STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365841	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health Campus	1247 North River Rd Fremont, OH 43420

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to timely notify the physician and responsible part regarding a new wound. This affected one resident (#1) of three residents reviewed for notification of change. The facility census was 58.Findings include:Review of Resident #1's medical record revealed an admission date of 06/02/25. Medical diagnoses included aphasia, anemia, weakness, constipation, a pressure ulcer of the sacral region that was unstageable, and a vitamin D deficiency.Review of Resident #1's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a memory problem with severe impairment. Resident #1 was always incontinent of bowel and bladder, was dependent for toileting, and needed substantial assistance for showers and personal hygiene. Review of Resident #1's admission skin assessment completed on 06/03/25 revealed no identified skin impairments to the buttocks or coccyx upon admission. Review of Resident #1's care plan revealed on 06/12/25 Resident #1 was at risk for skin breakdown related to a need for assistance with mobility, communication and cognitive deficits, and incontinence. Further review of Resident #1's care plan revealed on 07/15/25 Resident #1 had a pressure ulcer on her coccyx. Review of Certified Resident Care Associate (CRCA) #524's documentation in Point of Care (POC) regarding skin problems on 07/08/25 at 2:51 A.M. revealed Resident #1 had an open area on her buttock. Review of Resident #1's progress notes signed by Registered Nurse (RN) #232 dated 07/09/25 at 4:36 A.M. revealed Resident #1 had two new wounds on her buttocks. The left wound measured four centimeters (cm) by three cm. The inner right wound measured two cm by one cm. RN #232 documented she placed Xeroform on the left wound and Durafiber on the right wound. RN #232 documented the nursing staff were to monitor and wound care clinician would assess. There was no documentation the physician or family were notified. Review of Resident #1's physician orders revealed no order for the Xeroform or Durafiber dressing RN #232 placed on Resident #1. Review of Resident #1's physician orders revealed a new order was created on 07/11/25 at 9:21 P.M The order stated to cleanse the wound with wound cleanser or normal saline, pat dry, apply triad to the wound bed, and cover with dry dressing. This was to be changed daily. Interview with LPN #233 on 08/19/25 at 11:03 A.M. revealed the nurse had not provided notifications of the wound to the physician or family and had not contacted the physician for wound care orders. Furthermore, LPN #233 verified an order for a dressing was not in place until 07/11/25. Review of the facility policy titled Notification of Change in Condition with a last reviewed date of 12/17/24 revealed the physician should be notified when there is a need to alter the residents treatment such as a deterioration of health.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and facility policy review, the facility failed to accurately and timely identify and provide treatment for pressure ulcers. This affected two residents (#1 and #60) of three residents reviewed for wound care. The facility identified three residents with pressure ulcers. The facility census was 58. Findings include: 1.Review of Resident #1’s medical record revealed an admission date of 06/02/25. Medical diagnoses included aphasia, anemia, weakness, constipation, a pressure ulcer of the sacral region that was unstageable, and a vitamin D deficiency. Review of Resident #1’s admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a memory problem with severe impairment. Resident #1 was always incontinent of bowel and bladder, was dependent for toileting, and needed substantial assistance for showers and personal hygiene. The resident was identified with no pressure ulcers and was at risk for skin breakdown. Review of Resident #1’s admission skin assessment completed on 06/03/25 revealed no identified skin impairments to the buttocks or coccyx upon admission. Review of Resident #1’s care plan revealed on 06/12/25 Resident #1 was at risk for skin breakdown related to a need for assistance with mobility, communication and cognitive deficits, and incontinence. Interventions included keeping linens clean and dry, use moisture barrier product to perineal area as needed, low air loss mattress to bed, and encourage fluids. Further review of Resident #1’s care plan revealed on 07/15/25 Resident #1 had a pressure ulcer on her coccyx. Review of Certified Resident Care Associate (CRCA) #524’s documentation in Point of Care (POC) regarding skin problems on 07/08/25 at 2:51 A.M. revealed Resident #1 had an open area on her buttock. Review of Resident #1’s progress notes signed by Registered Nurse (RN) #232 dated 07/09/25 at 4:36 A.M. revealed Resident #1 had two new wounds on her buttocks. The left wound measured four centimeters (cm) by three cm. The inner right wound measured two cm by one cm. RN #232 documented she placed Xeroform on the left wound and Durafiber on the right wound. RN #232 documented the nursing staff were to