STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555446	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rossmoor Post Acute	1226 Rossmoor Parkway Walnut Creek, CA 94595

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure it kept accurate records of controlled medications (medication with a potential for abuse) as evidenced by: 1. The facility failed to ensure, for Residents 1-7, the scheduled (controlled medication, narcotic) medication system was complete (all documents available) and accurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered).2. The facility failed to ensure, between 2/1/24-5/31/24, the Consultant Pharmacist identified the scheduled (controlled medication, narcotic) medication system was incomplete (all documents available) and inaccurate (information matched). The record system included Shipping Manifests (pharmacy delivery receipt), Controlled Substance Accountability Sheets (CDR, Controlled Drug Record), Medication Administration Records (MAR, record of medication administration) and destruction logs. The facility records were incomplete. The facility records were inaccurate. These failures had the potential to result in undetected loss and diversion of scheduled medications. In addition, these failures had the potential to result in preventable medication errors (medication not given as ordered). 1. During an interview, on 8/27/25 at 9:18 a.m., Record Director (MRD), was asked to describe how medical records were filed and stored. Her description included that narcotic Shipping Manifests were stored onsite. MRD was asked to provide the Shipping Manifests between 2/1/24-5/31/24.During a concurrent observation and interview, on 8/27/25 at 9:30 a.m., on the Medbridge nursing unit, Registered Nurse (RN 1) was asked to describe the narcotic accountability process. Her description included pharmacy delivered medication and Shipping Manifests to the nursing station, a nurse signed the Shipping Manifest and took possession of the narcotic. The narcotic and CDR were placed in the medicine cart (stores medication at the nursing unit). She further described the narcotic was removed from the prescription card (bubble pack to organize and hold medication). The CDR was completed documenting the date, time, and nurse initials. The MAR was completed if the drug was administered. In addition, for discontinued narcotics she described the count was verified by two nurses on the CDR. The discontinued drug and CDR were placed in a lock box. During a concurrent interview and document review, on 8/27/25 at 12:08 p.m., MRD was requested to provide the CDR for Resident 1 R71146732 Oxycodone (narcotic pain reliever) 5mg (milligram) tablets 8 EA. MRD stated that the facility could not find the CDR. During a concurrent interview and record review, on 8/29/25 at 10:15 a.m., Director of Nursing (DON) identified the CDR for 72116314 Resident 2. The CDR showed two tablets were removed between 7/2/24 1315 and 7/2/24 2200. The Amount Remaining 50 line required information for Date, Time Amount Used and Administered By to be completed. None of the required fields were completed. DON acknowledged the required fields were not completed.Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 3 R71052004 Oxycodone 5 mg tablet CDR. DON (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.2/12/24 22002/13/24 08402/14/24 x 22/16/24 20002/21/24 21002/24/24 21002/26/24 1100Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 4 R71404810 Hydrocodone (narcotic)/Acet (acetaminophen, pain reliever) 5 mg/325 mg tablet CDR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.3/12/24 05003/14/24 0500, 0915 Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 3 R71480339 Hydrocodone 5 mg tablet CDR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.4/17/24 09004/18/24 untimed 4/19/24 11004/22/24 1700 4/26/24 2000Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 5 R71501657 Hydrocodone/Acetamino 10 mg/325 mg tablet CDR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and time listed below.3/24/24 0225Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 6 R71505886 Oxycodone 5 mg tablet CDR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the dates and times listed below. 4/9/24 12004/13/24 0800Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 7's CDRs. DON acknowledged the CDR removal did not have a corresponding MAR administration on the dates and times listed below.R71278950 Hydrocodone/Acet 5mg/325mg tablet CDR3/28/24 0800, 1200, 0900 3/30/24 0430 4/3/24 0100, 03004/4/24 10154/5/24 21004/6/24 19004/8/24 1130R17278950 Hydrocodone/Acet 5mg/325mg tablet CDR4/14/24 21004/15/24 19004/17/24 0730, 1200, 19004/20/24 0725, 11254/22/24 12004/23/24 11004/24/24 0800, illegible4/27/24 1900R71278950 Hydrocodone/Acet 5mg/325mg tablet CDR2/22/24 11002/23/24 10002/24/24 11002/25/24 12452/26/24 0645, 1130, 18002/27/24 11002/28/24 11003/1/24 06453/2/24 05003/3/24 1100, 19003/4/24 0500, 11003/5/24 11003/6/24 10303/9/24 1100During an interview, on 8/29/25 at 11:05 a.m., DON acknowledged the above issues with the scheduled medication record system. The issues identified included, but not limited to, Shipping Manifests, CDRs and MARs. The DON stated that it was the facility's expectation that narcotic tracking documents were complete and accurate. During an administrative record review, of the facility's Policy and Procedure for Controlled Substances (2001 Med-Pass) showed, Policy Interpretation and Implementation, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up., 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. records of personnel access and usage; b. Medication administration records;, c. Declining inventory records; and d. Destruction, waste and return to pharmacy records.15. The consultant pharmacist or designee routinely monitors controlled substance storage records. 