STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145294	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Village Healthcare Ctr	1024 West Walnut Jacksonville, IL 62650

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40650 Based on observation, interview and record review, the facility failed to provide privacy during care and promote dignity for 6 of 6 (R1, R5, R7, R29, R38, R43) residents reviewed for resident rights, in a sample of 29. Findings include: 1. On 05/12/2025 at 11:28 AM V6, Certified Nurse Assistant (CNA), stood over R5 to assist her with the mechanical soft chicken salad. She then performed hand hygiene and was standing over R1 holding R1's milk carton for her as she drank from a straw. R1 then wanted a bite of her pureed food, and while standing, V6 gave R1 a bite. V6 then performed hand hygiene, and R5 called for her to give her some water and V6 went over and gave R5 a drink of water while standing next to her. R5's Face sheet, dated 5/15/2025, documented diagnoses of Schizophrenia and Bipolar. R5's Minimum data set (MDS), dated [DATE], documented that her cognition was severely impaired and that she required supervision and touching assistance for eating. R1's Face Sheet, dated 5/15/2025, documented diagnoses of Parkinson's Disease and Schizoaffective Disorder. R1's MDS, dated [DATE], documented that she was rarely to never understood and that she required substantial to maximal assistance to eat. On 05/14/2025 at 11:05 AM V6, CNA, stated that she should have sat down when she assisted R5 and R1 with their lunch. On 05/14/2025 at 11:05 AM, V13, CNA, stated that he sits down with the residents when he is assisting them with their meals. 2. On 5/14/2025 at 9:20 AM, V5, Licensed Practical Nurse (LPN), entered R7's room and shut the door. Prior to and during R7's wound care, V5, LPN did not shut the blinds of R7's window that was opened. R7's MDS, dated [DATE], documented that her cognition was intact. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's Face sheet, documented diagnoses of Parkinson's Disease and Bipolar Disorder. 3. On 05/13/2025 at 11:51 AM, V7, LPN, performed hand hygiene, donned gloves and gown. V7 shut R29's door but did not close the privacy curtain nor did she close the window blinds and R29's roommate, R12, was present in the room during R29's enteral feeding. R29's MDS dated [DATE] documented that her cognition was severely impaired. R29's Face Sheet documented diagnoses Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominate side and Vascular Dementia. On 05/13/2025 at 12:00 PM, V7, LPN, stated that she should have pulled the privacy curtain and the window blinds prior to giving R29 her enteral feeding. 4. On 5/14/2025 at 9:55 AM, V5, LPN entered R38's room. She closed the door behind her. R38 was lying in bed. V5 proceeded to remove the blankets from R38 to perform wound care. V5 removed the dressing from R38's right heel, the window shades were up, and the activities department was outside with multiple residents that could be seen from R38's window. V5, LPN then performed wound care and after washing her hands and changing her gloves, R38 was positioned on to her left side, facing the door and her back was facing the open window. She removed R38's soiled depends, exposing her buttocks to the opened window. R38 was having a bowel movement and staff was retrieved to change her. R38's MDS dated [DATE], documented that her cognition was severely impaired. R38's Face Sheet documented diagnoses of Alzheimer's Disease and Diabetes Mellitus. 5. On 05/14/25 at 10:25 am, V5, LPN, entered R43's room. Shut the door to room behind her and pulled privacy curtain in front of room door. R43's window shades were not pulled down to provide privacy from the outside of the facility while performing the wound treatment to R43's sacral and left buttock treatment. During the treatment, R43 was lying on her left side facing the doorway and her exposed sacral and buttock area was facing the open window. R43's MDS dated [DATE] documented that her cognition was severely impaired. R43's Face Sheet documented diagnoses of Pressure Ulcer right buttock and Type 2 Diabetes Mellitus. On 05/14/2025 at 11:00 AM V5, LPN stated that she should have shut the blinds to the resident's windows when she performs treatments. On 5/15/2025 at 11:20 AM, V1, Administrator, stated that she does not have a policy on feeding assistance of residents. State of Illinois, Illinois Department on Aging, Residents' right for People in Long-term Care Facilities pamphlet, dated 3/2017, documented, Privacy: Your medical and personal care are private.