STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145358	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arista Healthcare	1136 North Mill Street Naperville, IL 60563

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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 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, interview, and record review, the facility failed to provide grooming/hygiene to residents who require assistance for activities of daily living (ADL) care.This applies to 4 of 7 residents (R3, R39, R52, R89) reviewed for ADL care in the sample of 23. The findings include:1. On April 13, 2026, at 11:52 AM, R39 was sitting in his wheelchair in the dining room. R39's fingernails on both hands were long with jagged edges, with brown- black substances under the fingernails. On April 14, 2026, at 12:42 PM, R39 was eating in the dining room. R39 was attempting to open a carton of milk, using his hands and a fork. R39 touched the inside of the milk container with his hands while attempting to open it and drank some of the milk. According to the Electronic Medical Record (EMR), R39 had multiple diagnoses, including unspecified dementia, cognitive communication deficit, muscle weakness (generalized), and other specified arthritis, multiple sites. R39's Minimum Data Set (MDS) dated [DATE], showed R39 had moderate cognitive impairment and required moderate assistance from the staff for personal hygiene, shower, and bath. R39's care plan initiated on October 24, 2025, showed R39 had Activities of Daily Living (ADL) self-care deficit, and the interventions included Certified Nursing Assistants (CNAs) to assist with hygiene tasks as needed. 2. On April 4, 2026, at 12:44 PM, R52 was in the dining room during lunchtime. R52's nail had brown, black substances underneath the fingernails of both hands. According to the EMR, R52 had multiple diagnoses, including active primary progressive multiple sclerosis, cognitive communication deficit, other symptoms and signs involving the musculoskeletal system, and other fatigue. R52's MDS dated [DATE], showed R52 had moderate cognitive impairment and was dependent on the staff for personal hygiene, and shower or bath. 3. On April 4, 2026, at 12:42 PM, R89 was sitting at the nursing station in his wheelchair. R89's fingernails had black substances underneath them. On April 4, 2026, at 1:05 PM, V3 (Assistant Director of Nursing/ADON) said R89 had some black substances underneath his fingernails, and CNAs are responsible for cleaning residents' nails during showers, baths, and as needed. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the EMR, R89 had multiple diagnoses, including vascular dementia, unspecified severity, disorder of muscle, unspecified, and other seizures. R89's MDS showed R89 had memory problems and required supervision and/or touching assistance for personal hygiene and showering or bathing. On April 15, 2026, at 10:52 AM, V2 (Director of Nursing/DON) said the CNAs are responsible for cleaning and trimming the residents' nails. V2 said the CNAs clean the residents' nails during showers or baths, and as needed. V2 said the residents' nails should always be clean to prevent the risk of infections. V2 said the residents' nails should not have jagged edges and should be trimmed to prevent scratches on their skin and prevent the risk of infections and skin conditions. 4. The Electronic Medical Record (EMR) shows R3 has multiple medical diagnoses including generalized muscle weakness, lack of coordination, and legal blindness. Minimum Data Set (MDS) dated [DATE], shows R3 is alert and oriented and requires assistance for grooming. On April 13, 2026, at 11:30 AM, R3 was resting in bed awake, R3 displayed thick, overgrown facial hair to upper lip and chin about 0.5 to 1 inch long. When asked if she wanted facial hair shaving, R3 touched her face and felt the overgrown facial hair and said she wants it shaven, but she needs someone to help shave her facial hair. On April 15, 2026, at around 2:35 PM, V2 (Director of Nursing/DON) stated hygiene/grooming includes oral, nail, and hair care, facial hair shaving for both men and women as needed or requested, shower, bathing and dressing. This must be provided for dignity and comfort.

