STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065191	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Care & Rehabilitation LLC	3131 S Federal Blvd Denver, CO 80236

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#24 and #80) of seven residents received treatment and care in accordance with professional standards of practice out of 53 sample residents.Specifically, the facility failed to:-Ensure physician's orders for wound care were followed for Resident #24; and,-Ensure Resident #80 was consistently administered pain medication per physician's orders.Findings include:I. Failed to ensure physician's orders for wound care were followed for Resident #24 A. Facility policy and procedureThe Wound Treatment Management policy, revised 4/7/26, was provided by the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. The policy read in pertinent part, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.B. Resident #241. Resident statusResident #24, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included an unspecified open wound on the right lower leg, lymphedema (swelling due to the fluid building up in the body's tissues) and unsteadiness on feet.The 3/27/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The MDS assessment indicated the resident was independent with completing most of his activities of daily living (ADL).The assessment indicated the resident had one venous and/or arterial ulcer (open wound that developed on the lower legs due to problems with blood circulation).2. Wound care observationsDuring a continuous observation of Resident #24's wound care on 4/2/26, beginning at 9:20 a.m. and ending at 9:49 a.m., the following was observed:The assistant director of nursing (ADON) and registered nurse (RN) #1 were observed providing wound care to Resident #24. The ADON collected wipes and began wiping down the treatment cart in the hallway. After wiping down the treatment cart, she placed a clean chuck (a disposable absorbent pad placed on a bed or chair to protect it from moisture) pad over the treatment cart where she laid out 4 by 4 gauze pads and rolled gauze.The ADON performed hand hygiene with alcohol-based hand rub (ABHR), applied a gown and gloves and entered Resident #24's room. The ADON began wiping down the resident's bedside table with disinfectant wipes and asked the resident if he had any pain. The ADON removed her gloves, performed hand hygiene with ABHR and put on new gloves. RN #1 handed the ADON two chucks pads. The ADON placed one chuck pad on the bedside table with the edges hanging over the table. The second chuck pad was placed under Resident #24's right lower leg. The ADON advised the resident if he had pain to let her know throughout the process.The ADON began by taking off an Ace bandage from around Resident #24's right lower leg, then removed the rolled gauze which was noted to have dry serosanguineous (a thin and light pink watery fluid coming from a wound) drainage to it. She removed three abdominal (ABD - a large thick padded dressing) pads from around Resident #24's leg. The ABD pads were noted to have copious amounts of serosanguineous drainage.The ADON removed her gloves, performed hand hygiene with ABHR and put on new gloves.RN #1 entered Resident #24's room with no gown or gloves and placed supplies on the bedside table consisting of 4 by 4 gauze pads, skin (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	may be included as a specific pain management need or goal.The Unavailable Medications/Emergency kit (Ekit) policy, revised 4/7/26, was provided by the NHA on 4/7/26 at 4:24 p.m. The policy read in pertinent part, This facility shall use uniform guidelines for unavailable medications. The facility maintains a contract with a pharmacy provider to supply the facility with routine, as needed (PRN), and emergency medications. A STAT (medical term meaning right away or immediately) supply of commonly used medications is maintained in-house for timely initiation of medications. As a first intervention, the nurse shall check the Ekit for availability of the medication before proceeding with other steps. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications.B. Resident #801. Resident statusResident #80, age less than 65, was admitted on [DATE]. According to the April 2026 CPO, diagnoses included chronic pain syndrome, spinal stenosis (narrowing in the spine that could press on nerves and cause pain or numbness) at cervical region (related to the neck area of the body) and alcoholic polyneuropathy (damage or disease affecting many nerves in the body at the same time).The 1/21/26 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment indicated the resident was independent with completing his ADLs.The MDS assessment indicated the resident had pain or hurting during the assessment look-back period. 