting. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/03/2025 at 10:23 AM, the DON indicated Care Plan meetings were supposed to be conducted quarterly. She stated she did not know why Resident #13 had not had a Care Plan meeting, since being admitted .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review, interview, and observation, the facility failed to ensure one (Resident #15) of one resident reviewed had formulated an advanced directive that provided a clear understanding of the resident's wishes. Specifically, documentation regarding Resident #15’s code status containing conflicting information regarding life-sustaining treatments. The findings include: A review of Resident #15’s Code Status, on 06/30/2025 at 8:14 PM, revealed a signed Acknowledgement of Receipt of Advance Directive was signed by their family member on 08/08/2023. A second acknowledgment of Receipt of Advanced Directives/Medical Treatment Decisions was signed on 08/09/2023 and read, “I have chosen to formulate and issue the following Advance Directives,” with the Do Not Resuscitate box checked and an enacted date of 08/08/2023. Another checked box stated, I do not choose to formulate or issue any Advance Directives at this time. I want efforts made to prolong my life and I want life-sustaining treatment to be provided. The family member who signed these documents were not documented as being Resident #15’s Power of Attorney (POA). A review of Resident #15’s admission Record revealed an admission date of 08/09/2023. A review of Resident #15’s Medical Diagnosis report revealed the resident was admitted with diagnoses which included dementia, attention and concentration deficit, cognitive communication deficit, and stage three chronic kidney disease. A review of Resident #15’s quarterly Minimum Data Set with an Assessment Reference Date of 04/04/2025, revealed the resident had a Brief Interview for Mental Status score of 03, which indicated severe cognitive impairment. During an interview on 07/01/2025 at 1:00 PM, this surveyor asked the Administrator for Resident #15’s Healthcare POA. The Administrator stated, We do not have a Healthcare POA on file for Resident #15.” During a concurrent record review and interview on 07/01/2025 at 1:00 PM, the Administrator reviewed the Acknowledgement of Receipt of Advance Directive signed by Resident #15’s family member on 08/08/2023. The Administrator also reviewed Resident #15’s second Acknowledgment of Receipt of Advance Directives/Medical Treatment Decisions, signed on 08/09/2023 with the, “I have chosen to formulate and issue the following Advance Directives” box checked. The document revealed there were two different documented decisions regarding Resident #15’s Advance Directive. The Administrator then called Resident #15’s family member and asked if they had the healthcare POA for Resident #15. The resident’s family member stated they did not, because Resident #15 was not competent to appoint them as the healthcare POA. The Administrator then told Resident #15's family member that a new form would need to be completed due to the conflicting information checked on the current form concerning whether to resuscitate Resident #15 or not. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility Policy “Advance Directives and Life-Sustaining Measures revealed: The decision of the resident or legal surrogate to forgo life-sustaining treatment will be honored, pursuant to advance directives completed prior to the resident being diagnosed as incompetent to make these decisions. Advance directives honored by this institution are a complete, signed, legal Durable Power of Attorney for Healthcare. A statement written in the resident’s own handwriting, dated and signed by the resident outlining their wishes for life-sustaining treatment. A verbal statement made by the resident and or surrogate informing Advanced Healthcare Management facility staff or medical staff of wishes.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and interview, it was determined the facility failed to complete a significant change Minimum Data Set (MDS) within 14 days after the facility determined there had been a significant change in a resident’s physical or mental condition for one (Resident #35) of one resident. The findings include: A review of Resident #35’s “admission Record indicated the facility initially admitted the resident on 01/06/2021, with diagnoses which included abnormal finding of blood chemistry and pneumonia. A review of Resident #35’s “Arkansas Department of Health and Human Services Evaluation of Medical Need Criteria” form indicated the resident was re-admitted from the hospital, on hospice services on 04/25/2025, with a diagnosis of acute kidney injury. The form indicated Resident #35 had multiple hospitalizations within the last month and had decided to transition to hospice care. A review of Resident #35’s Minimum Data Set (MDS) dashboard on