monitor and wound care clinician would assess. There was no assessment of the type of the wound, the depth of the wound, the wound bed, type of drainage, wound odor and condition of the surrounding skin. Review of Resident #1’s physician orders revealed no order for the Xeroform or Durafiber dressing RN #232 placed on Resident #1. Review of the Wound Management Detail Report (WMDR) created by Licensed Practical Nurse (LPN) #233 on 07/14/25 at 9:12 P.M. the left pressure ulcer was observed on 07/09/25 at 4:36 A.M. and was documented as follows: length of the left wound was four cm and the width of the left wound was three cm. There was light exudate from the wound that was serosanguinous. The tissue type was epithelial tissue. There was no assessment of the wound bed and condition of the surrounding skin. The wound stage was not identified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the WMDR created by LPN #233 on 07/14/25 at 9:08 P.M. her coccyx pressure ulcer was observed on 07/09/25 at 4:36 A.M. and was documented as follows: length of the coccyx wound was two cm and the width of the wound was one cm. There was light exudate from the wound that was serosanguinous. The tissue type was slough tissue. The wound stage was not identified. Review of the Resident #1’s physician orders dated 07/11/25 at 9:21 P.M. revealed an order to cleanse the wound with wound cleanser or normal saline, pat dry, apply triad to wound bed, and cover with a dry dressing. The order states to change the dressing daily. Observation on 08/18/25 at 3:30 P.M. of the dressing change for Resident #1 revealed a wound that was five cm by seven cm and was 3.2 cm in depth. Concurrent interview with LPN #233 revealed the wound was a [NAME] wound. Interview with LPN #233 on 08/19/25 at 11:03 A.M. revealed the nurse should have called the physician regarding the wound to obtain an order for a dressing. Furthermore, LPN #233 verified an order for a dressing was not in place until 07/11/25. Interview with CRCA #524 on 08/19/25 at 11:40 A.M. revealed she reported the open area on Resident #1’s buttocks to RN #232 on 07/08/25. Review of the facility policy titled “Notification of Change in Condition” with a last reviewed date of 12/17/24 revealed the physician should be notified when there is a need to alter the residents treatment such as a deterioration of health. Review of the facility policy titled “Pressure/stasis/arterial/diabetic wound guidelines” with a last reviewed date of 12/17/24 revealed that an appropriate wound incident should be completed in the electronic health record, the interdisciplinary team will review the incident, documentation should include a full wound assessment which includes length, width, depth, exudates, color, odor, wound margins, surrounding tissue, and tunneling and or undermining if applicable and wounds should be reviewed weekly. 2. Review of the medical record for Resident #60 revealed an admission date of 07/04/25 and a discharge date of 07/29/25. Diagnoses included pneumonia, chronic obstructive pulmonary disease, chronic kidney disease, heart failure, and atrial fibrillation and a history of stage two pressure ulcers (loss of partial thickness of the skin appearing as an abrasion, blister or shallow crater). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and no pressure ulcers. Resident #60 was occasionally incontinent of bladder and continent of bowel. The resident had skin tears and moisture associated skin damage (MASD). The resident required partial/moderate assistance with bed mobility, substantial/maximal assistance for toileting and transfers. Review of hospital documentation dated 07/03/25 revealed the resident’s buttocks were red with small open areas. Review of hospital documentation dated 07/04/25 revealed the resident had an open area on buttock, foam dressing and triad applied and change routinely as needed. The resident was at risk for skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurses admission skin assessment completed on 07/04/25 at 3:45 P.M. and documented on 07/05/25 at 7:47 P.M. revealed the resident had a laceration/abrasion to the left of the coccyx 0.5 cm in length, 0.4 cm in width, and 0.1 cm in depth. The resident had a laceration/abrasion to the right of the coccyx measuring 0.5 cm in length, 0.4 cm in width, and 0.1 cm in depth. There was no description of the wound bed or surrounding skin. Interventions included applying moisturizer to keep skin supple, monitoring for edema, pressure reducing cushion, ensure appropriate treatment implemented, pressure reducing mattress, and utilize draw sheet with repositioning. There was no documentation of MASD. Review of the skin risk assessment dated [DATE] revealed the resident was at risk for skin breakdown. Review of a physician order dated 07/04/25 revealed the resident had an order for a pressure reducing cushion and a low functioning air mattress. Review of a physician order dated 07/05/25 revealed to apply barrier cream to buttocks with incontinence care and monitor abrasions for signs of infection three times per day. Also to encourage resident to turn and reposition while in bed. Review of Physician #600’s History and Physical exam for Resident #60 dated 