2. Resident interviewResident #80 was interviewed on 3/30/26 at 2:03 p.m. Resident #80 said he had not received his morphine (pain medication) for 24 hours because the facility ran out of medication and they did not order it. Resident #80 said he was in pain, specifically down on his left leg. Resident #80 said he had not received his pain medication several times in the past because the facility ran out of pain medication and did not order it on time.3. Record reviewResident #80's pain management care plan, revised on 3/6/26, revealed the resident was at risk for pain related to a medical diagnosis of chronic pain. Interventions included administering medications as ordered, monitoring for possible adverse effects of pain management interventions, assessing pain every shift and as indicated and positioning for comfort.Review of Resident #80's April 2026 CPO revealed the following physician's order: Morphine Sulfate ER (extended release) oral tablet extended release 30 milligrams (mg). Give one tablet by mouth three times a day related to chronic pain syndrome, ordered 9/4/25. Review of Resident #80's January 2026 medication administration record (MAR) revealed Resident #80 did not receive his scheduled morphine on 1/1/26 and 1/2/26.Review of Resident #80's March 2026 MAR revealed Resident #80 did not receive his afternoon scheduled morphine on 3/30/26. The nursing progress note, dated 3/30/26 at 11:58 a.m., documented morphine sulfate oral tablet extended release 30 mg was waiting on reorder.-However there was no documentation indicating the reason the morphine medication was not administered to the resident on 1/1/26 and 1/2/26.C. Staff interviewsLicensed practical nurse (LPN) #4 was interviewed on 4/2/26 at 1:04 p.m. LPN #4 said the facility should not run out of medication. He said if a medication was not available, he would check the facility's Ekit and contact the pharmacy to get the access code to obtain the medication from the Ekit. LPN #4 said the physician's order should already be in place but sometimes the pharmacy delivery ran late. He said he would call the physician to follow up and ensure the pain medication prescription was sent to the pharmacy for an existing physician's order. LPN #4 said Resident #80's morphine order was already in the system but there was a delay in delivery of the medication. He said medications could sometimes take more than five hours to be delivered. LPN #4 said Resident #80 needed pain medication on 3/30/26 but the morphine ER 30 mg was not available at that time. He said there was only morphine ER 15 mg available in the Ekit. LPN #4 said he could not administer it to Resident #80 because it was not consistent with the physician's order. He said he should have gotten a new physician's order to administer the morphine 15 mg that was in the Ekit.LPN #2 was interviewed on 4/6/26 at 10:19 a.m. LPN #2 said Resident #80 did not get his morphine on 3/30/26 due to the medication being unavailable. LPN #2 said when he noticed it, he notified the physician who was present in the facility at that time. He said the physician did not place a new order because an order was already pending. LPN #2 said the Ekit had only morphine ER 15 mg but he could not administer it to Resident #80 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because there was no order for that dose.The pharmacist was interviewed on 4/6/26 at 3:16 p.m. The pharmacist said the pharmacy made two deliveries per day and followed specific order cut-off times for each delivery. She said orders received before 11:00 a.m. were included in the 1:00 p.m. delivery run, if they had no issues. She said it could take three to four hours for medications to be delivered to the facility. The pharmacist said even though morphine ER 15 mg was available in the Ekit, she did not expect the nurses to administer it to Resident #80 to make it 30 mg. She said a one-time physician's order would be required to administer the morphine ER 15 mg dose.The DON was interviewed on 4/6/26 at 5:57 p.m. The DON said if nurses noticed a resident had run out of pain medication at the time of administration, they should check the Ekit and medication storage. The DON said if the medication was available, they would have administered it to Resident #80. The DON said because the Ekit had morphine ER 15 mg, the nurse could have administered two tablets to Resident #80 to make the 30 mg dose.IV. Facility follow up The NHA provided the following information on 4/7/26 at 4:24 p.m., after the survey exit. The documentation provided revealed Resident #80 did not receive his afternoon dose of morphine on 3/30/26 because the facility ran out medication. The nurse documented that the medication was reordered. Resident #80 had no increase in pain related to the missed dose as evidenced by his pain being reported as 0 out of 10 on the following dose and the next day. The documentation indicated the nurse was provided re-education with the expectation that the physician be notified of missed medications and the expectation that the Ekit be utilized if medication was not available. -However, the morphine was a scheduled medication and the facility failed to order it on time to prevent missed doses of the medication.-Additionally, the re-education was not provided to staff until after the concern was brought to the attention of the facility during the survey.-The facility failed to include documentation of the in-service education provided to staff.