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to identify and prevent a pressure ulcer for 1 of 7 (R37) reviewed for pressure ulcers in the sample of 29. This failure resulted in R37 developing a pressure ulcer on the left heel while at the facility. Findings Include: On 5/13/25 at 8:50 AM, R37 stated he has a pressure ulcer on his left heel. R37 stated he did not know it was there and a nurse found it. R37 stated he was concerned because he lost his right leg due to a pressure ulcer on his foot that never healed, and they had to amputate his leg. R37 was questioned if the dressing is changed every day, R37 stated no it is not. On 5/13/25 at 12:53 PM, V8, Wound Nurse Practitioner, was at the nurses' station with the wound treatment cart. V8 is wearing gloves. V8 entered R37's room to provide left heel pressure ulcer treatment. V8 removed R37's shoe, sock, and pressure ulcer dressing. The dressing was dated 5/11/25 and had a moderate amount of brownish drainage on it. V8 rubbed the wound with her gloved hand. V8 retrieved wound cleanser and gauze from the cart and cleansed the pressure ulcer. V8 retrieved a wound ruler from the cart and measured the pressure ulcer. The pressure ulcer in its' entirety measured 5 centimeters (cm) by 4 cm. The middle of the pressure ulcer had a necrotic area that measured 3 cm x 2.5 cm. The pressure ulcer area that was not necrotic had beefy red tissue. V8 retrieved betadine and gauze from the cart and cleansed the pressure ulcer. V8 retrieved calcium alginate with silver, torn off a piece to cover the necrotic area and placed it over the necrotic area, placed the remaining calcium alginate with silver in the packaging and placed it back in the cart. V8 retrieved a gauze roll out of the cart, wrapped R37's left heel, retrieved scissors out of the cart, cut the gauze, placed the remaining gauze in the packaging, and placed it in the cart. V8 removed her gloves, retrieved tape out of the cart, taped R37's gauze wrap, and placed the tape back in the cart. On 5/13/25 at 1:04 PM, V8 stated R37's pressure ulcer did not appear overnight. V8 stated it appears the necrotic area was larger, but some has fallen off. V8 stated the wound will be difficult to heal but it will heal. R37's Face Sheet, undated, documents R37 was admitted [DATE] and has diagnoses of Diabetes, dependence on Renal Dialysis, and Polyneuropathy. R37's Progress Note, dated 5/8/25, documents He is able to move himself in bed and side to side and he is able to move his heel off of bed but he said he doesn't have much feeling on his left foot, writer did skin check tonight and he was noted with an open wound on his outer heel, cleaned and dressing applied foot offloaded, went through reasoning behind offloading his heel and how to prevent skin breakdown etc. (etcetera). He voices plan and acknowledgment, V9's (Physician) office updated and requested tx. (treatment). R37's Skin Integrity Conditions, dated 5/9/25, documents R37 has a facility acquired left heel unstageable pressure ulcer that was noted on 5/9/25. The pressure ulcer measures 3.5 cm x 5 cm x unknown depth, the wound bed has 50% eschar and 50% slough, is moist and necrotic, and has moderate serosanguineous drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R37's Physician Orders, dated 5/9/25, documents, cleanse left heel with NS (normal saline) apply calcium alginate cover with dry dressing/foam change daily and prn (as needed) Once A Day 07:00 AM - 07:00 PM. R37's May 2025 Treatment Administration Record fails to document R37's pressure ulcer treatment being done on 5/11/25. R37's Braden Scale for Predicting Pressure Sores, dated 3/20/25, documents R37 is not at risk for developing pressure ulcers. R37's Minimum Data Set, dated dated [DATE], documents R37 is cognitively intact and does not have a pressure ulcer. R37's Care Plan, dated 3/20/25, documents, Problem: (R37) is at risk for pressure ulcers R/T (related to) impaired mobility. Approach: Report any signs of skin breakdown (sore, tender, red, or broken areas). The policy Prevention of pressure Wounds, dated January 2017, documents, General Guidelines: 1. Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decreased of circulation to that area and subsequent destruction of tissue. 2. The most common site of a pressure injury is where the bone is near the surface of the body including the back of head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. It continues, 5. Once a pressure injury develops, it can be extremely difficult to heal. Pressure injuries are a serious skin condition for the resident. 6. The facility should have a system / procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. Interventions and Preventive Measures: 9. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. 10. Immediately report any signs of a developing pressure injury.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 32874 Based on observation, interview and record review the facility failed to provide a full time Director of Nursing (DON) and to provide a Registered Nurse (RN) 8 hours a day seven days a week. This failure has the potential to affect all 46 residents at the facility. Findings include: On 05/12/25 at 01:23 PM V1, Administrator stated she has not had a DON for 6 weeks. V1 stated the facility had advertised on different platforms and a DON is to start employment on 5/15/2025. The facility staffing schedule dated 4/28/2025-5/15/2025 documents 8 days out of 17 days the facility failed to provide RN coverage 8 hours a day on 4/30, 5/2, 5/8, 5/10, 5/11/, 5/13, 5/14, and 5/15/2025. On 5/13/2025, 5/14/2025 and 5/15/2025 a RN was not observed on duty at the facility. On 5/13/2025, 5/14/2025 and 5/15/2025 during the survey. There was no DON observed at the facility during the survey process from 5/12/20205-5/15/2025. The CMS-671 Long-Term Care Facility Application for Medicare and Medicaid dated 5/12/2025 documents a census of 46. The facility Staffing Policy, undated documents it is the policy of the facility to provide adequate number of staff to successfully implement resident functions and to meet resident needs. The policy documents the facility operates in compliance with applicable federal, state and local laws, regulations and codes with accepted professional standards and principles that apply to professionals. The policy documents a Registered Nurse (RN) will be scheduled seven days a week at least one continuous 8 hour shift. The policy documents all Department Directors will be employed for a forty hour week and generally work during normal business hours, except when necessary to provide supervision and support to other shifts and weekend staff. TH policy documents in addition to actual work hours, the administrator and Director of Nursing will be on call during non-working hours or will designate a qualified staff member to be on call.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33112 Based on interview, observation, and record review, the facility failed to dispose of expired medications, date multi-use medication vials, and insulin pens. These failures have the potential to affect all 46 residents living in the facility. Findings include: On 5/12/25 at 4:00 PM, the 300/400 hall medication cart was reviewed with V4, Licensed Practical Nurse. R38 had a Glargine insulin pen that had an open date of 3/24/25. R12 had a Glargine insulin vial that had an open date of 2/3/25. There was a stock vial of Lispro with an open date of 3/19/25. On 5/12/25 at 4:15 PM, the 100/200 medication room was reviewed with V3, Registered Nurse. In the medication refrigerator, there was an open used vial of Aplisol (tuberculin) without the open date. On 5/13/25 at 8:00 AM, V1, Administrator, stated all inulin pens, insulin vials, and any multi- use injectable medication should have the opened date on it. The nurses are the ones that use the TB (tuberculin) injection when a resident is admitted to the facility. On 5/13/25 at 3:24 PM, V1 stated the facility only keeps one Aplisol vial in the facility at a time. The Aplisol insert, undated, documents, Vials in use for more than 30 days should be discarded. The policy Storage of Medications dated 10/25/2014, documents, when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be (30) days unless the manufacturer recommends another date or regulations/guidelines required different dating. The Insulin Storage Recommendations, undated, documents Vials Opened Room Temperature Lispro and Glargine 28 days. Lantus (Glargine) pen Open Room Temperature 28 days. The Resident Census and Conditions of Residents, CMS 671, dated 5/13/25, documents that the facility has 46 residents living in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33112 Based on interview, observation, and record review, the facility failed to store food in a manner to prevent contamination by pests. This failure has the potential to affect all 46 residents residing in the facility. Findings include: On 5/13/25 at 11:10 AM, the dry storage was toured with V2, Dietary Manager. There was a large plastic storage bin that held an open 25 pound bag of breadcrumbs and an open 25 pound bag of flour. There was a large plastic storage bin that held an open 25 pound bag of sugar and an open large bag of instant oats. The storage bins did not have lids. The facility had one trash bag draped over each of the storage bins. On 5/13/25 at 11:25 AM, V2 agreed pests could crawl under the trash bag and get into the food. The policy Storage of Dry Goods/ Foods, undated, documents, 3. plastic containers with tight - fitting lids will be used for storing flour, sugar, bulk cereal, dried vegetables, etc. (etcetera). It continues, Open products are labeled, dated with the use by date and tightly covered to protect against contamination including from insects and rodents. The Resident Census and Conditions of Residents, CMS 671, dated 5/13/25, documents that the facility has 46 residents living in the facility.

