STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045317	A. BUILDING _____ B. WING _____	**07/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOOD-LAWN HEIGHTS	**2800 NEELEY STREET BATESVILLE, AR 72501**

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure nailcare was provided and facial hair was removed to promote good personal hygiene for 2 (Resident #20 and 75) and oral care was provided for 1 (Resident #75) of 2 (Residents #20 and #75) sample residents who required assistance with personal hygiene. This failed practice to affect 2 sample residents and had the potential to affect 120 residents as documented on the Resident Census and Condition of Residents form provided by the Assistant Administrator dated 7/6/2020. The findings are: 1. Resident #20 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/18/2020 documented the resident scored 9 (9 - 12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required physical assistance of 1 person for personal grooming. a. The Care Plan dated 10/4/2019 which documented , Keep fingernails trimmed . updated 01/07/20 . like nails to be done If refusing care, back off, reattempt, attempt different staff member---act super sweet - may comply then-per staff . updated 05/19/20 . I now require mostly extensive assist with ADL (Activities of Daily Care). b. On 07/08/2020 at 9:23 AM, the resident was in her room in a wheelchair. The resident had facial hair on her chin that measured approximately 1/4 inch long. The resident had brown stained fingernails. c. On 07/09/2020 at 10:15 AM, Registered Nurse (RN) #2 was asked, How often does the resident get her fingernails cut? RN #2 stated, Usually with showers, twice weekly, but sometimes she refuses. The RN was asked, What about chin facial hair, do you see any on the Resident? RN #2 stated, Yes. It needs to be trimmed. d. A form titled, Body Audit provided by the Assistant Director of Nursing (ADON) on 7/9/2020 at 11:06 a.m. documented, for the resident documented, . The resident refused nail care with a shower on 06/25/20, 06/28/20 and 07/05/20 e. On 07/09/2020 at 3:40 PM, The DON was asked, Should they have long brown fingernails? The DON stated No. The DON was asked, How often should fingernails be cleaned and trimmed? The DON stated, For diabetic residents weekly, and non-diabetic with showers, but sometimes they refuse. 2. Resident #75 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of 05/05/2020 documented the resident scored 0 (0 to 7 indicates severely impaired) on a BIMS; and required physical assistance of 2 staff assist for personal hygiene. a. The resident's Plan of Care with a revision date of 05/19/2020 documented, .My ADL's require mostly extensive to total staff assist at this time due to decline r/t (related to)[MEDICAL CONDITION] /Dementia .resident requires mostly extensive to total assistance by 2 staff with personal hygiene . b. On 07/08/2020 at 9:25 AM, the resident was lying in the bed with her eyes closed. The resident had facial hair on her chin that measured approximately 1/4 inch long. c. On 07/09/2020 at 10:18 AM, the resident was lying in the bed. The resident had dry cracked lips. d. On 07/09/2020 at 10:20 AM, RN #2 was asked, Do you see any chin facial hair on the resident? RN #2 stated, Yes. RN #2 was asked Does the Resident's lips look dry? RN #2 stated, A little bit. e. On 07/09/2020 at 3:40 PM, the Director of Nursing (DON) was asked, Should women have facial hair? The DON stated, No. The residents have it removed or shaved with their showers. If they won't let them, the Certified Nurse Assistants (CNA's) reattempt later.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure a hand roll or other preventive devices were in place to prevent further potential decline in range of motion for 1 (Residents (R) #81) of 7 sampled residents who had contractures and required a preventive devices. This failed practice had the potential to affect 20 residents who had contractures according to a list provided by the Assistant Director of Nursing (ADON) on 07/09/2020 at 02:00 PM. The findings are: 1. Resident #81 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] documented the resident scored 15 (13 - 15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) and had limited range of motion upper extremity on one side . a. An Admission Body Audit dated 5/3/19 provided by the ADON documented, .Left hand contractures . The most current Body audit dated 7/8/2020 was provided by the ADON documented a notation added on it in a different handwriting. The added notation documented, .limited ROM (left) . The ADON was asked, Can you explain the added notation? She stated, I was trying to clarify what she (the original author) had wrote. b. The Comprehensive Care Plan documented, .Problem Onset 5/10/19 .My ADLs (Activities of Daily Living) require mostly extensive assistance . Approaches: I have no use of left arm . Restorative/Skilled therapy as indicated/ordered . Problem Onset 05/03/19 .