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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 observation, interview, and record review, the facility failed to assess and monitor the nutritional intake of a resident who received a rapid acting insulin. This applies to 1 of 1 resident (R18) reviewed for insulin administration in the sample of 23. The findings include:R18's EMR (Electronic Medical Records) showed R18 was admitted to the facility on [DATE], with multiple diagnoses including type II diabetes, phantom limb syndrome with pain, absence of left and right legs above the knees, peripheral vascular disease, obesity, hypothyroidism, and anxiety disorder. R18's MDS (Minimum Data Set) dated March 3, 2026, showed R18 was cognitively intact and needed setup/clean-up assistance with eating and oral hygiene. On April 14, 2026, at 9:52 AM, there was a noise heard coming from R18's room. Once inside R18's room, R18 was in bed with her over the bed tray table in front of her. R18's breakfast tray was sitting on the over the bedside tray table. R18's body was shaking and coming into contact with the over the bed tray table causing the orange juice on her breakfast tray to spill on the bed and floor. R18 was saying ouch repeatedly and not able to answer questions appropriately as she had done earlier that morning. R18 was diaphoretic and flushed. At 9:53 AM, V22 (Licensed Practical Nurse, LPN) was notified about R18's condition. V22, V20 (Certified Nursing Assistant, CNA), and V3 (Assistant Director of Nursing, ADON), all went to R18's room. V22 checked R18's blood sugar, at 9:55 AM and it was 43 mg/dL. R18 continued to shake, say ouch, was diaphoretic and flushed. At 9:58 AM, R18 was given 1 mg (milligram) of Glucagon (emergency medication used to treat critically low blood sugar) subcutaneously. At 10:00 AM, V3 removed the plate cover from R18's breakfast tray and the scrambled eggs with cheese and toast were untouched. The yogurt container was opened but appeared untouched. The milk carton was open. There was a bowl of oatmeal on the tray, which was also untouched. At 10:04 AM, V3 gave R18 a nutritional supplement. R18 was able to drink the nutritional supplement and stated she was feeling better. At 10:06 AM, R18's blood sugar was 51 mg/dL, BP (Blood Pressure) was 88/44 mmHg (millimeters of mercury) and pulse was 66 bpm (beats per minute). V3 also fed R18 yogurt. R18's breakfast tray was still at the bedside, V3 the scrambled eggs, toast, oatmeal, and milk were all untouched. At 10:13 AM, R18's blood sugar was 71, BP was 106/42 mmHg and pulse was 72 bpm. R18's Order Summary Report showed a physician's order dated April 1, 2024, to check R18's blood sugar daily before meals and at bedtime, notify the physician or NP (Nurse Practitioner) if blood sugar was less than 7 or greater than 400. The Order Summary Report also showed a physician's order dated March 20, 2026, to administer 13 units of Insulin Lispro (rapid-acting insulin) daily with meals/15 minutes prior to meals. In addition, there was a physician's order dated March 20, 2026, to administer Insulin Lispro as per the sliding scale before meals (for blood sugars 151 to 200, give 4 units; for blood sugars 201 to 250, give 6 units; for blood sugar 251 to 300, give 8 units; for blood sugar 301 to 350, give 10 units). R18's Medication Administration Record (MAR) for April 14, 2026, showed R18's blood sugar at 7:00 AM was 163 mg/dL. Per the sliding scale, R18 was to receive 4 units of Insulin Lispro. At 8:36 AM, R18 was administered the 13 units of Insulin Lispro and the 4 units of Insulin Lispro per sliding scale. On April 14, 2026, at 12:56 PM, R18 stated she was eating less than what she normally eats, and stated she eats half or less than half of what she is served. R18's meal intake sheet from March 16, 2026, to April 14, 2026, showed R18's meal intakes were documented for only one to two meals per day, and R18's intake was 0 to 25 % (percent) for all meals, except one when the intake was 26 to 50 %. On April 14, 2026, at 12:25 PM, V22 stated she administered a total of 17 units of Lispro (4 units of sliding scale plus 13 units) at around 9:00 AM. V22 stated she has taken care of R18 before and R18 eats very slowly and eats independently. At 1:52 PM, V22 stated in the morning, R18 was half awake and half asleep, so she woke up R18, administered 17 units of Lispro, told R18 the breakfast tray was present, and left the room. V22 also stated R18 did not touch the breakfast tray. V22 also stated she makes sure the meal tray is on the table before administering insulin. On April 14, 2026, at 12:59 PM, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V21 (R18's CNA) stated R18 was sleeping when she placed the breakfast tray in the room at 8:00 AM. V21 also stated R18 eats slowly and sometimes it takes R18 till 11:00 AM to eat her breakfast. On April 14, 2026, at 1:02 PM, V20 (CNA) stated R18 does not eat much and she usually eats 25%. On April 14, 2026, at 2:00 PM, V23 (R18's Attending Physician) stated if the resident does not eat or if the resident's blood sugar is below 150 mg/dL, then insulin should not be given. V23 further stated the nurse should make sure there is oral intake before giving insulin. V23 stated R18 not eating may be a contributing factor since Insulin Lispro is short-acting and it peaks between 15 to 30 minutes up to two hours after administration. On April 14, 2026, at 2:29 PM, V24 (Pharmacist) stated rapid-acting insulin should be administered 15 minutes before eating. V24 also stated if a resident eats 0 to 25% of their meals, the physician should be notified and there should be hold parameters. V24 further stated the combination of R18 not eating and the administration of the insulin was the contributing factors for the hypoglycemic event. V24 further stated if the resident had eaten, he would not expect the blood sugar to drop that low. The package insert of Lispro shows change in meal pattern as a factor which may increase the risk of hypoglycemia.

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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, interview and record review, the facility failed to follow orders and therapy recommendations to apply upper extremity devices for residents that have functional limitations on one side.This applies to 2 of 3 residents (R1 and R90) reviewed for range of motions in the sample of 23. The findings include:1.R90's face sheet included multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, wrist drop, right wrist, paraplegia, other lack of coordination. R90's quarterly MDS (minimum data set) dated April 2, 2026, showed that R90 was cognitively intact and had functional limitation in range of motion due to impairment on one side. R90's POS (Physician Order Summary) showed to apply RWHFO (Right Wrist-Hand-Finger-Orthosis) before breakfast and remove after lunch 4-6 hours/daily as tolerated. Check for skin breakdown and maintain brace hygiene (revised October 6, 2025). On April 13, 2026, at 11:16 AM, R90 was sitting propped up in bed. R90's right arm appeared flaccid resting on R90's abdomen and R90 had no devices on right arm. R90 stated My right hand is weak. I don't get much exercise on my right hand. On April 13, 2026, at 3:55 PM, R90 was visited at bedside, and no devices were on R90's right arm. When asked whether staff put any devices on right arm, R90 stated that staff haven't put them on recently.On April 14, 2026, at 9:18 AM, R90 was in bed and there were no devices on R90's right arm.On April 14, 2026, at 9:45 AM, V6 CNA (Certified Nursing Assistant) stated I don't put any devices on. Only Restorative staff and Therapy put it on. When asked if R90 has any devise for her right hand, V6 responded, not that I know of.On April 14, 2026, at 10:45 AM, V14 (Restorative Nurse) stated that the right-hand splint devise is put on after breakfast by restorative aides. When told that the hand devise was observed not on R90's right hand for two consecutive days, V2 responded I don't know why they were not put on.On April 14, 2026, at 4:02 PM, at 3:05 PM, V16 (Restorative Aide) stated that R90 has splint devices for upper extremity, and the staff usually put it on after breakfast. V16 stated that she was not here yesterday, and she did not put it on today. R90's care plan revised December 27, 2023, included that R90 would benefit from participation in the following restorative programs: Splints due to generalized weakness, limited range of motion. Interventions included: Splint Schedule: Apply RWHFO before breakfast and remove after lunch 4-6 hours/daily as tolerated . 2.R1's face sheet showed diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, disorder of muscle, cognitive communication deficit, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, dorsalgia, other lack of coordination.R1's quarterly MDS dated [DATE], showed that R1 was moderately impaired in cognition and had functional limitation in range of motion due to impairment on one side.R1 did not have an order for any devices on POS. POS included 'Patient to be discharged from skilled OT (Occupation Therapist) services effective February 20, 2026' signed by V15 (Occupational Therapist). On April 13, 2026, at 11:59 AM, R1 was seated in her wheelchair, and her left arm was immobile and appeared flaccid. R1 was not wearing any devise on her left hand. When asked to open her fingers on her left hand, R1 was unable to do so. R1 stated that she has received therapies. On April 14, 2026, at 9:23 AM, R1 was in her room seated in her wheelchair and was not wearing any devices to left hand.On April 14, 2026, at 12:28 PM and 1:30 PM, V15 (OT) stated that she had followed R1 for Occupational Therapy and R1 was wearing a palm mitt all day to left hand at that time. V15 stated that R1 had a little bit of grasp' in her left hand. V15 stated that when she discharged R1, she recommended palm mitt to left hand to be placed overnight, and this is to prevent contractures. V15 stated that she does not enter the order in but sends it over to Restorative to follow up. V15 provided Therapy to Nursing Recommendations dated February 20, 2026, that showed left upper extremity palm mitt overnight. On April 14, 2026, at 1:17 PM, V14 (Restorative Registered Nurse) stated that she did not receive any orders from therapy for (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any devices. V14 stated that the restorative aides apply the devices and do the range of motion exercises for the residents. On April 14, 2026, at 3:05 PM, V16 (Restorative Aide), stated that R1 does not have any splint devices and that the restorative staff do range of motion for her. Restorative care plan created September 19, 2025, included that the resident would benefit from participation in the following restorative programs: Walking and AROM (Active Range of Motion) due to: Generalized weakness, Limited ROM (Range of Motion). Interventions included: AROM exercises RUE (Right Upper Extremity) and RLE (Right Lower Extremity) extremities as tolerated x 15 Reps (Repetitions). Encourage daily participation or as tolerated. Report pain or changes in ROM to nurse.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide peri-care in a manner that would prevent urinary tract infection (UTI), failed to ensure indwelling urinary catheter is secured, and failed to apply barrier cream after an incontinence care. This applies to 3 of the 4 residents (R13, R78, R90) reviewed for incontinence and catheter care in the sample of 23. The findings include:1. The electronic medical record (EMR) showed R90 is [AGE] years old who has multiple medical diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cholecystitis, stage 3 chronic kidney disease. On April 13, 2026, at 5:11 PM, V33 (Certified Nursing Assistant/CNA) rendered incontinence care to R90 who was saturated with urine. V33 used wet towels to wipe R90's groins and outer labia. However, V33 did not open and clean the inner area of the labial folds and the urethra, and proceeded to clean the back perineum. V33 finished the incontinence care without ensuring that the whole perineum was completely cleaned. Facility's Policy and Procedure for Perineal/Incontinence Care dated January 2026, shows: Purpose: To provide cleanliness and comfort to the resident, prevent infections and skin irritation, and observe the resident's skin condition. Procedure: Cleanse the resident's perineal area using an approved no-rinse incontinence cleansing product. For female residents, separate labia and cleanse on side, then the other, then the center of the labia towards the rectal area. 2. The EMR showed R13 is [AGE] years old who has multiple medical diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R13's Physician Order Summary (POS) dated August 7, 2024, shows Moisture Barrier Cream/Ointment to buttocks and groins as needed. CNA may apply. On April 14, 2026, at 1:34 PM, V12 and V13 (Both CNA) transferred R13 from wheelchair to bed and rendered incontinence care. R13 said that he had been sitting on his feces for about an hour. During incontinence care R13's fecal matter was dry and pasty with R13's skin flushed/red. V13 said that R13 just came back to facility after going out with friends. V13 cleaned R13 from front to back of the perineum, applied clean incontinence brief, and transferred R13 back to wheelchair without applying barrier cream to his perineum. On April 15, 2026, at 1:02 PM, V11 (Wound Care Nurse) stated that R13 has an order of barrier cream because he is incontinent of urine and bowel. The barrier cream needs to be applied for protection of skin against moisture of urine and feces. 3. The EMR showed R68 is [AGE] years old who has multiple medical diagnoses including muscle disorder, neuromuscular dysfunction of the bladder, abnormalities of gait and mobility, and muscle weakness. Minimum Data Sheet (MDS) dated [DATE], showed R68 is alert and oriented and requires assistance with toileting hygiene. On April 15, 2026, at 12:21 PM, V26 (CNA) transferred R68 from wheelchair to bed and then provided peri-care. R68 has an indwelling urinary catheter. The urinary tube was not secured to R68, it was dangling/moving loosely and getting pulled while R68 was being transferred, repositioned, and being cleaned. While V26 was providing perineal care, R68 asked V26 to secure the urinary tube to her thigh. When R68 was asked why she wanted the urinary tube to be secured to her thigh, R68 replied that it had been loose for several days and every time she was being assisted or moved, the inner catheter tube moved a lot inside her ureter causing pain and discomfort. R68 added, no staff attempted to secure it after it became loose. On April 15, 2026, at around 2:40 PM, V2 (Director of Nursing/DON) stated that indwelling urinary catheter tube must be always secured to prevent accidental pulling, tension, and/or trauma to the ureter and bladder. V2 also said when staff provides incontinence or peri-care the staff must ensure that the whole perineum is clean to prevent potential infection or urinary tract infection. The Facility's Policy and Procedure for Catheter Care dated January 2026, shows: Indwelling catheters will be secured to prevent trauma and tension.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to perform hand hygiene in between tasks during provisions of care and failed to wear complete PPE (Personal Protective Equipment) when providing care to a resident who is under EBP (Enhance Barrier Precautions). This applies to 3 of 23 residents (R3, R7, R90) reviewed for infection control in the sample of 23. The findings include: 1. R90 has multiple diagnoses including diabetes mellitus and presence of gastrostomy tube. On April 13, 2026, at 4:44 PM, V5 (Nurse) checked the gastrostomy tube (g-tube) placement of R90 and administered R90's medications via g-tube. After administration, V5 removed her gloves, touch other surfaces, and donned new set of gloves without hand hygiene then she proceeded to check R90's blood glucose level. 