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five percent (%).Specifically, the facility had a medication error rate of 7.41%, which was two errors out of 27 opportunities.Findings include:I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed., E.[NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environmentˆ.ˆ ˆˆProfessional Standards such as nursing scope ˆand standards of practice apply to the activity of medication administrationˆ. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. ˆMany medication errors ˆcan be linked ˆin some way to an inconsistency ˆin adhering to these seven rightsˆ: 1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Facility policy and procedureThe Medication Administration policy, revised 4/7/26, was provided by the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. It read in pertinent part, Review the medication administration record (MAR) to identify the medication to be administered.Compare the medication source (bubble pack, vial) with the MAR to verify the resident's name, medication name, form, dose, route, and time. Refer to the drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. Administer the medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Observe the resident consumption of the medication.III. Observations On 4/1/26 at 8:57 a.m. LPN #6 was preparing to administer medications for Resident #1. LPN #6 said she did not have the diclofenac external gel 1% (a topical nonsteroidal anti-inflammatory drug (NSAID) used to treat arthritis pain in joints such as the hands, knees and ankles) available in the medication cart. LPN #6 said she would re-order the medication and hopefully the medication would be delivered that day. -LPN #6 administered the remaining medications to Resident #1 and was unable to give the diclofenac.On 4/2/26 at 8:43 a.m. licensed practical nurse (LPN) #5 went into Resident #43's room. Resident #43 said she had eaten breakfast already. LPN #5 checked Resident #43's blood sugar. The blood sugar was 205 mg/dl (milligrams per deciliter). LPN #5 went back to the medication cart and retrieved Resident #43's medications. On 4/2/26 at 9:11 a.m. LPN #5 pulled an insulin lispro vial out of its packaging in an attempt to prepare it for Resident #43. The insulin vial was empty. LPN #5 said she would call the pharmacy to get another vial of insulin. -However, LPN #5 did not call the pharmacy, inform a supervisor or check other areas of the facility for insulin at that time. -LPN #5 administered the remaining medications to Resident #43 but did not administer the insulin lispro.Cross-reference F760 for failure to ensure residents were free from significant medication errors.IV. Record reviewReview of Resident #1's April 2026 CPO revealed the following physician's order:Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical). Apply to bilateral upper extremities topically three times a day for chronic pain. Apply 2 grams (gm) each administration, ordered 2/5/26.Review of Resident #1's April 2026 MAR revealed diclofenac sodium external gel was not documented as given, but instead was documented as 9 (other) for both the morning and afternoon due times.The 4/1/26 at 9:16 a.m. progress note revealed the diclofenac sodium external gel was ordered. The 4/1/26 at 1:25 p.m. progress notes revealed the physician was notified.Review of Resident #43's April 2026 CPO revealed the following physician's order:Insulin Lispro Injection Solution 100 units/ml (Insulin Lispro). Inject 20 units subcutaneously before meals for type 1 diabetes. Check blood glucose prior to administration and record glucose level, ordered 3/1/26.Review of Resident #43's April 2026 medication administration record (MAR) revealed LPN #5 documented Resident #43's blood sugar as 125 mg/dl and that she gave the insulin lispro on 4/2/26.-However, Resident #43's blood sugar was 205 mg/dl and the resident did not receive the insulin lispro on 4/2/26 (see observations above).V. Staff (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	InterviewsLPN #6 was interviewed on 4/1/26 at 9:26 a.m. LPN #6 said diclofenac sodium gel treated chronic pain and was placed topically on the pain site. LPN #6 said she would call the pharmacist and notify the nurse practitioner (NP) that Resident #1 did not receive the medication.On 4/2/26 at 11:54 a.m. LPN #5 was interviewed to follow-up on Resident #43's omitted insulin administration (see observation above). LPN #5 said she had not had time to give the insulin to the resident yet.Cross-reference F760 for failure to ensure residents were free from significant medication errors.On 4/2/26 at 12:10 p.m. the director of nursing (DON) and the regional clinical resource were alerted that Resident #43 had not received her morning dose of lispro insulin. The DON said LPN #5 should have retrieved insulin lispro from the facility's emergency kit (E-kit) which had multiple insulin vials available. The DON said LPN #5 should have reached out to other staff members for help to retrieve the insulin. The DON said LPN #5 could have then administered the insulin. The DON said staff should not document