[MEDICAL CONDITIONS], Left Sided [MEDICAL CONDITION], Right Mass .Approaches: Monitor participation in restorative program .Monitor for appliances as required (note splint, sling .) . c. On 07/06/2020 at 12:39 PM, R #81 was lying in bed awake. The fingers on her left hand were curled inward towards her palm. She was asked, Does staff ever put a rolled washcloth or other device in your hand? She stated, No. I wish they would . maybe if they had put something in there earlier. My daughter bought a ball one time, but it was too big. She was asked, Can you open your hand or extend your fingers? She stated, No. I've had 3 [MEDICAL CONDITION]. She attempted to use her right hand to uncurl her fingers, but they would curl back inward. She was asked, Were your fingers curled inward like that when you were admitted here? She stated, Yes. d. On 07/06/2020 at 12:39 PM, the resident's granddaughter was asked during a telephone interview, Was R #81 admitted with the left-hand contracture? She stated, Yes. I bought a ball once, but it was too big. She was asked, Has the facility ever discussed putting any kind of device or rolled wash cloth in her hand? She stated, No. She did have an arm sling when she first came, and I think they do have a Restorative group that will be working with her. e. On 07/08/2020 at 10:01 AM, the Restorative Certified Nursing Assistant (CNA) was asked, How are you made aware of residents who need hand devices? She stated, The nurses will refer them if they need some kind of therapy . She was asked, Have you seen, or do you have knowledge of (R #81) ever having a hand device or rolled wash cloth placed in her hand consistently? She stated, Not that I know of, but I can go get her one. She was asked, Are you presently doing restorative work with (R #81)? She stated, No. But I can talk to my boss about it and see what she says. f. A Medicare Note dated 5/3/19 provided by the MDS Coordinator documented, .Resident admitted to skilled bed .left sided [MEDICAL CONDITION] on non-dominant side .Resident does have limited movement to lue (left upper extremity) . Note signed by Registered Nurse (RN) #3. g. On 07/09/2020 at 3:38 PM, the ADON was asked, Should (Resident #81} have been provided a hand roll or other preventive device before the surveyor began asking questions? She stated, I think they tried with her, but she refused. She was asked, Is there documentation in the nurses notes or care plan that she refused? She stated, Let me check. The ADON left and returned approximately 45 minutes to an hour later with forms spanning a 4-month period (January to April) that had no initials or signatures, and all appeared to be in the same handwriting. She was asked, Who documented on this form why are there no initials or signatures? She stated,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) The one CNA is out right now and I'm not sure who the other one is. She was asked, Where did you get these forms because when I asked the Restorative CNA for copies of documentation from the log, she said there was no documentation in the Restorative log for (R #81)? The ADON stated, They were in the back of the book. j. On 07/07/2020 at 12:02 PM, a form titled Approved Policies and Procedures provided by the ADON documented, Positioning, mobility, and range of motion .Procedure: To determine, Positioning, ROM and Mobility of a resident . (1) Assessment of positioning, ROM and Mobility is done upon admission . k. On 07/70/2020 at 12:02 PM, a form titled Restorative Nursing Programs provided by the ADON documented, .Restorative Nursing Programs .Policy: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practical level .Policy Explanation and Compliance Guidelines: (3) Nursing personnel are trained on basic, or maintenance, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight .this training may include, but is not limited to: (e) Assisting residents in adjustment to their disabilities and use of any assistive devices .
