STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165442	A. BUILDING _____ B. WING _____	09/28/2017

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F 000	INITIAL COMMENTS Correction date 10/2/17- 314 10/11/17 others √ksc 10/23/17 The following deficiencies relate to the facility's annual health survey and investigation of complaint #70846. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C) Facility reported incident #69763 & #70979 was not substantiated.	F 000		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to develop interventions to prevent the development of a pressure ulcer for 2 of 4 residents reviewed (Residents #9 and #11). The facility reported a	F 314		

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

President/CEO — 10-23-17 — 10/09/2017

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.

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F 314	Continued From page 1 census of 104 residents. Findings included: Resident #9 had a Minimum Data Set (MDS) assessment with a reference date of 2/28/17. The MDS identified the resident had a Brief Interview for Mental Status score of 13. A score of 13 identified the resident had no cognitive problems. The MDS indicated Resident #9 required extensive assistance staff with bed mobility, transfer, dressing, toilet use, personal hygiene and total dependence for bathing. The MDS identified the resident had no impairment in upper extremity and presented with impairment lower extremity range of motion. The MDS indicated this resident used a walker and wheelchair for mobility. The resident's diagnoses included presence of left hip joint, unspecified fall, vascular dementia, anxiety, and depression. The MDS further indicated the resident assessed was at risk of developing pressure ulcers, and had no unhealed pressure ulcers. The MDS identified the following was used for skin and ulcer treatments utilized: pressure reducing device for bed. A Braden Scale for Prediction of Pressure Sore Risk dated as completed 2/21/2017 documented the resident's score of 20. A score of 20 indicated the resident is low risk for pressure sore development. The MDS with a reference date of 4/20/17 identified descriptions of Stages of Pressure Ulcers: Stage I-Intact skin with non-blancable redness of a localized area usually over a bony prominence.	F 314	F314 1. On 9/26/17 the Skin Nurse/Nurse Supervisor RN conducted a skin assessment on Resident #11 of the pressure area on right lower extremity. At this time, the wound was measured, staged, treatment initiated per standing order, and notification to physician was completed. Appropriate revisions were made to the care plan to reflect current pressure injury prevention interventions. Nursing management spoke with the nurses involved on 9/26/2017 reiterating the importance of pressure ulcer prevention, skin assessments when devices are ordered, and initiating treatment and interventions. Direct staff involved reeducated 10/02/17. 2. The nurse management team began audits/reviews on 10/06-17 the care plans of all residents at risk for skin breakdown based on Braden Scale scoring to ensure proper interventions are in place. 3. Nursing staff (nurses and CNAs) will be in-serviced by a wound nurse from AMT on pressure ulcer prevention on November 1, 2017. All nursing staff (including nurses and CNAs) will be assigned an in-service on preventing pressure ulcers for December 2017; nursing staff will complete annual pressure ulcer in-services thereafter.	

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F 314	Continued From page 2 Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II-Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage Iull- Full thickness tissue loss. Subcutaneous fat may be visible but the bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage live-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. The wound often includes undermining and tunneling. The Weekly Skin Assessment form with an entry dated 2/21/17, indicated the heel(s) intact with no sponginess noted. Buttocks are intact. Has surgical wound(s) present to left hip. Staples are dry and intact. No drainage noted. The surrounding tissue is pink and intact with small amount of edema present. No signs of infection noted, groin and abdominal folds are pink and intact. The resident returned from the hospital on this date. The Weekly Skin Assessment form with an entry on 3/23/17, identified the resident had a small open area on coccyx, and Desitin (skin barrier) was applied to the area. The Weekly Skin Assessment form continued to identify the following:	F 314	F314 - continued from page 2 4. The nurse management team began auditing 10/06/17 care plans for appropriate skin integrity interventions based on resident's functional status with every hospitalization or significant change (using MDS guidelines) for one year or until substantial compliance has been achieved. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 314	Continued From page 3 On 3/24/17, the measurement entry identified the resident had a 1cm x 1 cm with .5 cm depth to the coccyx on the inner right buttock. On 3/25/17, the area on the coccyx presented as slough at the center with open granulation (healing) to edges. The open area measured 1.1 by 1.2 by 0.4cm. The open area to the coccyx remained open, and tunneling, area measured 1cmx1.3cm with 1 cm of depth, Wound bed described as black and necrotic (death of most of all of the cells in an organ or tissue) area had minimal amount of yellow slough present. Edges are dark pink non blanchable (does not turn red when pressed on) that is spongy. No odor present. Area was assessed by IMPACT nurse practitioner and staff received new orders. Resident will be seen by Wound Clinic on 4/3/17 for further evaluation. A Care Plan for skin integrity with an onset date of 1/25/17, identified what the resident wanted to happen was to have no sores or open areas. The Care Plan revealed skin interventions were updated with a low air mattress put into place on 3/29/17 and in wheelchair on 3/30/17 after the pressure area had developed. The record identified as treatment administration record dated 9/20/17 identified the wound treatment was to cleanse the wound with normal saline, gently pack with Aquacel HG, (wound dressing contained silver) cover with Meplix border every other day. Observations identified the following: On 9/25/17 at 11:30 a.m. Resident #9 observed in	F 314		

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F 314	Continued From page 4 room, resting in bed, watching television. A pillow was under the left hip area. The bed was in low position. On 9/25/17 at 1:10 p.m., observed cares on this resident and a dressing was present over the coccyx area. Skin surrounding Mepilix dressing was intact and without redness. After cares were completed, resident requested to go back to lying on side to continue watching television and a pillow was placed under left side, under hip area. On 9/26/17 at 7:41 a.m. observation identified Staff G (licensed practical nurse) complete the dressing change as ordered regarding pressure area on coccyx. Staff G used a saline flush to cleanse the wound and patted the area dry. Staff G measured the pressure area at this time and the area measured 1.2cmx1.2cmx.6cm. A silver AG dressing (wound dressing) was applied into wound and wound was covered with Mepilex. (dressing) On 9/26/17 at 8:36 a.m. resident was brought to the dining room for breakfast. Resident was asked what she wanted for breakfast and ate independently. Staff G brought resident a glass of Arginaid (resource drink that promotes wound healing.) In an interview on 9/26/17 at 10:30 a.m. Staff G was asked if resident had the pressure area before the fall with fracture and Staff G stated no. In an interview on 9/26/17, Staff F (Registered Nurse) was asked when air mattress was placed on the resident's bed and the resident's wheelchair had been initiated. Staff F stated she would have to get back to me. Staff F then	F 314		

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F 314	Continued From page 5 verified that the air mattress and air cushion were initiated after the pressure area developed. In an interview on 9/27/17 at 8:00 a.m. with Staff H, (WP health supervisor) acknowledged the pressure area had not developed for over a month after surgery. She stated the resident was still getting up out of bed but when questioned and acknowledged that this resident was spending more time in bed then before resident had fallen. Staff H acknowledged the air mattress and air cushion for the wheelchair were placed after the pressure area discovered. Staff H referred to the documentation from the Advanced Registered Nurse Practitioner that revealed perhaps area was suspicious for a deep tissue injury from surgery. In an interview on 9/27/17 at 1:00 p.m. the surgeon stated this pressure area would not be from surgery. Resident would have been placed on their side during the surgery. On 9/27/17 at 1:47 p.m. the Advanced Registered Nurse Practitioner (ARNP) was interviewed about documentation indicating perhaps the cause of the pressure was from how positioned during the surgery. The ARNP stated that this was speculation because of how fast the pressure area opened and worsened. On 9/27/17 at 2:15 p.m. Staff A (Health Supervisor), Staff B (Health Supervisor), and Staff F were interviewed and informed of the statement made by the surgeon and the ARNP. Staff F stated the wound progressed so quickly that is why the ARNP was contacted to get this resident into the wound clinic quicker. Staff F also stated it was not their standard of practice to	F 314		

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F 314	Continued From page 6	F 314		

automatically put an air mattress on a bed and that no other preventative interventions were in place prior to the pressure wound being discovered.
2. The MDS assessment dated 8/12/17 for Resident #11 identified a BIMS score of 3. A score of 3 indicated the resident had a severe cognitive impairment. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, transfers, and dressing. The MDS documented range of motion impairment on 1 side of the lower extremity. The MDS identified diagnoses that included other fracture and non-Alzheimer's dementia. The MDS recorded no unhealed pressure areas.

The Care Plan focus area, revised 7/14/17, identified an ADL (Activities of Daily Living) self-care performance deficit related to dementia and impaired mobility with right fibula fracture currently. The Care Plan directed staff to provide 1 or 2 (person) assist with dressing and 1 assist transfer with walker for stability. The care plan informed staff to use 2 (person) assist as needed and the resident NWB (non-weight bearing) to the right lower extremity with CAM (controlled ankle movement) boot on at all times; elevate as much as possible. The focus area revised 7/14/17 identified a potential for skin breakdown related to impaired mobility and incontinence. The care plan directed staff to check the resident's skin weekly for breakdown and report to the physician as needed.

The Weekly Skin Assessment dated 9/17/17 at 10:39 p.m. documented the resident's skin WNL (with-in normal limits), skin intact, and free from breakdown.

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F 314	Continued From page 7 The Weekly Skin Assessment dated 9/23/17 at 12:20 p.m. documented no skin areas under sections abrasion/skin tear/rash, pressure, or other. Observation on 9/26/17 at 8:00 a.m. revealed Staff C, RN, Staff E, Certified Nurse Aide (CNA), and Staff D, RN, entered the resident's room to provide cares. Staff C removed the resident's CAM boot from the right lower extremity. Staff C then removed the inner brace off the foot revealing the presence of a skin area on the back of the right heel/Achilles tendon area. The nickel coin sized skin area with a dime-sized, dark scabbed center area; with reddened skin surrounding did not blanch easily when touched. Staff C commented the area did not quite look like that on the previous Friday. Staff C reapplied the brace and CAM boot on the resident without measuring the area. In an interview on 9/26/17 at 9:50 a.m., Staff A, (Health Supervisor), and Staff B, (Health Supervisor) provided documentation regarding Resident #11. Staff A and Staff B clarified nurses were to do weekly skin assessments and CNA staff should observe for skin issues daily reporting any changes or new areas. Staff A and Staff B stated they would have expected staff to note and report observed area on the heel when the boot removed. Staff A and Staff B stated the MDS nurse is responsible for measurements on the first floor. Staff A and Staff B said the plan going forward was to measure area, Stage it, and report it to the physician. In an interview on 9/26/17 at 9:55 a.m., Staff C (Registered Nurse) agreed the area observed	F 314		

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F 314	Continued From page 8 appeared the approximate size of a nickel coin. Staff C confirmed she saw the area on the back of the right heel/Achilles tendon area on 9/22/17. Staff C commented the area looked the same size on 9/22/17 as it did on 9/26/17 but the scabbed center not as dark. Staff C stated normally she checks skins on shower days and then documents the areas. Staff C said on 9/22/17 it was a hectic day and she did not document the skin area and she should have. Review of the clinical record on 9/26/17 at 10:00 a.m. revealed the record lacked documentation of the skin area observed on the back of the right heel/Achilles tendon area.	F 314		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interview, the facility failed to ensure staff completed a restorative program as recommended for one of fourteen residents reviewed. (Resident #4) The facility census was 104 residents.	F 318		

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F 318	Continued From page 9 Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/23/17, documented Resident #4 had diagnoses that included peripheral vascular disease and diabetes mellitus and required limited assistance of one for bed mobility and transfer and scored a 15 on the Brief Interview for Mental Status assessment (cognitively intact). An Occupational Therapy Restorative Program dated 8/28/17, included the following exercises up to 6 times per week: a. Theraband exercises with green-blue band, 1-2 sets, 10-15 repetitions-shoulder flexion extension, shoulder abduction/adduction, shoulder horizontal abduction/adduction, shoulder external/internal rotation, elbow flexion/extension, wrist flexion/extension. b. Dowel exercises with 3 pound weight, 1-2 sets, 10-15 repetitions-shoulder abduction/adduction, shoulder horizontal abduction/adduction, shoulder flexion/extension, chest press, forward/backward circles, elbow flexion/extension. c. Arm bike 10-15 minutes. Comment section requested staff to please encourage resident to participate. A Physical Therapy Restorative Program sheet dated 9/8/17, included the following recommendations for exercises to be completed on the bilateral sides of the residents body up to six times per week:	F 318	F318 1. On 9/27/2017 the Restorative Program Coordinator RN immediately educated restorative aides on the importance of restorative programs and maintaining highest level of independence for residents. 2. All residents of the facility who have restorative programs ordered have the potential to be affected. 3. On 10/11/2017 the Restorative Program Coordinator RN met with restorative staff and discussed expectations of the restorative program. Therapy in-serviced the restorative aides on 10/16/2017 and will again on 10/23/2017 to review restorative programs. The restorative aides will give a daily list of residents that did not received their restorative program that day to the Restorative Program Coordinator RN or designee communicating the reasons why. These residents will be reassigned during the week to compensate for missed time.	

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F 318	Continued From page 10 a. 2 sets/15 repetitions of standing exercises-hip flexion/extension, side steps, marching, mini squats and hip abduction/adduction. b. Level 6 Nu Step (arm/leg exercise machine) for 10-15 minutes. During interview on 9/26/17 at 9:30 a.m., the resident stated they would be on a rehabilitation program two weeks prior but staff had only been in once for exercises. A Look Back Report for the restorative program for September 2017, revealed the resident received restorative on two days during the month on 9/16/17 and 9/26/17. During interview on 9/27/17 at 2:00 p.m., Staff N, Certified Occupational Therapy Aide, COTA stated if an exercise program was set up for a resident to be completed up to six times per week it would be expected that the facility complete it six times per week. During interview on 9/27/17 at 2:28 p.m., Staff J, Certified Nurse Aide, CNA verified they functioned as a restorative aide in the facility but had frequently been pulled from the restorative position to work the floor and residents did not all receive restorative as planned. Staff J stated they were pulled to the floor probably 50 percent of the time and felt it affected how much residents received restorative. During interview on 9/27/17 at 2:34 p.m., Staff I, CNA stated they were a designated restorative aide and was frequently pulled to the floor to work when other staff called in and believed it caused residents to miss restorative.	F 318	F318 - continued from page 10 4. The Restorative Program Coordinator RN or designee will audit completion of restorative program and documentation on everyone on restorative daily for one week, then those scheduled for the day three times per week for one month and then weekly thereafter. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 318	Continued From page 11 During interview on 9/27/17 at 2:40 p.m., Staff K, CNA stated they worked full-time as a restorative aide and did get pulled to work the floor and not restorative at times. Staff K stated there was times residents may not have received restorative. During interview on 9/27/17 at 2:45 p.m., Staff A, Registered Nurse, RN stated restorative staff did on occasion get pulled to work the floor and it had mainly been due to call ins On 9/28/17 at 7:30 a.m., Staff B, RN verified there was no other restorative documentation for the resident.	F 318		
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or	F 363		

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F 363	Continued From page 12 other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, facility menu review and staff interview, the facility failed to follow the planned menu and serve correct portions during one of three meals observed. The facility census was 104 residents. Findings include: 1. The facility Week 3 menu identified a 6 ounce (oz) serving of cereal (equivalent to approximately 3/4 cup) and a #12 scoop (equivalent to approximately 1/3 cup) of ham and cheese scrambled eggs as part of the breakfast meal on 9/27/17. Observation on 9/27/17 at 7:22: a.m., revealed Staff M, Dietary Aide, assigned to serve breakfast in the first floor dining room. Staff M used a #8 scoop (equivalent to approximately 1/2 cup) to serve the oatmeal and a #16 scoop (equivalent to approximately 1/4 cup) to serve the ham and cheese scrambled eggs to residents Observation on 9/27/17 at 8:15 a.m., revealed Staff L Dietary Aide, assigned to serve breakfast in the Evergreen Arbor dining room. Staff L used a #10 scoop (equivalent to approximately 2/5 cup) to serve oatmeal to residents. During interview on 9/27/17, at 9:25 a.m., Staff L reported she would know what portion sizes to	F 363	F363 1. The dietary aides involved were immediately educated on the importance of proper nutrition/ serving sizes and the proper scoops/serving sizes were shown and explained. 2. The facility has determined that all residents who consume food by mouth have the potential to be affected. 3. Reminders of meal serving sizes and proper scoops are given at the preservice meeting prior to every meal. Starting 10/18/2017 each kitchen server will be given a sheet for each meal that includes the correct scoop/serving size for each meal item and will keep it with them for the entirety of the meal service for one month or until substantial compliance has been met. The Dietary Manager will in-service dietary staff on 10/18/2017 on adequate nutrition and proper scoop/serving sizes.	

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	165442	A. BUILDING _____ B. WING _____	09/28/2017

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F 363	Continued From page 13 serve from "showtime" (a short pre-meal meeting), where the Executive Chef or a cook would review with meal service staff the portion devices required for the menu items at that meal. During interview on 9/27/17, at 9:40 a.m., Staff M reported she would know what portion sizes to serve from showtime, where one of the cooks, Executive Chef or Director of Dining Services would review the portion devices needed for the menu items right before the meal. During interview on 9/27/17, at 2:00 p.m., the Executive Chef reported the portion sizes for all menu items are identified on the menus, which dietary staff are expected to follow. The Executive Chef reported there was a copy of the menus located in each kitchenette for meal service staff to refer to for portion sizes. In addition, he reported the department holds a pre-meal service meeting where they review the portion sizes and show what each scoop looks like.	F 363	F363 - continued from page 13 4. The dietary manager, dietitian, or designees will audit every meal in each kitchenette for one week, then one meal in each kitchenette weekly for three months, and then one meal in each kitchenette at least monthly for six months or until substantial compliance has been achieved. Each dietary aide will be audited at least once during this process. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		

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F 371	Continued From page 14 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure dietary staff serve food under sanitary conditions in order to reduce the risk of contamination and food-borne illness during two of three meals observed. The facility census was 104 residents. Findings include: 1. Observation on 9/26/17 at 7:25 a.m., revealed Staff L, Dietary Aide assigned to serve the breakfast meal in Evergreen Arbor dining room, washed hands and donned a glove on her left hand and measured the temperature of the pancakes. Staff L recorded the temperature and donned a glove on her right hand. Staff L began meal service and touched a variety of surfaces with the gloved hands including, but not limited to, kitchenette door handle (both exiting and entering), cupboard door handles, cheerios container, syrup container and refrigerator handle and went on to use their gloved hands to place toast on plates served to seven residents. Observation on 9/27/17 at 8:15 a.m., revealed Staff L assigned to serve the breakfast meal in	F 371	F371 1. The dietary aide involved was immediately educated on the importance of infection control, including handwashing, when to wear/change gloves, and cross-contamination. 2. The facility has determined that all residents who consume food by mouth have the potential to be affected. 3. Reminders of infection control measures are given at the preservice meeting prior to every meal. The Dietary Manager will in-service dietary staff on 10/18/2017 on sanitation, gloving, and handwashing. Reminders will also be given at the preservice meeting that happens prior to every meal. 4. The dietary manager, dietitian, or designees will audit every meal in each kitchenette for one week, then one meal in each kitchenette weekly for three months, and then one meal in each kitchenette at least monthly for six months or until substantial compliance has been achieved. Each dietary aide will be audited at least once during this process. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 371	Continued From page 15 Evergreen Arbor dining room. donned gloves previous to the beginning of the observation period. During the observation period, Staff L touched a variety of surfaces with the gloved hands including, but not limited to, refrigerator handle, cupboard handles, donut tray and the brown sugar container and went on to use their gloved hands to place toast on plates served to seven residents and donuts served to two residents. During interview on 9/27/17, at 9:25 a.m., Staff L reported she received training regarding glove use and recalled the need to wash hands prior to donning and removing gloves and the need to use gloves for food items such as toast, but did not recall training regarding the need to change gloves in between tasks. During interview on 9/27/17, at 2:00 p.m., the Director of Dining Services, Hospitality Manager and Executive Chef confirmed dietary staff receive training as new employees and on an ongoing basis on food safety and sanitation, including appropriate glove us. The Director of Dining Services reported new staff are assigned a computer training module which includes training on glove use and an annual training module. The Executive Chef acknowledged the observations of Staff L's inappropriate glove use would potentially contaminate any ready-to-eat food handled. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry requires single-use gloves be used for only one task, such as working with ready-to-eat food and used for no other purpose and discarded when damaged or	F 371		

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F 371	Continued From page 16 soiled or when interruptions occur in the operation.	F 371		