the resident's electronic health record revealed the resident’s Significant Change MDS was started on 04/28/2025. A review of Resident #35’s MDS dashboard within the electronic health record on 07/03/2025, revealed the Significant Change MDS status was pending completion from the MDS Coordinator. A review of Resident #35’s Hospice admission Order indicated the resident was admitted to hospice services on 04/25/2025. A review of Resident #35's Care Plan Report, last revised on 04/01/2024, did not indicate the resident was admitted to hospice services. A review of Resident #35’s Order Summary revealed the resident had an order for Evaluate and Treat for Hospice Services, with a start date of 04/25/2025. A review of a telephone order for Resident #35, from the hospice company on 04/25/2025 at 12:47 PM, indicated Evaluate and treat for hospice services, and was signed by the physician. During an interview on 07/03/2025 at 8:29 AM, the MDS Coordinator revealed, A Significant Change Minimum Data Set should be completed within 14 days of the change. The MDS Coordinator reviewed Resident #35’s MDS dashboard and confirmed, There is a Significant Change MDS, with a start date of 04/28/2025, that is not complete. It should have been completed 14 days from 04/28/2025, which would have been around 05/09/2025. When the MDS is completed, it should update the Care Plan. I don’t know why it did not show up on my dashboard. A review of Required Assessment Summary Ombudsman Budget Reconciliation Act(cont.) indicated that a significant correction to prior comprehensive Minimum Data Sheet must be complete within 14 calendar days after determination that significant error in prior comprehensive assessment occurred.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, it was determined that the facility failed to ensure an entry Minimum Data Set (MDS) comprehensive assessment was encoded and transmitted in the allotted timeframe for one (Resident #35) of one resident reviewed for MDS requirements. The findings include: A review of Resident #35's admission Record indicated the facility initially admitted the resident on 01/06/2021, with diagnoses which included chronic obstructive pulmonary disease and pneumonia. A review on 07/03/2025 of Residents #35's electronic health record revealed a discharge MDS with an assessment review date (ARD) of 04/23/2025. Also present was an entry MDS, ARD date of 04/25/2025, with n export ready status, a significant change MDS with an ARD of 04/28/2025, with an in-progress status, and a quarterly MDS with an ARD of 06/20/2025, with an in-progress status. A review of Resident #35's Care Plan Report, last revised on 04/01/2024, did not reflect any of the resident's changes in care, such as the resident being admitted to hospice services. During an interview on 07/03/2025 at 8:39 AM, the MDS Coordinator stated the facility did not have a policy for Minimum Data Set timing, but that they followed the Required Assessment Summary Ombudsman Budget Reconciliation Act (RAI OBRA) for MDS timing. The RAI manual indicated a significant change MDS should be completed within 14 calendar days of the significant change. A quarterly MDS should be completed within 92 calendar days from the previous MDS. The MDS Coordinator reviewed Resident #35's MDS dashboard and confirmed, There is a significant change MDS with a start date of 04/28/2025, that is not complete. It should have been completed 14 days from 04/28/2025, which would have been around 05/09/2025. There is also a quarterly and a discharge [MDS] that are in progress and should have been completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the interdisciplinary team reviewed and revised the comprehensive care plan after each assessment or change in condition for four (Resident #10, #47, #35, and #43) of five sampled residents. The findings include: Resident #10 A review of Resident #10’s Medical Diagnosis record revealed diagnoses which included muscle wasting and atrophy, dementia with behavioral disturbance, anxiety disorder, cognitive communication deficit, schizophrenia, dementia with agitation, and schizoaffective disorder. A review of Resident #10’s annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. A review of Resident #10’s Care Plan, revised on 09/02/2024, the Care Plan identified the resident to be at high risk for falls, with the resident’s last fall documented on 03/11/2024. A review of Resident #10’s Progress Notes revealed the following documented fall: On 05/19/2025 at 11:30 AM, a Certified Nursing Assistant reported Resident #10 was on the floor, the nurse observed the resident’s upper body lying on the fall mat with their head resting on a pillow and their legs on the bed. The nurse noted she was unable to complete a head-to-toe assessment because the resident was uncooperative. She noted no visible injuries and Resident #10 was positioned back in bed. During a concurrent observation and