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the oxygen tubing and humidifier were dated for Resident #3; failed to ensure the oxygen concentrator filters were cleaned for Resident's #93 and #114; and failed to ensure the nebulizer mask were stored to reduce the potential for respiratory complications for Resident #93. This failed practice had the potential affect 10 (#5, #14,#25, #42, #57, #81, #93, # 105, #114 and #115) sample residents who had physician orders [REDACTED]. Resident # 93 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/24/2020 documented the resident scored 11 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required limited assist of 1 person for bed mobility, transfer, and extensive assist for dressing, toileting, and personal hygiene; and did not document whether the resident used oxygen therapy. a. Physician orders [REDACTED]. oxygen at 2-4 liters via nasal cannula as needed for shortness of breath . b. The Care Plan documented, . Problem/Need 3/02/2020 I have the potential for complications r/t (related to) [MEDICAL CONDITION] .Approaches: Observed for signs of respiratory infection (chills, fever, cough, increased respirations, malaise, weakness, aching pains, restlessness or blood-tinged sputum . c. On 07/07/2020 at 04:44 PM, the resident was lying on her back with oxygen on at 2 LPM (liters per minute) via (by way of) N/C (nasal canula) humidified mist. The filters on the oxygen concentrator had approximately 1/4 to -inch dust on the filters. The resident had a nebulizer lying on the stand, by the bed. The nebulizer mask was not covered and was sitting next to a clear plastic bag. A photograph of the nebulizer mask was taken at this time. d. On 07/08/2020 at 09:11 AM, the resident was lying on her back with oxygen on at 2 LPM via N/C humidified mist. The filters on the oxygen concentrator had approximately 1/4 to -inch dust on the filters. The resident had a nebulizer was lying on the stand, by the bed. The nebulizer was not covered and was sitting next to a clear plastic bag. e. Physician orders [REDACTED]. oxygen at 2-4 liters via nasal cannula as needed for shortness of breath . f. On 07/09/2020 at 07:15 AM, the resident was lying on her back with oxygen on at 2 LPM via N/C humidified mist. The filters on the oxygen concentrator had approximately 1/4 to -inch dust on the filters. The resident had a nebulizer mask that was lying on the stand, by the bed. The nebulizer mask was not covered and was sitting next to a clear plastic bag. Registered Nurse (RN) #2 was asked, Can you tell me if the oxygen concentrators filters are clean? She said, They have some fuzz on them. RN #2 was asked, Should the nebulizer mask be laying on the stand, by the bed? Should the nebulizer mask be stored in a bag? She stated, Yes. e. On 07/09/2020 at 08:42 AM, the Director of Nurses (DON) was asked, How often are the oxygen filters to be cleaned? She stated, Every week. They are due today. The DON was asked, Should the nebulizer mask be stored on the table by the bed? She stated, No. f. On 07/09/2020 at 09:24 AM, the ADON provided a copy of a form titled, Oxygen Administration that documented, .Purpose: to administer oxygen to the resident when insufficient oxygen is being carried by the blood tissue . 8. Oxygen concentrators external air filters must be cleaned weekly . She provided the policy for, Administration of Aerosol medications, that documented, .Policy: To deliver medications in aerosol form in a way that served the resident while meeting physician orders [REDACTED].B Tubing/nebulizer should be stored in a clean plastic when not in use . g. On 07/09/2020 at 10:38 AM, Registered Nurse, Care Plan Coordinator provided the manufacture guidelines for the, Platinum Series XL, 5, 10 that documented, . page 8. WARNING . Keep the openings free from lint, hair and the like . 