that a medication was given on the MAR if the medication was not given. The regional clinical resource said the facility would let the physician know that Resident #43 did not receive her morning dose of insulin. She said Resident #43 would have her blood sugar checked and receive her afternoon dose of insulin.The DON and the regional clinical resource were interviewed together a second time on 4/2/26. The regional clinical resource said residents' blood glucose levels were recorded just before nurses administered insulin to residents. The DON said LPN #5 was an agency staff member and it was her first shift at the facility. The DON said agency staff received verbal education on policies and procedures before working at the facility. The DON said education was also uploaded to the care system for agency staff to view. The DON said she would review the agency nurse education and orientation that was in place for agency staff. The pharmacist was interviewed on 4/6/26 at 3:16 p.m. The pharmacist said insulin was a hormone naturally created in the body. She said type 1 diabetes was a disease where the pancreas did not produce enough insulin to control the blood sugar in the body. The pharmacist said insulin medication was used to get residents' blood sugar levels to a normal level. The pharmacist said it was important for residents to receive insulin before eating because every time people ate there were carbs and sugars in the food consumed. The pharmacist said it was important to give the insulin before eating to help counteract the escalation of blood sugar right after a resident ate. The pharmacist said if a resident missed a dose of insulin, generally it would cause an increase in the resident's blood sugar and if blood sugar levels got high enough, a resident could go into a coma.The pharmacist said diclofenac was a topical NSAID used for inflammation and arthritis. The pharmacist said that in a resident who had chronic pain syndrome, a missed dose would cause a lack of anti-inflammatory effects. The pharmacist said this could lead to an increase in pain and swelling.The DON and the regional clinical resource were interviewed together again on 4/6/26 at 5:26 p.m. The DON said nurses should follow the five rights of medication administration. The DON said the five rights of medication administration were right person, right time, right route, right dose and right reason.The DON said if residents ran out of pain medication, the nurses could go to the facility's emergency kit and look for the medication there. The DON said it was important to receive pain medication timely so residents did not have pain. The DON said nurses should contact the physician if the pain medication was unavailable.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from significant medication errors for one (#43) of four residents out of 53 sample residents. Specifically, the facility failed to ensure Resident #43 was administered an insulin medication per physician's orders.Findings include:I. Facility policy and procedureThe Medication Administration policy, revised 4/7/26, was provided by the nursing home administrator (NHA) on 4/7/26 at 4:24 p.m. It read in pertinent part, Review the medication administration record (MAR) to identify the medication to be administered.Compare the medication source (bubble pack, vial) with the MAR to verify the resident's name, medication name, form, dose, route, and time. Refer to the drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. Administer the medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Observe the resident consumption of the medication.II. Resident #43A. Resident statusResident #43, age less than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included type 1 diabetes mellitus (a condition where the pancreas makes little to no insulin, which was required to allow glucose into cells to produce energy), hypothyroidism (low thyroid levels) and asthma (chronic long-term respiratory disease).The 3/18/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS assessment revealed Resident #43 was receiving insulin.B. ObservationsOn 4/2/26 at 8:43 a.m. licensed practical nurse (LPN) #5 went into Resident #43's room. Resident #43 said she had eaten breakfast already. LPN #5 checked Resident #43's blood sugar. The blood sugar was 205 mg/dl (milligrams per deciliter). LPN #5 went back to the medication cart and retrieved Resident #43's medications. On 4/2/26 at 9:11 a.m. LPN #5 pulled an insulin lispro vial out of its packaging in an attempt to prepare it for Resident #43. The insulin vial was empty. LPN #5 said she would call the pharmacy to get another vial of insulin. -However, LPN #5 did not call the pharmacy, inform a supervisor or check other areas of the facility for insulin at that time. -LPN #5 administered the remaining medications to Resident #43 but did not administer the insulin lispro.Cross-reference F759 for failure to ensure the facility was free from a medication error rate of five percent (5%) or greater. On 4/2/26 at 12:43 p.m. registered nurse (RN) #1 was observed checking Resident #43's lunch time blood sugar level. RN #1 cleaned Resident #43's finger with alcohol, drew a drop of blood from the finger, and used the glucometer to test the blood sugar. The glucometer read 191 mg/dlC. Record reviewReview of Resident #43's April 2026 CPO revealed the following physician's order:Insulin Lispro Injection Solution 100 units/ml (Insulin Lispro). Inject 20 units subcutaneously before meals for type 1 diabetes. Check blood glucose prior to administration and record glucose level, ordered 3/1/26.Review of Resident #43's April 2026 medication administration record (MAR) revealed LPN #5 documented Resident #43's blood sugar as 125 mg/dl and that she gave the insulin lispro on 4/2/26.-However, Resident #43's blood sugar was 205 mg/dl and the resident did not receive the insulin lispro on 4/2/26 (see observations above).Review of Resident #43's progress notes on 4/2/26 at 2:21 p.m. revealed the physician was notified that Resident #43 missed a dose of insulin in the morning. The note revealed no adverse reactions were noted. -However, the progress note was not documented until after the concern of the morning insulin dose not being administered to Resident #43 was brought to the facility's attention on 4/2/26 (see interviews below).III. Staff interviewsOn 4/2/26 at 11:54 a.m. LPN #5 was interviewed to follow-up on Resident #43's omitted insulin administration (see observation above). LPN #5 said she had not had time to give the insulin to the resident yet.On 4/2/26 at 12:10 p.m. the director of nursing (DON) and the regional clinical resource were alerted that Resident #43 had not received her morning dose of lispro insulin. The DON said LPN #5 should have retrieved insulin lispro from the facility's emergency kit (E-kit) which had multiple insulin vials available. The DON said LPN #5 should have (continued on next page)

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	065191	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Care & Rehabilitation LLC	3131 S Federal Blvd Denver, CO 80236

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reached out to other staff members for help to retrieve the insulin. The DON said LPN #5 could have then administered the insulin. The DON said staff should not document that a medication was given on the MAR if the medication was not given. The regional clinical resource said the facility would let the physician know that Resident #43 did not receive her morning dose of insulin. She said Resident #43 would have her blood sugar checked and receive her afternoon dose of insulin.The DON and the regional clinical resource were interviewed together a second time on 4/2/26. The regional clinical resource said residents' blood glucose levels were recorded just before nurses administered insulin to residents. The DON said LPN #5 was an agency staff member and it was her first shift at the facility. The DON said agency staff received verbal education on policies and procedures before working at the facility. The DON said education was also uploaded to the care system for agency staff to view. The DON said she would review the agency nurse education and orientation that was in place for agency staff. The pharmacist was interviewed on 4/6/26 at 3:16 p.m. The pharmacist said insulin was a hormone naturally created in the body. She said type 1 diabetes was a disease where the pancreas did not produce enough insulin to control the blood sugar in the body. The pharmacist said insulin medication was used to get residents' blood sugar levels to a normal level. The pharmacist said it was important for residents to receive insulin before eating because every time people ate there were carbs and sugars in the food consumed. The pharmacist said it was important to give the insulin before eating to help counteract the escalation of blood sugar right after a resident ate. The pharmacist said if a resident missed a dose of insulin, generally it would cause an increase in the resident's blood sugar and if blood sugar levels got high enough, a resident could go into a coma.The DON and the regional clinical resource were interviewed together again on 4/6/26 at 5:26 p.m. The DON said nurses should follow the five rights of medication administration. The DON said the five rights of medication administration were right person, right time, right route, right dose and right reason.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen.Specifically, the facility failed to ensure appropriate use of gloves when handling ready-to-eat foods. Findings include:I. Professional referenceThe Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 4/7/26. It revealed in pertinent part, Food employees may not contact exposed ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (3-301-11) Food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped to provide water at a temperature of at least 29.4oC (85oF) through a mixing valve or combination faucet.