2. During an interview, on 8/27/25 at 9:18 a.m., Record Director (MRD), was asked to describe how medical records were filed and stored. Her description included that narcotic Shipping Manifests were stored onsite. MRD was asked to provide the Shipping Manifests between 2/1/24-5/31/24.During a concurrent observation and interview, on 8/27/25 at 9:30 a.m., on the Medbridge nursing unit, Registered Nurse (RN 1) was asked to describe the narcotic accountability process. Her description included pharmacy delivered medication and Shipping Manifests to the nursing station, a nurse signed the Shipping Manifest and took possession of the narcotic. The narcotic and CDR were placed in the medicine cart (stores medication at the nursing unit). She further described the narcotic was removed from the prescription card (bubble pack to organize and hold medication). The CDR was completed documenting the date, time, and nurse initials. The MAR was completed if the drug was administered. In addition, for discontinued narcotics she described the count was verified by two nurses on the CDR. The discontinued drug and CDR were placed in a lock box. During a concurrent interview and document review, on 8/27/25 at 12:08 p.m., (continued on next page)

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Rossmoor Post Acute	1226 Rossmoor Parkway Walnut Creek, CA 94595

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MRD was requested to provide the CDR for Resident 1 R71146732 Oxycodone (narcotic pain reliever) 5mg (milligram) tablets 8 EA. MRD stated that the facility could not find the CDR. During an interview on 8/28/25 at 10:15 a.m., the DON was requested to provide the Consultant Pharmacist inspection reports. The facility provided the Quality Improvement: Consultant Pharmacist Summary, Rossmoor Post Acute reports.During a concurrent interview and record review, on 8/29/25 at 10:15 a.m., Director of Nursing (DON)identified the CDR for 72116314 Resident 2. The CDR showed two tablets were removed between 7/2/24 1315 and 7/2/24 2200. The Amount Remaining 50 line required information for Date, Time Amount Used and Administered By to be completed. None of the required fields were completed. DON acknowledged the required fields were not completed. Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 3 R71052004 Oxycodone 5 mg tablet CDR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.2/12/24 22002/13/24 08402/14/24 x 22/16/24 20002/21/24 21002/24/24 21002/26/24 1100Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 4 R71404810 Hydrocodone (narcotic)/Acet (acetaminophen, pain reliever) 5 mg/325 mg tablet CDR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.3/12/24 05003/14/24 0500, 0915 Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 3 R71480339 Hydrocodone 5 mg tablet CDR. DON acknowledged the CDR removals did not have a corresponding MAR administration on the dates and times listed below.4/17/24 09004/18/24 untimed 4/19/24 11004/22/24 1700 4/26/24 2000Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 5 R71501657 Hydrocodone/Acetamino 10 mg/325 mg tablet CDR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the date and time listed below.3/24/24 0225Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 6 R71505886 Oxycodone 5 mg tablet CDR. DON acknowledged the CDR removal did not have a corresponding MAR administration on the dates and times listed below. 4/9/24 12004/13/24 0800Continuing the concurrent interview and medical record review, on 8/29/25 at 10:15 a.m., DON identified Resident 7's CDRs. DON acknowledged the CDR removal did not have a corresponding MAR administration on the dates and times listed below.R71278950 Hydrocodone/Acet 5mg/325mg tablet CDR3/28/24 0800, 1200, 0900 3/30/24 0430 4/3/24 0100, 03004/4/24 10154/5/24 21004/6/24 19004/8/24 1130R17278950 Hydrocodone/Acet 5mg/325mg tablet CDR4/14/24 21004/15/24 19004/17/24 0730, 1200, 19004/20/24 0725, 11254/22/24 12004/23/24 11004/24/24 0800, illegible4/27/24 1900R71278950 Hydrocodone/Acet 5mg/325mg tablet CDR2/22/24 11002/23/24 10002/24/24 11002/25/24 12452/26/24 0645, 1130, 18002/27/24 11002/28/24 11003/1/24 06453/2/24 05003/3/24 1100, 19003/4/24 0500, 11003/5/24 11003/6/24 10303/9/24 1100During an interview, on 8/29/25 at 11:05 a.m., DON acknowledged the above issues with the scheduled medication record system. The issues identified included, but not limited to, Shipping Manifests, CDRs and MARs. The DON stated that it was the facility's expectation that narcotic tracking documents were complete and accurate. During a concurrent interview and record review, on 8/29/25 at 11:05 a.m., DON identified the Quality Improvement: Consultant Pharmacist Summary, Rossmoor Post Acute reports, for dates 2/1/24-2/29/24, 3/1/24-3/31/24, 4/1/24-4/30/24, 5/1/24-5/31/24 and 6/1/24-6/30/24. She acknowledged the reports did not document issues with incomplete or inaccurate scheduled medication records. An administrative record review, of the Facility's Quality Improvement: Consultant Pharmacist Summary, Rossmoor Post Acute, 2/1/24-8/31/24, Showed Controlled Substances (F755, F761), c) Controlled substance documentation is accurate and complete, including, but not limited to proof of use sheet, MAR documentation, etc. The reports for February, March, April, May, June, July, and August were reviewed. Under Evaluation No irregularities observed was documented. The reports did not identify issues with scheduled medication accountability.During an administrative record review, of the (continued on next page)