07/07/25 revealed a stage two pressure ulcer was noted in the diagnoses summary. Physician #600 noted skin impairments including an open area to the left lower extremity, a scab on the left upper cheek, and noted buttocks and provide treatments as ordered with no further description of the impairment to the buttocks. Review of wound care notes dated 07/08/25 at 8:42 A.M. revealed the left buttock dermatitis wound was four cm in length by 2.5 cm in width. The right buttock measured five cm in length by seven cm in width. The resident was noted with bilateral buttock dermatitis, bright red but blanching, active bleeding, and excoriated skin. Resident reported being continent of urine and stool since admission but was not while at the hospital. There was no description of the wound bed and no documentation if the depth of the wound was assessed. Review of a physician order dated 07/08/25 revealed to apply Triad wound dressing to bilateral buttocks twice daily, Review of a nurses note dated 07/09/25 at 12:43 A.M. revealed the nursing assistants reported the resident had a pressure wound to his bottom. Upon assessment, there were two wounds dry, red, and peeling of skin with no measurements and no thorough wound assessment completed. Wound was cleansed and hydrogel island dressing applied. Nursing would continue to monitor and the wound care clinician to assess. There was no physician order for the wound dressing applied. Review of an event report dated 07/09/25 at 12:51 A.M. revealed the resident had wounds to buttock. No event details were completed. The event report was invalidated on 07/29/25 at 9:34 A.M. noting the wounds were identified on admission and were not new. Review of wound care notes dated 07/15/25 at 8:39 P.M. revealed dermatitis to the left buttock measured four cm in length by 2.5 cm in width. The right buttock dermatitis wound measured five cm in length by seven cm in width. The area was bleeding. Treat with zinc oxide twice a day. There was no description of the wound bed and no documentation if the depth of the wound was assessed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 07/19/25 revealed to cleanse wounds to bilateral buttocks with normal saline, pat dry, apply xerofoam, cover with nonadherent bandage and change each shift and as needed. Also, an order to check and change and reposition the resident every two hours. Review of a physician order dated 07/21/25 revealed to cleanse bilateral buttock wounds with soap and water, rinse well, apply zinc oxide twice daily. Review of wound care notes dated 07/22/25 revealed the left buttock dermatitis wound was five cm in length by two cm in width. The right buttock dermatitis wound measured four cm in length by two cm in width. Light bleeding was noted with peri wound pink and blanchable. Continue zinc oxide. There was no description on the wound bed and no documentation if the depth of the wound was assessed. Review of a physician order dated 07/27/25 revealed to cleanse right buttocks with wound cleanser, pat dry, apply hydrophilic wound dressing, cover with Alleyvn or hydrocolloid dressing daily every shift. Review of a Physician #600 progress note dated 07/28/25 at 7:30 A.M. revealed the resident had a low air loss mattress with seat cushions on his wheelchair and recliner. The physician noted the resident had skin impairment with treatment orders changed on 07/27/25. There was no further description of the skin impairment. The physician noted continuing with low air loss mattress, seat cushions on the wheelchair and recliner, and therapy for off loading with frequent position changes. The wound nurse would reassess this morning and document new findings with changes. Continue nutrition encouragement. The physician noted the previous 07/19/25 orders for repositioning every two hours and document reviewed with staff in compliance. Review of a wound care note dated 07/28/25 at 11:17 A.M. revealed the resident was noted with dermatitis with the right buttock wound measuring 4.5 cm in length, two cm in width and 0.1 cm in depth. The wound to the left buttock measured 5.8 cm in length, 3 cm in width by 0.1 cm in depth. The peri wound was red and blanchable with possible fungal infection. The nurse practitioner was notified with new orders to add antifungal cream to peri wound, continue Triad to wound bed and cover with hydrocolloid dressing. Wounds discussed with the residents Power of Attorney (POA). Review of a nurses progress note dated 07/29/25 at 10:05 A.M., LPN #233 noted a wound assessment was completed. The peri wound was a ruddy color showing improvement with antifungal cream. Wound bed beefy red with light bleeding noted. Hydrocolloid dressings not sticking to wound due to antifungal cream, lidocaine cream, and triad. New orders received from nurse practitioner to change the dressing type from hydrocolloid to large Allevyn. Resident representative aware of changes. Review of an Interdisciplinary Team (IDT) progress note dated 07/29/25 at 3:00 P.M. and recorded as a late entry on 07/30/25 at 12:57 P.M. revealed the Administrator, Director of Nursing, Social Worker, and Wound Care Nurse met with the resident and resident representative. Wound care dressing orders were