2. Resident # 114 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 6/9/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS; and required limited assist of 1 person for bed mobility, transfer, and extensive assist of 1 for dressing, toileting, and personal hygiene. a. On 07/07/2020 at 4:34 PM, the resident was lying in the bed with oxygen on at 2 LPM via NC humidified mist. The filters had approximately 1/4 to -inch dust and dirt in the filters on both sides of the concentrator. b. On 07/08/2020 a 09:04 AM, the resident was lying in the bed with oxygen on at 2 LPM via NC humidified mist. The filters had approximately 1/4 to -inch dust and dirt in the filters on both sides of the concentrator. The resident was asked, Does the staff clean your filters on the concentrator? She stated, Yes. The resident was asked, Do you know when was the last time they were cleaned? She stated, No. I don't. c. The most recent physician orders [REDACTED]. d. On 07/09/2020 at 07:15 AM, the resident was lying in the bed with oxygen on at 2 liters per minute (LPM) via nasal cannula (NC) humidified mist. The filters had approximately 1/4 to 1/2 inch dust and dirt in the filters on both sides of the concentrator. Registered Nurse #1 was asked, Can you tell me if the oxygen concentrators filters are clean? She stated, No. 3. R #3 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set ((MDS) dated [DATE] documented the resident scored 3 (0 - 7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS); and was totally dependent on staff for care. a. A physician's orders [REDACTED].O2 (Oxygen) (at) 2-4 L (Liters) /Min (Minute) via NC (Nasal Cannula) as needed for Shortness of Breath . b. The Current Care Plan (Problem Onset 09/03/2019) documented, .My ADLs (Activities of Daily Living) require extensive staff assistance .Approaches: I sleep/nap with oxygen on a lot, monitor for dyspnea, SPO2 (oxygen saturation rate) . Documentation related to labeling of the tubing and humidifier was not found. c. On 07/06/2020 at 11:10 AM, R #3 was lying on her back in bed with eyes closed. She was not wearing the nasal cannula. It was in a storage bag. The oxygen tubing and the humidifier bottle had no date or label. A photograph of tubing and humidifier bottle with no date was taken at this time. d. On 07/10/2020 at 09:12 AM, R #3 was not in her room. Her oxygen tubing and nasal cannula was lying on her bed. The Surveyor walked to the dining room and R #3 was being fed by Certified Nursing Assistant (CNA) #4. CNA #4 was asked, How long as resident been up? She stated, She's been up and had her shower and is almost finished with her breakfast. RN #3 was on the hallway when surveyor entered resident's room after knocking. RN #3 was later observed walking in the hallway with tubing in her hand. She did not go directly to the resident's room. She walked toward the dining room with the tubing, then down another hallway. She came back and stood in the hallway watching two activities staff dance for the residents. The Surveyor could see the tubing in her hand. She was finally asked, Who is the new tubing for? She stated, It's for R #3. She was asked, Should oxygen tubing be left lying on the resident's bed when not in use? She stated, That's why I'm taking this down there. CNA #4 stated resident had been up long enough to get a shower and eat her breakfast. e. On 07/07/2020 at 4:11 PM, Registered Nurse (RN) #1 was asked, Who is responsible for changing and labeling/dating the oxygen tubing and humidifier bottles? She stated, The 7P (p.m.) to 7A (a.m.) shift? She was asked, When is the tubing changed? She stated, On Wednesdays . She was asked, Who monitors to see if it's been done? She stated, Any nurse can monitor and if it hasn't been done, can do it. f. On 07/09/2020 at 2:13 PM, the ADON was asked, Who is responsible for changing and dating oxygen tubing? She stated, It has to be done by a licensed nurse. She was asked, When is it done? She stated, At different times on different units. The ADON left to find out the day tubing is changed for Willow unit. She stated, For Willow, it's changed on Wednesdays. She was asked, Should R #3's tubing and humidifier bottle been dated on 07/06/20? She stated, She stated, It could be that it had to be changed that night .maybe something happened to it . g. On 07/09/2020 at 4:30 PM, a facility Policy provided by the ADON and dated 07/08/2020 was reviewed. It documented, .Oxygen Administration .Responsibility: Licensed Nurse .Purpose: to administer oxygen to the resident .Procedure: (9) Oxygen tubing, nasal cannula/face mask must be changed weekly. When not in use the tubing, cannula, and face mask must be stored in a clear plastic bag to keep it free from contamination .Documentation: (6) Change humidifier bottle weekly, label with date change .