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Rossmoor Post Acute	1226 Rossmoor Parkway Walnut Creek, CA 94595

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's Policy and Procedure for Controlled Substances (2001 Med-Pass) showed, Policy Interpretation and Implementation, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up., 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. records of personnel access and usage; b. Medication administration records;, c. Declining inventory records; and d. Destruction, waste and return to pharmacy records.15. The consultant pharmacist or designee routinely monitors controlled substance storage records.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to ensure adequate kitchen oversight when:1. The facility did not have any Dietary Manager or equivalent, and the Registered Dietitian did not provide fullˆtime oversight of the kitchen for two weeks; and2. The facility did not have a qualified Dietary Manager, and the Registered Dietitian did not provide fullˆtime oversight of the kitchen for one week.This failure to provide adequate oversight of the kitchen resulted in staff not adhering to safe hand hygiene practices (see Fˆtag 880) and placed all residents who received meals from the kitchen at risk of foodˆborne illness.1. During an interview on 8/27/25, at 1:50 p.m. with Human Resources (HR), HR stated the previous Certified Dietary Manager (CDM)'s last day at the facility was 8/21/25. HR stated CDM was working at another healthcare facility, and another dietary manager would start on 9/4/25.During an interview on 8/27/25, at 3:05 p.m. with Registered Dietitian 1 (RD 1), RD 1 stated the dietary manager was responsible for supervising day to day kitchen activities. RD 1 stated their daily activities were to assess residents, monitor weights, manage residents on tube feeding and attend care conferences. RD 1 stated they did not perform any duties in kitchen activities but will do random checks of the freezer or walkthroughs of the kitchen. RD 1 stated the previous CDM was no longer the dietary manager, and the duties of the CDM were split between the Sous Chef (SC) and other staff. RD 1 stated SC was responsible for supervision of the kitchen during meal preparation.During an observation and interview on 8/27/25, at 3:27 p.m. with SC, the surveyor entered the kitchen entrance without a hairnet. SC invited the surveyor into the kitchen for a tour and stated a hairnet was not required to be in the kitchen. SC stated they were not a certified dietary manager. SC stated their primary duties was cooking and ordering supplies for the kitchen. SC stated the previous CDM was no longer working at the facility.During an interview on 8/28/25, at 4:10 p.m. with RD 1, RD 1 stated a dietary manager needed to be qualified to understand detail of food safety and infection prevention.During an interview and record review on 8/27/25, at 5:30 p.m. with Administrator (ADM) and Director of Nursing, the facility's plan for kitchen responsibilities titled, CDM duties, dated 8/21/27, was reviewed. ADM stated the facility planned to split the CDM role to different people with Administrator 2 (ADM 2) being the primary supervisor for the kitchen, and CS assigned to supervise daily kitchen activities. ADM stated they did not plan or attempt to find a temporary certified dietary manager while the facility because ADM stated their plan was adequate for the facility and disagreed with the health and safety requirement for full-time, qualified supervision of kitchen activities.2. During an interview on 5/11/26, at 9:37 a.m. with Dietary Manager (DM), DM stated RD 1 was no longer working at the facility. DM stated RD 1 had left for about a week. DM stated they were responsible for full-time oversight of the kitchen and was working on the educational requirements for the CDM role. DM stated Registered Dietitian 4 (RD 4) was starting today, and there was no full-time registered dietitian oversight of the kitchen.During an interview on 5/11/26, at 10:26 a.m. with SC, SC stated RD 1 stopped working at the facility in the beginning of the month. SC stated Registered Dietitian 2 (RD 2) was working part time in the evening on the clinical dietitian work and did not oversee the kitchen.During a concurrent interview and record review on 5/11/26, at 10:35 a.m. with HR, RD 1 and RD 2's work hours were reviewed. HR stated RD 1 was working part-time since the 4/30/26, and RD 2 was a part time employee. A review of their work hours indicated:RD 1 worked on 5/7, 5/9 and 5/10 for a total of 5.75 hours which RD 1 was working remotely.RD 2 worked on evenings