reviewed. Recommendations at time of admission for fluid restriction and no added salt (NAS) diet refused by the resident and resident representative were reviewed and refused again. The POA adamantly requested resident transfer to a hospital at this time with transfer arrangements made and resident discharged per their request. Review of the Treatment Administration Records dated 07/04/25 through 07/29/25 revealed treatments were completed per physician orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of emergency department (ED) physician note dated 07/29/25 at 4:52 P.M. revealed Resident #60 had stage two decubitus ulcers of the right and left buttocks. Further review of the physician note revealed the resident was brought by emergency medical services (EMS) at the request of the family for evaluation of gluteal wounds his family stated had developed several days ago and appeared to be worse. The ED wound evaluation noted at the apex of both gluteal areas there were two open wounds noted as stage two pressure sores with the epidermal layer gone and not into the subcutaneous fat. There was some granulation around the area, without any undermining or fluid buildup or deeper structure. There was some surrounding redness at the region without signs of infection. Each wound measuring three centimeters in length by two centimeters in width. The wounds were cleansed with orders to apply barrier ointment and specialized padded dressing and to follow up with a wound clinic or wound specialist. The resident was discharged on 07/29/25 at 6:49 P.M. to another nursing home facility. Interview on 08/18/25 at 1:32 P.M., Licensed Practical Nurse (LPN) #233 revealed she was the facility wound nurse and was on vacation when Resident #60 admitted to the facility. LPN #233 revealed Resident #60 admitted to the facility with moisture associated skin damage (MASD) to the bilateral buttocks. LPN #233 verified the resident had been incorrectly identified with a laceration/abrasion to the buttocks during his admission skin assessment. LPN #233 revealed the staff nurses may not have the knowledge on how to assess and identify different types of wounds. LPN #233 revealed a wound nurse from another facility assessed the resident’s wounds on 07/08/25 and had identified the wounds as MASD. LPN #233 revealed she assessed the wounds on 07/15/25 and the wounds blanched and were not pressure ulcers. LPN #233 revealed the wounds had looked the same at discharge as when she first assessed the wounds. LPN #233 revealed the POA for the resident wanted a different wound treatment using Allevyn and hydrocolloid dressings which were used for pressure ulcers. LPN #233 revealed she had educated the POA this dressing would hold in moisture and cause further skin breakdown. LPN #233 revealed the resident had an air mattress in place along with pressure reducing cushions to the wheelchair and recliner. LPN #233 revealed the facility had not photographed the wounds, but the resident’s POA had photographed the wounds. Interview on 08/19/25 at 7:52 P.M., the Director of Nursing (DON) revealed she had assessed Resident #60’s wounds as MASD and described the wounds as raw and red. The DON stated the wounds were not pressure ulcers. Interview on 08/19/25 at 8:03 A.M., Physician #600 revealed he had assessed Resident #60’s wounds on 07/28/25. Physician #600 revealed the resident had bilateral wounds to the buttocks in the area where you would sit. Physician #600 revealed there were two open areas which were raw where the skin had sloughed off and was bleeding. Physician #600 revealed there was no blanching of the two wounds. Physician #600 revealed the skin was just missing about two centimeters by three centimeters. Physician #600 was not sure of the wound depth. Physician #600 described the wound beds as raw, irritated, and beefy red. Physician #600 was unable to state the stage of the pressure ulcers. Physician #600 stated the area was unusual and not a traditional pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/19/25 at 2:25 P.M. with LPN #233 and Regional Clinical Registered Nurse (RCRN) #700 of four photographs of Resident #60’s wounds taken by the POA on 07/29/25. Further observation revealed three photographs were of a person lying down in bed wearing an orange shirt. Another photograph shows a resident with the same wounds wearing a blue shirt with the room window blinds visible. One photograph showed the resident’s bedside table, and two of the photographs showed a dressing on the left buttock dated 07/29/25. In all four of the photographs, the person had large areas of MASD covering almost the entire bilateral buttocks. There were two open wounds near the midline of the bilateral middle buttocks with defined edges and a dark red wound bed. Wound measurements could not be determined from the photographs. The wounds appeared to be bilateral stage two pressure ulcers of the buttocks. Interview on 08/19/25 at 2:25 P.M., RCRN #700 revealed she could not verify the wounds were stage two pressure ulcers from the photographs. Interview on 08/19/25 at 3:04 P.M., LPN #233 after viewing photographs of the resident’s wounds stated she was confident the resident in the photograph was Resident #60. LPN #233 verified Resident #60’s orange shirt, bedside table and window blinds in the photograph. LPN #233 verified the wound dressing in one of the photographs had been dated 07/29/25 and recognized the staff nurse initials on the dressing. LPN #233 verified the wounds in the photographs were how the resident’s wounds had looked since her first assessment of the wounds on 07/15/25. LPN #233 stated for the wounds to be classified as a stage two pressure ulcer the wounds would have to be further down through the dermis. LPN #233 reiterated the two wounds blanched and were not pressure ulcers. Review of the facility policy “Guidelines for General Wound and Skin Care,” dated 05/10/17 revealed staff would know the indications and contradictions for the wound products used. Staff would document type of wound, location, stage (if applicable), length, width, depth in centimeters, base, drainage, peri wound tissue, and treatment of the wound weekly using the wound/skin treatment flow sheet. Staff would notify the wound nurse/nurse supervisor for all new stage two to four pressure ulcers or with any questions. Review of the facility policy “Pressure Injury Staging Guide,” dated 2016, revealed a stage two pressure injury was partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink, or red, and moist. Adipose tissue would not be visible, and deeper tissues were not visible. Granulation tissue, slough, and eschar would not be present. This stage should not be used to describe MASD including incontinence associated dermatitis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and facility policy review, the facility failed to ensure proper infection control standards during incontinence care and a wound dressing change. This affected one resident (#1) of three residents reviewed for incontinence care and wound care. The facility census was 58. Findings include:Review of Resident #1's medical record revealed an admission date of 06/02/25. Medical diagnoses included aphasia, anemia, weakness, constipation, a pressure ulcer of the sacral region that was unstageable, and a vitamin D deficiency.Review of Resident #1's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a memory problem with severe impairment. Resident #1 was always incontinent of bowel and bladder, was dependent for toileting, and needed substantial assistance for showers and personal hygiene. Review of Resident #1's admission skin assessment completed on 06/03/25 revealed no identified skin impairments to the buttocks or coccyx upon admission. Review of Resident #1's care plan revealed on 06/12/25 Resident #1 was at risk for skin breakdown related to a need for assistance with mobility, communication and cognitive deficits, and incontinence. Further review of Resident #1's care plan revealed on 07/15/25 Resident #1 had a pressure ulcer on her coccyx. Observation on 08/18/25 at 3:30 P.M. of incontinence care and wound care for Resident #1 revealed LPN #233 rolled the patient to get the incontinence brief out from under the resident. When LPN #233 rolled the resident, LPN #233's gown was hanging loosely do to being untied around the back at the waist and her shirt was touching the resident. After removing the soiled brief, LPN #233 properly provided incontinence care and placed the soiled brief on Resident #1's bed. LPN #233 changed her gloves and completed hand hygiene between gloves. With the clean gloves, LPN #233 saturated gauze with Vashe wound cleansing solution and applied the gauze to Resident #1's wound per the physician orders. LPN #233 removed her gloves and discarded them. While waiting for the five minutes for the gauze to sit on the wound, Resident #1 appeared cold. LPN #233 moved the dirty brief with an ungloved hand from Resident #1's blanket and covered Resident #1 with the blanket. LPN #233 discarded the brief in a trash can. LPN #233 completed hand hygiene and applied clean gloves to complete the rest of the dressing change.Interview with LPN #233 on 08/18/25 at 3:51 P.M. verified she grabbed the soiled brief with an ungloved hand. Furthermore, LPN #233 verified she had not tied her gown and her shirt along with the untied gown touched Resident #1's body. Further interview with LPN #233 revealed she then placed the soiled wound dressing and soiled brief directly on the bedding. Review of the undated policy from the Centers for Disease Control (CDC) titled Sequence for Putting on Personal Protective Equipment revealed the gown should fully cover the torso from neck to knees, arms to the end of the wrist, and wrap around the back. The gown should be fastened in the back of the neck and the waist. Review of the facility policy with a reviewed date of 12/16/24 titled perineal care for incontinence revealed to pay particular attention to infection prevention and control techniques when performing pericare. Review of the facility policy Standard Precaution Guidelines, reviewed 12/17/24 revealed it is important for staff to use appropriate protective equipment as a barrier to exposure to any body fluids. Furthermore, the disposal of waste is also handled as though all body fluids are infectious. Potentially contaminated articles are stored and disposed of in appropriate containers.