2. The EMR (Electronic Medical Record) shows R3 has multiple diagnoses including type 2 diabetes mellitus with foot ulcer and end stage renal failure (ESRD). R3 receives dialysis from Monday through Friday and has a dialysis access port in the right upper chest. R3's Care Plan shows R3 is at high risk for infection secondary to dialysis and left foot wound. This same care plan shows interventions which includes wearing PPE (Personal Protective Equipment) during high contact resident care activities such as dressing, bathing transferring, changing linens, providing hygiene, changing briefs/toileting etc. During observations from April 13 through April 15, 2026, there was a signage of Enhance Barrier Precautions (EBP) on R3's bedroom door. R3 was also observed for wound care on April 15, 2026, at 10:01 AM. R3 has an arterial wound in her left foot. On April 15, 2026, at 9:39 AM, V32 (Certified Nursing Assistant/CNA) entered R3's bedroom wearing only a pair of gloves and without wearing a gown. V32 turned R3 from side to side to check for incontinence and removed the mechanical lift sling underneath R3. Afterwards, V32 straightened R3's bedding, and left the room without hand hygiene. On April 15, 2026, at around 2:45 PM, V2 (Director of Nursing/DON) stated staff must perform hand hygiene before starting care to resident, in between tasks from dirty to clean and before leaving the room. The staff must also change gloves and do hand hygiene before donning new gloves. If a resident is on EBP, the staff must wear complete PPE including gloves and gown. These are to be done to prevent potential spread of infection. Facility's Policy and Procedure for Hand Hygiene dated January 2025, shows: The purpose of this policy and procedure is to provide guidelines on proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. It also shows the use of gloves does not replace hand hygiene and hand hygiene is always the final step after removing and disposing of personal protective equipment (PPE). The Policy and Procedure of Enhance Barrier Precaution (EBP) dated April 28, 2025 shows: The purpose of this policy and procedure is to reduce the transmission of novel and targeted (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multi-drug-resistant organisms (MDRO). This same policy shows the EBP requires the use of gown and glove during high contact resident care activities. EBP may apply to residents with a wound (chronic wounds) or similar dressing or indwelling device (e.g. central line), even if the resident is not known to be infected or colonized with MDRO. 3. According to the Electronic Medical Record (EMR), R7 had multiple diagnoses, including generalized muscle weakness, a disorder of muscle, unspecified hypertensive heart disease with heart failure, and unspecified lack of coordination. R7's MDS (Minimum Data Set) dated March 23, 2026, showed R7 had impairments to upper and lower extremities and was dependent on the staff for toileting hygiene. On April 14, 2026, at 12:50 PM, V27 (Certified Nursing Assistant/CNA) brought a bowl of soup to R7's room. R7 was sitting up in bed with a bedside table in front of R7. There was a urinal containing some urine on R7's bedside table. V27 placed the bowl of soup on R7's bedside table next to the urinal containing urine. V27 grabbed the urinal containing urine with her bare hands without wearing gloves and went to empty the urine in R7's toilet. V27 left R7's room without washing her hands and without using hand sanitizer. V27 went to the hallway and pulled out one meal tray from the tray cart parked in the hallway. V27 looked at the items on the tray and returned the tray to the cart. V27 then walked to the nurses' station. Immediately after V27 left the tray cart area, R50 was in the wheelchair, wheeling herself in the hallway. R50 went to the tray cart and pulled out the same tray V27 touched. R50 looked at the items on the tray and returned the tray to the cart. On April 15, 2026, at 9:00 AM, V2 said V27 should have removed the urinal from R7's table prior to placing the bowl of food on the table. V2 said V27 should have worn gloves when grabbing the urinal containing urine. V2 said V27 should have performed hand hygiene with soap and water immediately after emptying the urinal and before touching any other surfaces to prevent the spread of infection and potential cross-contamination. The facility's policy titled Policy and Procedure Hand Hygiene, dated January 1, 2020, with a review date of January 2025, showed, Purpose: Provide guidelines on proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. Washing Hands with Soap and Water: 1. Staff will perform hand hygiene by washing hands for at least twenty seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following conditions: . e. After handling items potentially contaminated with blood, body fluids, or secretions.