from 5/1 to 5/10 for a total of 25 hours.During an interview on 5/11/26, at 11:49 a.m. with RD 4, RD 4 stated they were starting to work full time at the facility starting today. RD 4 stated Registered Dietitian 3 (RD 3) had been overseeing the kitchen.During an interview on 5/11/26, at 11:55 a.m. with DM, DM stated RD 3 was here for two days to do a mock survey inspection and present the results to the staff.During an interview on 5/11/26, at 12:20 p.m. with ADM 2, ADM 2 stated RD 3 was a registered dietitian for the corporate entity and was performing (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a mock survey to prepare for state inspection.During a review of facility job description for a dietary manager titled, Job Description: Dietary Manager, dated 2/2024, the job description indicated the dietary manager must be a graduate of an approved dietary manager's course that meet the state and federal care regulations.During a review of the California Code, Health and Safety Code - HSC S 1265.4, showed the requirements of subdivision (b) included:(1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility.(2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration.(3) A graduate of a dietetic assistant training program approved by the American Dietetic Association.(4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.(5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.(6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision.(7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure staff followed infection control practice when:1. [NAME] 1 did not adhere to hand hygiene practice while checking temperatures of ready to eat foods,2. non-kitchen staff entered the kitchen without performing hand hygiene to get fruit, and3. [NAME] 1 contaminated the dinner tray line with raw fish.This failure placed residents in the Medbridge unit at risk of foodborne illness which had the potential for death.1. During an observation on 8/27/25 at 4:21 p.m., [NAME] 1 was at the tray line wearing gloves while using the temperature probe to measure food temperatures. After taking the temperature of pureed potato, [NAME] 1 adjusted their glasses with their gloved hand, then removed an alcohol wipe from their pants pocket with the same gloved hand. Without performing hand hygiene or changing gloves, [NAME] 1 continued to take the temperatures of chicken patties and then fish patties.2. During an observation on 8/27/25 at 3:37 p.m., in the kitchen, a maintenance staff (MS) entered the kitchen and, without performing any hand hygiene, grabbed a banana from the fruit container near the tray line table.3. During an observation on 8/27/25 at 4:25 p.m., [NAME] 1 had a plate of raw fish and placed it next to an oven.During an observation 8/27/25 at 4:50 p.m., [NAME] 1 was at the dinner tray line, wearing gloves and plating food. At the tray line was a metal basket of chopped green onions. [NAME] 1 went to a plate of raw fish next to the oven and placed the raw fish into the oven. [NAME] 1's right hand had touched the raw fish, and without performing hand hygiene or changing gloves, [NAME] 1 returned to the tray line to continue plating food using the serving utensils and placed their right hand onto the green onions. [NAME] 1 garnished the chicken entrees with the green onions.During a concurrent observation and interview on 8/27/25 at 4:51 p.m. with Sous Chef (SC), the plate of raw fish in the oven was inspected. SC stated the plate of fish in the oven was raw.During an observation and interview on 8/25/25 at 5:30 p.m. with SC, SC stated the food cart had been sent up to the floor to the residents.During an observation on 8/25/25, at 5:40 p.m. on the first floor Medbridge unit, the food cart was observed on the unit with trays already passed out to residents.During an interview on 8/28/25 at 4:10 p.m. with Registered Dietitian (RD), RD stated staff were expected to perform hand hygiene and change gloves when changing tasks of handling raw fish to handling ready-to-eat foods to prevent cross-contamination. RD stated supervisors including kitchen supervisors should not be responsible for oversight of hand hygiene and infection control practices because individuals need to be responsible to themselves to adhere to hand hygiene and infection control practices. RD stated the Dietary Manager, or the RD would be responsible for monitoring the tray line for infection control adherence.During a review of facility policy and procedure (P&P) titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practice, dated 2001, the P&P indicated staff must wash their hands.whenever entering or re-entering the kitchen.after handling raw meat, poultry or fish and when switching between working with raw food and working with ready-to-eat food.after engaging in other activities that contaminate the hands.Antimicrobial hand gel is not used in the place of handwashing in food service areas.gloves are considered single-use items and must be discarded.between handling raw meats and ready to eat foods.A review of Federal Food and Drug Administration (FDA) Food Code, dated 2022, the FDA food code indicated food employees shall clean their hands.when switching between working with raw food and working with ready-to-eat food. The code also indicated single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled.