STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Baptist Village	4747 North Canfield Avenue Norridge, IL 60656

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review, the facility failed to assist residents with feeding in a dignified manner.This applies to 3 of 3 residents (R56, R83, and R79) reviewed for dignity in a sample of 25. Findings include:1. On 8/05/2025 at 12:50 PM, V7 (Registered Nurse/RN) was assisting R56 with her meal in the dining room. V7 mixed R56's served pureed entree food items together. V7 proceeded to feed R56 her mixed pureed meal.On 8/07/2025 at 8:50 AM, R56 was in bed. V8 (RN) was standing over R56 and assisting her with her meal. V8 mixed R56's served pureed entree food items together. V8 said R56 was served eggs, hash brown, and an unknown brownish food item. V8 said R56 consumed 50 % of the main entree.R56's care plan reviewed on 8/07/2025, said R56 was cognitively impaired and required physical staff assistance with eating. R56's care plan did not include mixing all R56's different pureed foods together for meals.2. On 8/05/2025 at 12:20 PM, R83 was in the dining room for lunch. R83 was exhibiting increased anxiety. R83 was attempting to grab her pureed meal items. V7 was assisting R83 with her meal. V7 attempted to redirect R83 and then mixed all R83's served pureed entree food items together. V7 proceeded to feed R83 her mixed pureed meal.R83's care plan reviewed on 8/07/2025, said R83 was cognitively impaired and required physical staff assistance with eating. R83's care plan did not include mixing all the pureed foods together for meals.3. On 8/07/2025 at 8:40 AM, R79 was in bed. V9 (Certified Nurse Assistant/CNA) was assisting R79 with his meal. V9 was standing over R79 and assisting him with his meal.R79's care plan reviewed on 8/07/2025, said R79 was cognitively impaired and required physical staff assistance with eating.On 8/07/2025 at 1:15 PM, V1 (Administrator) said residents with impaired cognition who require assistance with feeding should be treated with dignity. V1 said staff should not stand over a resident or mix pureed food items together when assisting a resident with feeding. The facility's policy titled Resident Dignity dated 3/26/2025, said Purpose: To ensure that residents are cared for in a manner that promotes and enhances quality of life, dignity, and respect.Staff members shall strive to promote resident dignity and to create a positive and enjoyable experience during mealtimes.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) cares for residents who require assistance with their ADLs.This applies to 2 out of 2 residents (R5 and R64) reviewed ADLs in a sample of 25.The findings include:Findings include: 1. On 8/05/2025 at 10:58 AM, R64 was sitting in her wheelchair in the hallway right outside of her room. Her call light was going off. R64 was observed crying. R64, stated, I have to go to the bathroom, but my roommate is in our bathroom. R64 stated she pressed the call light and is waiting for staff to clean her up but she herself has been waiting a long time to be taken to the bathroom. R64 stated It's been a while I really have to go .I can't wait any longer .someone came and then left .I think I'm going in my pants. At 11:35 AM, R64 was in the day room. Her hair was greasy and not combed. She had hair strands above her lip. R64 said she was blind and wanted the whiskers above her lip shaved. R64 stated staff didn't comb her hair today and staff didn't brush her teeth either when they got her dressed. On 8/06/2025 at 11:26 AM, V2 (DON—Director of Nursing) stated CNAs (Certified Nursing Assistants) are supposed to shave residents. V2 said, During morning care, they will see if they need to be shaved. They also can offer shaving during shower days. V2 stated CNAs should help residents brush their teeth if they need it. V2 stated if a resident's roommate is using the bathroom, then staff should bring the resident to the shower room to use the bathroom in there. V2 stated she does not have a policy on ADL's (Activities of Daily Living). Facility's job description for CNA's (12/2016) shows: Essential job duties:--Assist residents with daily dental and mouth care (i.e., brushing teeth.). Assist residents with hair care functions (i.e., combing, brushing, shampooing, etc.). Keep hair on female residents clean shaven (i.e., facial hair). R64's face sheet shows the following diagnoses: transient cerebral ischemic attack, unspecified, visuospatial deficit and spatial neglect following cerebral infarction, other abnormalities of gait and mobility, other lack of coordination. R64's most recent MDS (Minimum Data Set) showed for oral hygiene, R64 needs partial assistance. For toileting hygiene, she is dependent. R64 is frequently incontinent of urine and occasionally incontinent of bowel. R64's care plan (6/18/25) shows she has an ADL self-care performance deficit related to weakness, impaired vision and expressive aphasia, secondary to TIA (Transient Ischemic Attack). Intervention: The resident requires physical assistance by staff with personal hygiene and oral care. The resident requires physical assistance by staff for toileting. R64 has bowel and bladder incontinence related to impaired mobility, weakness secondary to TIA and diagnoses of diabetes mellitus and history of CVA (Cerebrovascular Accident). Intervention: Toilet/Check R64 for incontinence every 2 to 3 hours and PRN (As Needed). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 8/05/2025 at 11:25 AM, R5 was seated in the dining room. Her hair appeared greasy and uncombed, and she had noticeable long, thick facial hair on her upper lip. R5 reported that she has requested assistance from staff on multiple occasions for facial hair removal, stating, staff keep saying they will, but never get around to it. R5 said she is unable to manage facial hair removal independently. R5's face sheet lists a diagnosis of need for assistance with personal care, along with a medical history including hypertensive heart disease, diabetes mellitus, generalized muscle weakness, cognitive communication deficit, and anemia. R5's 7/2/2025 Minimum Data Set (MDS) showed she requires staff assistance with self-care tasks. R5's 5/16/25 care plan identified a self-care performance deficit related to impaired mobility. Care /plan interventions direct staff to provide physical assistance with ADLs, including personal hygiene and bathing. Review of R5's Electronic Medical Record (EMR) showed no documented refusals of care or combative behaviors. On 8/06/2025 at 12:43 PM, V2 (Director of Nursing) stated the facility does not have a formal policy regarding ADL provision, adding staff are expected to provide ADL assistance in accordance with each resident's individual care plan.

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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. Based on observation, interview, and record review, the facility failed to apply left and right palm protectors as ordered by physician.This applies to 1 resident (R76) reviewed for range of motion and contractures in a sample of 25.The findings include:On 8/6/25 at 11:41 AM R76 was observed sitting in large activity room with no palm protector on her right hand. Her right hand was closed with fingers extended against palm. On 8/6/25 at 11:46 AM, V8 (LPN/Licensed Practical Nurse) was asked if R76 had an order for palm protectors. V8 said he was not sure and V7 (RN/Registered Nurse) was R76's nurse. On 8/6/25 at 11:49 AM V7 was observed removing R76 from the dining room. V7 (RN) said the CNA (Certified Nurse Assistant) forgot to put R76's palm protectors on this morning. On 8/6/25 at 11:58 AM, V7 wheeled R76 back into dining room for lunch and pointed out to surveyor that she put both R76's left and right palm protector on. Both R76's left and right palm protectors remained on throughout lunch service. On 8/6/25 at 2:19 PM, V12 (CNA) said she was taking care of R76, and it was her responsibility to put her palm protectors on and off, but she forgot. V12 said palm protectors are important because they help prevent worsening contractures and if they are not applied and taken off as ordered. R76's contractures can get worse and R76 can get wounds on her palms from her fingernails. On 8/6/25 at 2:09 PM, V11 (Restorative Aide) said it is her responsibility to put on and take off R76's palm protectors, but she forgot. V11 said R76 is supposed to have the left palm protector put on after she finished breakfast, and the right palm protector does not get put on until later in the day. V11 said R76 is supposed to have both palm protectors off during meals. V11 said it is important to apply and remove palm protectors as ordered because otherwise the contractures can get worse, and application of the palm protectors can become painful for the resident.R76's POS (Physician Order Sheet) shows orders dated 5/30/25:Left Palm protector ON at bedtime and REMOVE in the morning. Right palm protector ON at all times; remove during meals, personal hygiene, and showers. R76's MDS (Minimum Data Set) dated 5/28/25 shows her decision making is severely impaired and she has impairments to both upper extremities. R76's Care Plan last revised 3/11/24 shows she has an ADL (Activities of Daily Living) self-care performance deficit related to impaired cognition and mobility secondary to diagnoses of dementia, stroke, contracture, and possible pain to hands/fingers. Interventions last revised on 1/25/25 include Nursing/Restorative: Splint/Brace Program: Apply right palm protector on at all times, remove during meals, personal hygiene, and showers. Apply left palm protector on at bedtime and off in the morning.On 8/7/25 at 1:36 PM, V2 (DON/Director of Nursing) said the responsibility of putting on and taking off palm protectors falls more on the CNA than the restorative aide, but the physician's order needs to be followed.The facility's undated policy titled, Orthosis states, Purpose: It is the policy of this facility to provide orthosis (such as brace or splints) to all residents who require them. It is overseen by Restorative Nursing.Procedures: Training is provided to all nurses and nursing assistants to assure that the orthoses are being applied as ordered.

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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. Based on observation, interview, and record review, the facility failed to provide catheter care in a manner to prevent urinary tract infections for a resident with an indwelling urinary catheter. This applies to 1 resident (R8) reviewed for urinary catheters in a sample of 25.The findings include:R8's Face Sheet shows the following diagnoses: flaccid neuropathic bladder, personal history of urinary tract infections, retention of urine, and dementia. R8's POS (Physician Order Sheet) showed a 3/21/2024 order of catheter care (clean catheter with soap and water. Start at entry site. Clean catheter every incontinence episode).On 8/6/25 at 12:24 PM, R8 was in her wheelchair in the dining room. R8's urinary catheter drainage bag was in a privacy bag under her wheelchair. The privacy bag was dragging on the floor and had a dried-up white stain on it across the entire width of the bag, about halfway up the bag. On 8/7/25 at 9:50 AM, R8's catheter care was performed by V13 (CNA/Certified Nurse Assistant). V13 emptied R8's drainage bag. R8's urinary catheter privacy bag was attached to her bed and had the same dried white splatter stains as the privacy bag on the wheelchair did that were noted the day before. V13 provided perineal care for R8. V13 wet a towel with water only and wiped R8's left and right groin front to back and left and right inner labia front to back. V13 did not clean urinary catheter tubing. V13 then turned R8 to her side and cleaned her buttocks and a small bowel movement smear was seen. V13 then placed a clean incontinence brief on R8 with the same soiled gloves she provided perineal care with. On 8/7/25 at 12:19, R8 was observed in the dining room in her wheelchair with the urinary catheter drainage bag in the same soiled privacy bag with the white horizontal stain.On 8/7/25 at 12:47 PM, V13 (CNA) said catheter care should be done if a resident has a bowel movement. V13 said she does catheter care with a towel with hot water. V13 said she did not use soap when she provided perineal care for R8. On 8/7/25 at 1:36 PM, V2 (DON/Director of Nursing) said V2 the CNA who provides perineal care on a resident after a bowel movement, should also be cleaning the urinary catheter tubing. On 8/7/25 at 1:44 PM, V4 (ADON/Assistant Director of Nursing) said soap and water are supposed to be used to clean the resident during catheter care because that is the facility policy. V4 said the catheter tubing should be cleaned in one motion, wiping away from the resident down the length of the flexible tubing. V4 said if the privacy bag is soiled with white residue, it should be changed because that means the bag is contaminated. V4 said the privacy bag should never be touching the floor because that is an infection control concern and poses a risk of cross contamination.R8's Care Plan last revised 12/18/24 states resident has an indwelling urinary catheter in place secondary to hypotonic bladder and she takes Methenamine Hippurate due to recurrent urinary tract infections. Interventions include keep catheter tubing and drainage bag off the floor at all times and perform careful perineal care and keep catheter free from crusting, etc. Care Plan last revised on 7/7/25 states resident was taking oral antibiotic on 7/3/25 for 7 days related to urinary tract infection (UTI) and remains at risk for UTIs related to the use of the indwelling urinary catheter. Interventions include check resident at least every 2-3 hours for incontinence. Wash, rinse, and dry soiled areas.The facility's policy titled, Catheterization last reviewed 3/31/25 states, Policy Statement: Use of indwelling catheters (Foley) is discouraged unless required to monitor output in seriously ill residents. Procedure:2. General Guidelines: e. Never let any part of the drainage system touch the floor.