interview on 06/30/2025 at 11:59 AM, this surveyor observed Resident #10 lying half off the side of the resident’s mattress. The resident was positioned with their elbows on the floor and was attempting to crawl off the bed. The Director of Nursing (DON) went to the resident’s room and confirmed Resident #10’s extra mattress on the floor. The DON stated it was because the resident kept sliding off the bed onto the fall mat and the mattress provided more padding. The resident kept trying to get onto the floor. Resident #47 A review of Resident #47 admission Record revealed the resident was admitted to the facility on [DATE], with diagnoses which included end stage renal disease, high blood pressure, compression of vein, and chronic pain syndrome. A review of Resident #47’s Medical Record on 07/02/2025 at 10:00 AM, revealed the facility had not developed a comprehensive Care Plan, following Resident #47’s admission date of 06/10/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/02/2025 at 10:30 AM, the MDS Coordinator stated the Care Plan should have been reviewed and updated upon admission, at least quarterly, and with each new MDS. She verified the MDS should have been updated with any change of condition or with any new findings. The MDS Coordinator stated the Resident Assessment Instrument (RAI) requirements were to complete the MDS and Care Plan upon admission, and depending on payor source, maybe quarterly. She said the Care Plan team, which included all departments, developed the Care Plan. She said the development of the baseline Care Plan was developed by all departments, because it was a collaboration to ensure the resident was getting what they needed. The MDS Coordinator was asked to review Resident #47's MDS and Care Plan. She stated Resident #47 did not have a comprehensive Care Plan. She stated the baseline Care Plan was due within 24 hours of admission, and that the next review was due on 06/23/2025, but it had not been done. She stated it was important for the Care Plan to be done timely, so staff had it available as a reference tool when providing care to the residents. The MDS Coordinator was then asked to review Resident #10’s MDS and Care Plan. She stated Resident #10’s last review was on 10/13/2024. She also stated that Resident #10’s Care Plan should have been updated in January, but there was not a record review completed. She stated Resident #10's annual was done on 12/30/2024, and the review should have been completed with that annual. The MDS Coordinator revealed Resident #10 had a quarterly MDS on 03/28/2025 and stated there should have been a Care Plan review at that time. She then said, Resident #10 has had several trips out to the hospital, but I do not have a review recorded for those hospitalizations. Resident #35 A review of Resident #35’s admission Record indicated the resident was admitted on [DATE], with diagnoses which included Parkinson's Disease, abnormalities of gait and mobility, muscle wasting, and unsteadiness on feet. A review of Resident #35’s Order Summary revealed the resident had an order to Evaluate and treat for hospice services, with a start date of 04/25/2025. A review of a telephone order for Resident #35, from the hospice company on 04/25/2025 at 12:47 PM, indicated to Evaluate and treat for hospice services, signed by the physician. A review of Resident #35's Care Plan Report, revised on 04/01/2024, did not indicate the resident was on hospice services. Resident #43 A review of Resident #43’s Progress Notes indicated the resident had falls on the following dates: An unwitnessed fall on 04/07/2025, with no interventions noted. On 05/13/2025, indicated the resident reported falling earlier in the week (no date documented), with no interventions noted. An unwitnessed fall on 05/28/2025, with an intervention for Certified Nursing Assistants (CNAs) to offer the resident help with toileting and to remind the resident to use the call light for assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A witnessed fall in the dining room on 06/30/2025, with no interventions noted. An unwitnessed fall on 06/30/2025, with an intervention of resident was reminded to use call light to ask for assistance. A review of Resident #43’s Care Plan Report indicated the resident was at a high risk for falls related to confusion, gait/balance problems, incontinence, psychoactive drug use with interventions that included directed staff to ensure the resident’s call light was in reach, to encourage the resident to use the call light for assistance, and to ensure the resident was wearing appropriate footwear when ambulating. The Care Plan report did not indicate the resident had falls dated 04/07/2025, 05/13/2025, 05/28/2025, 06/19/2025, or 06/30/2025. During an interview on 07/03/2025 at 8:29 AM, the MDS Coordinator revealed, A Significant Change Minimum Data Sheet should be completed with 14 days of the [significant] change. The MDS