F 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** **Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.**

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F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Based on observation, record review, and interview, the facility failed to ensure pureed meals were prepared and served according to the planned, written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. This failed practice had the potential to affect 2 residents plus one PRN (as needed) residents who received pureed diets on the Aspen Hall dining room, 2 residents plus 2 PRN residents who received pureed diets on the Orange Blossom Hall dining room, 2 residents who received pureed diets on the Willow Hall dining room, one resident who received pureed diet on the Magnolia Hall dining room, and 5 residents who received pureed diets on the Oak Hall dining room, according to the Diet List provided by the Dietary Supervisor on 7/7/2020. The findings are: 1. On 7/6/2020, the menu for the noon meal documented residents on regular and mechanical soft diets were to receive 8 ounces (oz) of pork lions. Residents on pureed diets were to receive two # (number)8 scoop (8 oz) of pureed Ziti. a. On 7/6/2020 at 12:09 p.m., Home maker #1 who served pureed food items on the Aspen Hall dining room used the #8 scoop to serve a single portion of pureed Ziti, instead of 2 #8 scoops as per the written menu. At 12:42 p.m., Home maker #1 was asked many how many residents do you have on pureed diets. She stated, I have 3 full pureed with one in the hospital. She was asked how many servings of pureed ziti you gave to each resident. She stated, I gave a scoop each. She was asked how much pureed Ziti was left in the pan after serving. She stated, I have 3 servings left over. She was asked, Should you have had anything left? There was no bread serve to the residents on pureed diets. At 1:00 p.m., Home maker #1 was asked if she serve bread to the residents on pureed diets. She stated, No. b. On 07/06/2020 at 12:22 p.m., Home Maker #2 who served pureed food items on Orange Blossom dining room used the #8 scoop to serve a single portion of pureed Ziti, instead of 2 # 8 scoops. There was no bread served to the residents on pureed diets. At 12:46 p.m., Home maker #2 was asked how many servings of pureed Ziti he served to the residents on pureed diets. He stated, I gave one serving with #8 scoop. He was asked how much pureed Ziti was left in the pan after serving. He stated, I have 2 servings left. He was asked should you have had anything left. He stated, I shouldn't have had anything left. He was asked if he serve bread to the residents on pureed diets. He stated, No. c. On 7/06/2020 at 12:37 p.m., Dietary Employee #1 who prepared the pureed food items was asked if she prepared bread for the residents on pureed diets, she stated, I didn't do bread. d. On 7/6/2020 at 1: 11 p.m., there was no bread prepared and served to the residents on pureed diets. The Dietary Employees served pureed trays without any type of bread.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure foods stored in the refrigerator were maintained to prevent potential for cross contamination to prevent food borne illness for residents who received meals from 1 of 1 kitchen; failed to ensure cold salad was maintained at or below a temperature of 41 degrees Fahrenheit (F); failed to ensure hot food items on the steam table were maintained at a temperature at or above 135 degrees Fahrenheit while awaiting service, to prevent food borne illness for residents who received meals from 5 of 5 dining room with steam tables; failed to ensure dietary staff changed gloves and washed their hands between dirty and clean tasks and before handling clean equipment or food items to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen; and failed to ensure expired food items were promptly removed /discarded on or before the expiration or use by dates to prevent potential food borne illness for residents who received meal trays from 1 of 1 kitchen. These failed practices had the potential to affect 116 residents who received meals from the kitchen (Total census 120), as documented on a list provided by the Dietary Supervisor on [DATE]. The findings are: 1. On [DATE] at 10:46 a.m., the following observations were made in the walk-in refrigerator in the main kitchen: a. An open zip lock bag of slices of turkey was on a shelf in the walk-in refrigerator. b. There were 2 containers of chicken salad on a shelf in the walk-in refrigerator with used by date of [DATE]. One container has been opened with some of the chicken salad eaten out of it. 2. On [DATE] at 10:54 a.m., there were 4 bags of hotdog buns on the bread rack with an expiration date of [DATE]. The bun had mold on it. There were 2 hamburger buns on the bread rack with an expiration date of [DATE]. 