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to aspirate gastric contents to check the placement of a resident's gastrostomy tube (GT). This applies to 1 of 1 (R3) residents reviewed for GT care in a sample of 25.Findings include:On 8/5/25 at 1:40 PM, V17 RN (Registered Nurse) used a large syringe and pushed 10-15 ml of air through R3's GT and auscultated her abdomen to check the placement of the tubing.On 8/6/25 at 11:23 AM, V10 (RN) used a large syringe and pushed 15 ml air into the GT and auscultated R3's abdomen with a stethoscope. V10 stated she heard the gurgling sound of the air being pushed in. V10 then pushed 160 ml water with the syringe into the GT as per orders. V10 stated the facility had taught them to check for GT placement in this manner.R3's 4/24/2025 care plan showed, check for tube placement and gastric contents prior to beginning feeding. R3's physician orders showed a 4/6/25 order to check G-tube placement before feeding and medication administration every shift.On 8/7/25 at 12:30 PM V2 (DON-Director of Nursing) stated facility has not revised their policy since 2013. V2 stated, facility will investigate it and revise their policy.Facility policy on enteral feeding was dated 2/9/13. The policy was reviewed on 4/4/25 yet was not revised to the current standard of practice.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to administer medications as ordered. There were 30 opportunities with 3 errors resulting in a 10% error rate. This applies to 1 of 5 residents (R17) observed in medication pass.The findings include:Findings include:On 08/06/2025 at 9:20 AM, V10 (Registered Nurse/RN) prepared R17's 8:00 AM scheduled medications. R17's prepared medications did not include tablets of spironolactone 25 mg (milligram) tablet, vitamin B12 1000 mcg (microgram) tablet, or the furosemide 40 mg tablet. V10 said she forgot to include the medications as ordered. On 08/07/2025 11:50 AM, V4 (Assistant Director of Nursing) said nurses received medication administration training routinely to ensure safe administration of medications. V4 said V10 should have checked R17's EMAR (Electronic Medication Administration Record) to ensure all scheduled medications were prepared and administered as ordered. On 08/07/2025 11:25 AM, V2 (Director of Nursing/DON) said nurses were expected to check medication rights prior to administering medications to ensure resident safety. R17's Order Summary Report showed orders for vitamin B12 1000 mcg 1 tablet, furosemide 40 mg 1 tablet, and spironolactone 25 mg 1 tablet to be administered at 8:00 AM daily. The facility's policy titled Administering Oral Medications showed The purpose of this procedure is to provide guidelines for the safe administration of oral medications.Check the label on the medication and confirm the medication name and dose with MAR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to perform hand hygiene when providing resident care and failed to ensure staff adhered to Enhanced Barrier Precautions. This applies to 6 of 6 (R3, R4, R6, R44, R81, and R8) residents reviewed for infection control in a sample of 25. Findings include: 1. [DATE] at 11:00 AM, V14 (CNA-Certified Nursing Assistant) and V18 (CNA) provided morning care to R6. R6 had a supra-pubic catheter draining urine into the urine bag. V14 emptied the urine from the urine drainage bag into a urinal. After emptying, V14 did not clean the spout and replaced it in its slot. After discarding the urine into the toilet, V14 removed his gloves, did not perform hand hygiene and put on another pair of gloves. V14 opened R6's soiled diaper, and while wearing the same gloves, reached into his pockets and pulled out a roll of plastic bags, tore off two bags, and placed the roll back in his pockets. V14 turned R6 to her right side, held by V18 (CNA), and wiped off stool from R6's buttocks using a wet towel. V14 did not change gloves or perform hand hygiene, and while wearing the same gloves, V14 opened the bathroom door, went in and brought out another wet towel. V14 cleaned R6's buttocks again. After the perineal care, neither V14 CNA or V18 CNA performed hand hygiene or changed gloves. They dressed R6's in clothes and placed the mechanical lift sling under R6. Without changing gloves or performing hand hygiene, V14 opened R6's room door, went outside and brought in R6's wheelchair. With the same soiled gloves, V14 then removed the foot rest from the wheelchair and placed it on the side, moved the cardiac table aside, placed the mechanical lift near R6 in position, and hooked up the loops of the sling. Then V14 lifted the mechanical lift with the remote control and weighed R6. While still wearing the same soiled gloves, V14 reached into his pockets, took out a pen and paper, wrote down the weight and placed the pen and paper back in his pockets. Together they lowered R6 onto the wheelchair and in the process, the urine bag fell on the floor. V18 opened R6's drawer, took out a comb and combed R6's hair. V14 also wiped R6's face with a wet towel, using the same soiled pair of gloves. Then V18 took R6 out of the room. V14 used the same soiled gloves to tie up the garbage bag and the linen bag and placed both bags onto a pillow that was on a chair next to the bed. At that point, V14 removed gloves but did not wash his hands. V14 took the mechanical lift out of the room, brought in clean linen and placed a draw sheet on R6's bed. V14 tidied bed without gloves. After that he placed the garbage bag and the soiled linen bag that was on the chair onto R6's bed, tidied the bed space, and then took the garbage bag and the soiled linen bag out of the room. On [DATE] at 1:45 PM, V4 (ADON – Assistant Director of Nursing) stated, she educates the nursing staff on how to do their procedures. While emptying the urine bag, they should clean the spout with normal saline before replacing it in the slot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:15 AM, observed V15 (WCN – Wound care nurse) changed the dressing for R6's wound on the right ischium. V15 turned R6 onto her right side. R6 had stool at the anus and around the perineal area. V15 did not wipe the perineal or gluteal area, removed the soiled brief, and placed the fresh disposable brief under R6. V15 changed the dressing without cleaning R6's perineal area and R6 was in the process of passing stool. After changing the dressings for all the wounds, V15 (WCN) tied up the garbage in a plastic bag. With same used gloves, in the right hand V15 picked up the garbage bag and the clean bag with clean box of gloves and hand sanitizer, opened the room by touching the door knob with left hand, placed the bag with clean box of gloves on her treatment cart and discarded the garbage bag. Then re-entered the room, removed PPE (Personal Protective Equipment) and washed her hands. 2. On [DATE] at 11:04 observed V16 (CNA) and V14 (CNA) transfer R4 from bed to wheelchair. After settling R4 in the wheelchair, V16 removed gloves and wheeled R4 out of the room without performing hand hygiene. V14 removed his gloves without performing hand hygiene, removed mechanical lift from the room to outside, and tidied up the bed space. 3. On [DATE] at 1:40 PM, V17 (RN-Registered Nurse) prepared to perform a gastrostomy tube (GT) flush for R3. V17 donned PPE (Personal Protective Equipment) and handled R3's GT. Without changing her gloves and performing hand hygiene, V17 touched the door knob to open the bathroom, filled water in a cup from the sink, and came back to R3. After handling R3's GT again, and wearing the same gloves, V17 opened the bathroom door, replaced the stethoscope and syringe back on the IV pole, and moved the privacy curtain back. On [DATE] at 11:23 AM, V10 (RN) prepared to flush R3's GT. After the procedure and with same soiled gloves on and no hand hygiene, V10 removed the stethoscope from her neck and replaced the syringe into its plastic bag and hung both on the IV pole next to the bed. V10 also handled the cardiac table and opened the bathroom door by touching the door knob while wearing the same soiled gloves. On [DATE] 11:39 AM, V5 (IP-Infection Preventionist) stated hand hygiene must be done before and after using gloves. V5 stated, doors and door knobs must not be touched with soiled gloves. V5 stated staff should not reach into their pockets or touch their own clothes while wearing gloves. V5 stated after emptying the urine from the urine bag, they must clean the spout with a alcohol wipe before replacing it back in its slot. On [DATE] at 12:30 PM, V2 (DON-Director of Nursing) stated, staff must do hand hygiene before and after removing gloves. V2 stated they cannot touch door knobs with gloves or after removing gloves and without performing hand hygiene. V2 stated after any procedure, they must remove gloves, perform hand hygiene and then wear another clean glove for the next procedure. V2 stated before replacing the spout of the urine bag after emptying the urine, they should clean it with alcohol swab. 4. On [DATE], at 12:08 PM, Resident R81 was observed in bed with family present at the bedside. Certified Nursing Assistants (CNAs) V18 and V19 entered the room. V19 placed R81's lunch tray on the overbed table. Both CNAs donned gloves without performing hand hygiene. V18 pulled the privacy curtain around R81's bed. V18 and V19 repositioned R81 and touched her bed linens and incontinence pad to assess whether incontinence care was needed. While still wearing the same soiled gloves, V19 then touched items on R81's lunch tray, and V18 opened the privacy curtain. Both CNAs then removed their gloves and exited the room without performing hand hygiene. They immediately proceeded to distribute meal trays to other residents in the hallway. (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 - Some	R81's care plan reviewed on [DATE], indicates a self-care performance deficit related to impaired mobility. Interventions include physical staff assistance for activities of daily living (ADLs), including incontinence care and bed mobility. 5. On [DATE] at 10:55 AM, R44 was bed. V6 (Certified Nurse Assistant/CNA) was rendering incontinence care to R44. R44 had a small smear of bowel movement. V6 cleaned R44's peri-area and then buttock area with her gloved hands. After V6 completed R44's incontinence care, V6 did not change her gloves or perform hand hygiene. V6 then applied a clean incontinence brief to R44. V6 then proceeded to remove R44's gown, assisted with dressing, and placed a mechanical lift sling underneath R44. V6 then lowered R44's bed by touching the control with the same soiled gloves. V6 said she was done and left the room to get assistance with transferring R44. V6 removed her gloves and left the room without performing hand hygiene. R44's care plan reviewed on [DATE], said R44 was dependent on staff assistance with toileting and dressing. 6. R8's Face Sheet shows the following diagnoses: flaccid neuropathic bladder, personal history of urinary tract infections, retention of urine, and dementia. R8's POS (Physician Order Sheet) shows an order dated [DATE] maintain enhanced barrier precautions for indwelling urinary catheter. On [DATE] at 9:50 AM, R8's catheter care was performed by V13 (CNA/Certified Nurse Assistant). V13 emptied R8's drainage bag while only wearing gloves, no gown. Enhanced Barrier Precaution signage noted at entrance to R8's room instructing staff to wear gown and gloves. V13 then provided perineal care for R8. V13 wet towels with water only and wiped R8's left and right groin front to back and left and right inner labia front to back. V13 then turned R8 to her side and cleaned her buttocks by wiping front to back, small bowel movement smear noted. V13 then placed a clean incontinence brief on R8 with the same soiled gloves she provided perineal care with. On [DATE] at 1:36 PM, V2 (DON/Director of Nursing) said staff need to wear gown and gloves when emptying the urinary catheter drainage bag of a resident because that is what is required for enhanced barrier precautions. V2 said there is a risk of cross contamination/carrying germs to another resident if a gown is not worn while emptying a urinary catheter drainage bag. R8's Care Plan last revised [DATE] states resident is on enhanced barrier precautions related to long term use of indwelling urinary catheter. Interventions state staff to wear gown and gloves throughout high/close contact resident care activity including changing incontinence brief and indwelling medical device care. The facility's policy titled Hand Hygiene dated [DATE], said Purpose: Hand hygiene (washing with soap and water or using alcohol-based hand sanitizer) is the most important way to prevent the spread of infections. Germs on hands can transmit dangerous organisms to others .the Five Moments for Hand Hygiene .Before clean/aseptic procedure .After body fluid exposure risk .Before touching a patient .After touching a patient . After touching the patient's surroundings .