Coordinator reviewed Resident #43’s MDS history. The MDS Coordinator indicated, There is a Significant Change MDS with a start date of 04/28/2025 that is not complete. It should have been completed 14 days from 04/28/2025 which would have been around 05/09/2025. When this is completed, it should update the care plan. A review of the Comprehensive Plan of Care policy indicated, Upon completion of the comprehensive assessment the interdisciplinary team will develop the plan of care for the resident. All Care Assessment Areas (C.A.A.) triggered by the Minimum Data Set (M.D.S.3.0) will be considered in developing the plan of care. Any other factors identified by the interdisciplinary team will also be considered. The facility’s rationale for deciding whether to proceed with care planning will be evidenced in the clinical. The Comprehensive M.D.S. 3.0 Resident Assessment Instrument (R.A.I.) will be completed within 14 days of admission; quarterly, annually, and with a significant change of status. The comprehensive plan of care will be completed within 7 days of the completed admission R.A.I., annually, and with a significant change of status assessments. The plan of care will be reviewed and revised quarterly, annually, with a significant change of status and as needed to enhance the residents ability to meet his/her objectives.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review, observation, interviews, facility document review, and facility policy review, the facility failed to ensure a resident was checked and changed every two hours for perineal care and repositioned to prevent the risk of infection and skin breakdown for one (Resident #39) of one resident reviewed. The findings include: During an observation on 07/01/2025 at 3:00 PM, this surveyor observed Certified Nursing Assistant (CNA) #1 and CNA #2 transfer Resident #39 from a wheelchair to their bed, using a gait belt. When the resident was assisted in placing their legs on the bed, this surveyor observed a large, dark wet spot on the back of both legs going from the groin to just above the knees, and a dark wet spot streaking across the front of Resident #39's jeans. CNA #1 described the resident's jeans as soaked and dirty. The resident's demeaner indicated embarrassment. This surveyor was granted permission to observe care by the resident nodding their head. During an observation on 07/01/2025 at 3:10 PM, this surveyor observed Resident #39 during perineal care and noted a full, wet saturated brief containing stool. CNA #1 stated, [Resident 39] was last changed early this morning and CNA #2 agreed with this and revealed it could have been “around 8:00 [AM],” but CNA #2 was not sure. CNA #1 said they had been asked to help with other residents and that [Resident #39] had been overlooked. CNA #2 revealed staff were trained to bring residents to the room and check to see if they were wet or dirty every two hours to ensure their skin was clean and dry. A review of Resident #39’s Medical Diagnosis report revealed the resident had diagnoses which included stroke, dementia, and depression. A review of Resident #39’s quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 04/04/2025, revealed the resident had a Brief Interview for Mental Status score of 02, which indicated severe cognitive impairment. The MDS also revealed Resident #39 was dependent on staff for toileting, bathing, dressing, and personal care, and that the resident was always incontinent of bladder and frequently incontinent of bowel. A review of Resident #39’s Care Plan, dated 02/02/2024, revealed the resident had mixed incontinence related to cognitive impairment and impaired mobility. The resident’s Care Plan included interventions that directed staff to check Resident #39 as required for incontinence, change clothing as needed, and to monitor for signs and symptoms of urinary tract infection. Resident #39’s Care Plan also revealed the resident had an activities of daily living self-care deficit related to stroke, revised 11/27/2023, and the resident required maximum assistance of one staff for toileting. The resident's Care Plan indicated Resident #39 had an actual fall related to poor communication comprehension, with an included intervention that directed certified nursing assistance (CNA)s and nursing staff to monitor the resident with frequent rounds every hour, while Resident #39 was sitting up in a wheelchair. During an interview on 07/03/2025 at 8:19 AM, Registered Nurse (RN) #6 said, CNAs are responsible for peri-care. RN #6 stated they were not sure what the process was for checking residents sitting in wheelchairs. Nursing rounds on the hour, but I'm not sure about the CNAs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/03/2025 at 8:21 AM, the Treatment Nurse revealed she worked the floor and nursing staff oversaw the CNAs, but everyone is responsible for checking residents, and heavy wetters should be checked on every