(2-301-12)II. ObservationsDuring a continuous observation of the dinner meal service on 4/1/26, beginning at 4:25 p.m. and ending at 5:55 p.m. the following was observed:At 4:30 p.m. dietary aide (DA) #2 placed three plates on the serving line. She picked up three hot dog buns with her bare hands and placed one bun each on a plate. At 4:38 p.m. DA #2 picked up a hot dog bun bare hands and placed it on a plate and assembled a meatball sandwich.At 4:40 p.m. DA #2 picked up a meal ticket. Without performing hand hygiene DA #2 picked up a hot dog bun with her bare hands and placed it on a plate. She assembled a meatball sandwich and passed the plate to cook (CK) #1.At 4:41 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich.At 4:42 p.m. DA #2 touched the counter top and picked a plate and put it on the counter top. Without washing her hands, she picked up a hot dog bun and placed it on the plate. She assembled a meatball sandwich and passed the plate to CK #1.At 4:45 p.m. DA #2 touched a wet towel on the table to her left with her right hand. CK #1 adjusted her shirt and apron around her waist with her bare hands.At 4:45 p.m. CK #1 picked up a meal ticket order]. She picked up a hot dog bun bare hands and placed it on the plate.At 4:46 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich.At 4:47 p.m. DA #2 picked up a meal ticket with bare hands. Without performing hand hygiene DA #2 picked up a hot dog bun with her bare hands and placed it on a plate. She assembled a meatball sandwich and passed the plate to CK #1. At 4:52 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich.At 4:54 p.m. DA #2 touched another meal ticket. Without performing hand hygiene, she picked up a hot dog bun and prepared a meatball sandwich. DA #2 swiped a plate with food bare hands with the chef.At 4:55 p.m. DA #2 brought trays bare hands from the dishwasher room. She grabbed meal tickets and placed them on the trays, picked up plates and placed them on the trays bare hands. She picked up hot dog buns bare hands and placed them on the plates.At 4:57 p.m. DA #2 picked up a hot dog bun bare hands and placed it on a plate and assembled a meatball sandwich.At 4:59 p.m. CK #1 touched her wrist watch with bare hands. Without washing her hands she picked a bowl, grabbed an utensil and scooped a spoonful of macaroni onto the bowl.At 4:59 p.m. without wearing gloves, DA #2 picked up a bun with her right hand, and assembled a meatball sandwich. CK #1 did not wash her hands after adjusting her shirt and apron and touching the plate. DA #2 picked up meal tickets on the table with both hands. She then picked up a plate with her right hand and placed a hot dog bun on the plate with her bare left hand. CK #1 finished assembling the plate and placed the plate on a tray in the window to be served to a resident.At 5:00 p.m. DA #2 touched her clothes. Without washing her hands, she resumed serving meals. At 5:16 pm DA #1 started assembling the meal plates and placed them in the meal cart bare hands.At 5:18 p.m. the staff continued to assemble meal plates bare hands and placed them in the meal cart.At 5:21 p.m. DA #2 washed her hands and picked a hot dog bun without wearing gloves and assembled a meatball sandwich.At 5:23 p.m. CK #1 washed her hands and scooped pasta salad onto a plate with a utensil.At 5:25 p.m. DA #1 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	started to assemble two meal plates. She used her bare hand to place a hot dog bun on two plates. The meal plates were assembled and placed in the meal cart for service.At 5:25 p.m. DA #2 touched her clothes with her hands. Without washing her hands she picked a meal ticket, read it and put it back on the tray. She picked a hot dog bun bare hand and placed on the plate, grabbed an utensil and scooped meatball onto the plate, passed the plate to CK #1 .At 5:27 p.m. DA #1 started to assemble three meal plates. She used her bare hand to place a hot dog bun on two plates. The meal plates were assembled and placed in the meal cart for service.At 5:45 p.m. DA #2 wore gloves and went to get more trays from the dishwashing room. She removed gloves and resumed serving meals bare hands.III. Staff interviewsDA #3 was interviewed on 4/2/26 at 3:20 p.m. DA #3 said she washed her hands, went to the serving line, served food, and washed her hands again before serving the next meal. DA #3 said she took a handwashing break between serving the next meal. DA #3 said she could not touch bread or buns with bare hands and avoided direct contact with ready-to-eat food. She said gloves should be worn and changed as needed after use. DA #3 said they did not wear gloves when serving food because they washed their hands consistently. She said DA #2 and CK #1 were not supposed to handle hot dog buns with bare hands.The kitchen manager was interviewed on 4/2/26 at 3:38 p.m. The kitchen manager said kitchen staff should wash their hands consistently between tasks. He said they should use tongs or wear gloves for a single task while handling ready-to-eat food. The dietary cook said DA #2 and CK #1 should not touch hot dog buns with bare hands. The kitchen manager said the dietary staff should have worn gloves when handling the hot dog buns.The nursing home administrator (NHA) was interviewed on 4/6/26 at 2:34 p.m. The NHA said the kitchen staff were educated on proper hand hygiene during meal preparation and service on 4/1/26.