3. On [DATE] at 11:07 a.m., the following observation was made on Willow Hall Kitchenette. There was a 46 Fl oz carton of thickened lemon-flavored water on a shelf in the refrigerator with no lid on it. 4. On [DATE] at 11:17 a.m., the following observation were made on Magnolia Hall Kitchenette refrigerator and storage area: a. There was an open bag of cheese slices in a compartment in the refrigerator. b. There was a bag of hamburger bun in a cabinet with an expiration date of [DATE]. 5. On [DATE] at 11:21 AM, the following observations were made in Orange Blossom Hall kitchenette: a. An open bag of cheese slices was on a shelf in the refrigerator. The bag was not sealed. b. An open container of pure sugar was in the cabinet. The container was not covered. 5. 0n [DATE] at11:23 AM, the following observations were made on Aspen Hall kitchenette: a. There was a zip lock bag with slices of cheese in it on a shelf in the refrigerator. The zip lock bag was not sealed. b. There were 2 - 5 pound (lb). boxes of baker source golden butter milk pancake and waffle mix in a cabinet with an expiration date of [DATE]. One of the boxes had been opened some of the pancake or waffle mix has been and used. 6. On [DATE] at 02:41 p.m., Dietary Employee #2 turned the faucet of the sink on and washed her hands. She then turned off the sink faucet with her bare hand. She removed a paper towel from the dispenser and used it to dry her hands. She then picked up clean dishes and stacked them on the carts to be used in serving supper meal with fingers touching the interior surfaces of the dishes. She picked glasses by the rims and stacked them on a clean cart to be used in serving beverages to the resident at supper meal. 7. On [DATE] at 3:59 p.m., Dietary Employee #3 picked up a bag of bread from the bread rack and placed it on the counter, took out 4 cartons of whole milk from the refrigerator and placed them on the counter. She washed her hands and placed gloves on her hands. She removed 9 slices of white bread from the bag and placed them into a blender, she opened 2 cartons of milk and poured them on the slices of bread in the blender and pureed. She removed 9 more slices of bread from the bag and placed them in the blender, opened 2 more cartons of milk and poured them in the blender. Dietary Employee #3 did not wash her hands, before she removed slices of bread from the bag and placed them into a blender to be pureed and served to the residents on pureed diets. 8. On [DATE] at 11:44 a.m., the temperature of the food items when tested and read by the Dietary Supervisor on the steam table on willow kitchenette were: a. Salad with cheese 51 degrees Fahrenheit. b. Broccoli 101 degrees Fahrenheit. 9. On [DATE] at 11:51 a.m., the temperature of the food item when tested and read by the Dietary Supervisor on the steam table on Magnolia kitchenette was pureed broccoli 99.1 degrees Fahrenheit. 10. On [DATE] at 11:56 a.m., the temperature of the food items when tested and read by the Dietary Supervisor on the steam table in Orange Blossom kitchenette were: a. Salad with cheese 58 degrees Fahrenheit. b. Puree broccoli 103 degrees Fahrenheit. 11. On [DATE] at 02:41 p.m., Dietary Employee #2 turned the faucet of the sink on and washed her hands. She then turned off the sink faucet with her bare hand. She removed a paper towel from the dispenser and used it to dry her hands. She then picked up clean dishes and stacked them on the carts to be used in serving supper meal with fingers touching the interior surfaces of the dishes. She picked glasses by the rims and stacked them on a clean cart to be used in serving beverages to the resident at supper meal. 12. On [DATE] at 3:59 p.m., Dietary Employee #3 picked up a bag of bread from the bread rack and placed it on the counter, took out 4 cartons of whole milk from the refrigerator and placed them on the counter. She washed her hands and placed gloves on her hands. She removed 9 slices of white bread from the bag and placed them into a blender. She opened 2 cartons of milk and poured them on the slices of bread in the blender and pureed. She removed 9 more slices of bread from the bag and placed them in the blender and opened 2 more cartons of milk and poured them in the blender. Dietary Employee #3 did not wash her hands, before she removed slices of bread from the bag, placed them into a blender to be pureed, and served to the residents on pureed diets. 13. On [DATE] at 11:47 a.m., the temperature of the food item when tested and read by the Dietary Supervisor on the steam table on Aspen kitchenette was: Pureed cut green beans, 129 degrees Fahrenheit.