two hours or as needed because we do not want skin breakdown or infection, so it is important to make sure residents are clean and dry. During an interview on 07/03/2025 at 8:25 AM, the Director of Nursing (DON) revealed CNAs, and ultimately the nurses should check residents every two hours and keep the residents clean, dry, and turned. The DON stated the nursing staff was expected to supervise to make sure rounding and changing residents is being done. The DON revealed residents in wheelchairs should be checked every two hours the CNAs should take residents to the room and check to see if the residents need to be changed. During an interview on 07/03/2025 at 9:30 AM, the Administrator revealed staff were expected to check perineal care and positioning of residents in wheelchairs every two hours. Some residents could tell you when they were wet, and staff could feel to see if residents were wet to ensure their skin was clean and dry. If CNAs refused to help other aids or yelled at residents for soiling themselves, they would not work here. A review of a policy titled Prevention of Pressure Ulcers, dated January 2014, revealed pressure ulcers occur when residents remain in the same position for an extended time, with a combination of pressure, which could result in decreased circulation and moisture irritants including urine and feces. Residents should be repositioned and on a change program, at least every two hours. A review of a policy titled Bowel and Bladder Habits, Urinary incontinence, Catheter Care, revised 09/15/2022, revealed residents that were incontinent of urine should receive appropriate care to prevent urinary tract infections. The attached in-service revealed CNA #1 and CNA #2 were both educated on perineal care. A review of an untitled in-service from 02/26/2024, revealed residents were to be checked for turning, repositioning, hydration, and episodes of incontinence every two hours, and that a charge nurse was to be notified if a resident refused care. The sign-in sheet for this in-service revealed CNA #1 and CNA #2 both were educated on this matter. A review of the Facility Assessment, dated 01/03/2025, revealed responding to bathroom and toileting assistance promptly were addressed in order to maintain continence and integrity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045442	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cavalier Healthcare of England	400 Stuttgart Highway England, AR 72046

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. Based on observations, interviews, and facility policy review, it was determined that the dietary staff failed to ensure hand hygiene was completed for one of one meal service observed. The findings include: During an observation on 07/01/2025 at 11:20 AM, this surveyor observed Dietary [NAME] (DC) #4 open a box of rolls, without gloves on. DC #4 then reached into the box with their bare hands and took out a hand full of rolls to prepare, without washing their hands in between touching the outside of the box and the food. During an interview on 07/01/2025 at 11:42 AM, DC #4 stated, I touched the box and didn't wash my hands. I should have washed my hands after opening the box before touching the rolls because it is cross contamination. During an observation on 07/01/2025 at 12:33 PM, DC #4 opened the lid to the hot metal plate warmer container, retrieved a metal plate, and closed the lid with his bare hands. DC #4 then placed the metal plate on the base of the heat keeper combination. Then DC #4 opened the ceramic hot plate container with his bare hands, retrieved a ceramic plate, and placed the ceramic plate on top of the metal hot plate, and proceeded to the tray line to serve. No hand hygiene was performed by DC #4 between touching the top of the hot plate warmer container and returning to the tray line. During an interview on 07/01/2025 at 3:06 PM, the Administrator stated, The staff should not have to open and close anything to get the plates out, because it was spring loaded and all they had to do was take the round tops off and use the suction cup to pick up plates and put them on the base. An unidentified Dietary Aide present during the interview indicated, We don't have one for those. We had them when they were on the tray line table. The Administrator agreed the staff could not touch the top of the plate warmers, wash their hands, and then return to the tray line. The Administrator stated, The top of the plate warmer was considered dirty, so every time staff touched the top to open it, staff hands were considered dirty when returning to the tray line. A review of a facility policy titled, Hand Washing, dated 2013, indicated, Clean hands and exposed portions of arms (or surrogate prosthetic devices) immediately before engaging in food preparation including working with exposed food. After handling soiled equipment or utensils. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.