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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** 32874 Based on observation, interview and record review the facility failed to wear Personal Protective Equipment (PPE), perform hand hygiene, change gloves when soiled and cleanse reusable medical equipment for 5 of 16 residents (R7, R22, R23, R37 and R39) reviewed for infection control in the sample of 29 Findings include: 1. On 5/14/2025 at 8:18AM V5, Licensed Practical Nurse (LPN) cleansed hands and donned gloves, V5, did not a don gown and entered R39's room to do treatment to R39's Right heel. Sign posted on wall outside R39's room documents Enhanced Barrier Precautions Everyone Must: clean their hands, including before entering and when leaving the room. The sign documents providers and staff must also wear gloves and a gown for the following Resident Care Activities. Dressing, Bathing/Showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. R39's Physician orders (PO) dated 2/18/2025 documents Enhanced Barrier Precautions d/t open wound. On 5/14/2025 at 9:12 AM V5 LPN asked why did not wear a gown prior to entering R39's room. V5 stated I thought I did. 40650 2. On 5/14/2025 at 9:20 AM, V5, LPN, donned gloves without benefit of hand hygiene, opened treatment cart, took scissors out of cart, did not cleanse them, retrieved all dressing packages and with gloved hands, she donned an isolation gown. R7 had signage on wall that she was on enhanced barrier precautions. She then entered R7's room, laid down all the dressing packages and scissors on top of R7's dresser without a clean barrier. She then exited the room back to the treatment cart, with same gloved hands, obtained a hand full of gloves and placed them in her pocket of her scrub top and re-entered R7's room and shut the door behind her with the same gloved hands. V5, LPN then removed R7's dressing to her right foot using the scissors that she brought into R7's room. V5, LPN, then took the scissors, that were lying on the dresser and not on a clean field and cut the Silver alginate dressing for R7's wound. She then laid the scissors down on the bare dresser. She dressed the right heel and re applied the pressure relieving boots. She then performed hand hygiene and changed her gloves. V5 then removed the dressing to the right buttock dated 5/13/2025. She then performed hand hygiene, donned gloves took the scissors off the dresser and cut the calcium alginate dressing and then applied the dressing to R7. R7's Minimum Data Set, dated dated [DATE], documented that her cognition was intact. R7's Face sheet, documented diagnoses of Parkinson's Disease and Bipolar Disorder. On 5/14/25 at 11:00 AM, V5, LPN stated that she did wash the scissors in the sink in between wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/25 at 03:10 PM, V1, Administrator, stated that they would use the Sani-cloth to clean the scissors or an alcohol wipe to clean bandage scissors and put down a clean barrier for wound care treatments. The facility's policy, Cleaning and Disinfection of Resident Care items, dated 07/20214, documented, 7. Intermediate and low-level disinfectants for non-critical items include: a. Ethyl or isopropyl alcohol; b. Sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions); c. Phenolic germicidal detergents; d. Iodophor germicidal detergents; and e. Quaternary ammonium germicidal detergents (low-level disinfection only). The facility's policy, Dressings Non- Sterile (Aseptic), dated 1/2017, documented, Procedure: 1. Prepare a clean, dry work area at bedside. 2. Bring supplies into resident's room. Individual resident supplies may be placed on the over bed table after it has been disinfected and a protected barrier placed on the table (clean towel, plastic bag, small chux, foam tray and etc.). Cut strips of tape adequate for securing dressing and add date and initials or if adhesive dressing used, label dressing at this time. Treatment cart may ONLY be taken into room and used as a dressing table if disinfected in advance and disinfected after use. May use Virex, facility approved disinfectant solution, or bleach solution (1 part bleach to 5 parts water) to wipe down the top, front and sides of the treatment cart. The treatment cart should remain in line of vision of the treatment nurse or be locked when not in view. 3. Explain procedure the resident and/or family and provide privacy. 4. Place plastic trash bag within easy reach of worksite. 5. Wash hands. 6. Prepare/open any necessary supplies and place on top of clean barrier. 7. Apply gloves. In the event that personal contamination is anticipated, personal protective equipment such as gown and mask should be worn. 8. Assist resident to required position and expose area to be dressed. Avoid overexposing the resident unnecessarily. If needed, place waterproof pad under affected area. 9. Remove soiled dressing and place in plastic trash bag. 10. Remove soiled gloves and place in plastic trash bag. 11. Wash hands, if hands are not visibly soiled, an alcohol-based hand gel may be used to decontaminate the hands. When decontaminating hands with an alcohol-based hand gel, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Follow the manufacturer's recommendations regarding the volume of product to use. 12. Apply clean gloves. 33112 3. On 5/12/25 at 3:51 PM, V4, Licensed Practical Nurse (LPN) with gloves prepared R23's evening medications. V4 pulled R23's pill cards and stock bottles from the medication cart for the medication pass. When getting the medications, V4 would dump the medication into her hand if it came from a bottle and then pick one pill and put it in the medication cup. V4 would pop the pills from the pill card into her hand, and then put it the medication into the medication cup. R23's zinc 50 milligram (mg) tablet, vitamin C 500 mg tablet, cefdinir 300 mg tablet, Doxycycl 100 mg tablet, Atorvastatin 40 mg tablet all were given. R23's Face Sheet, undated, documents that R23 was admitted on [DATE]. 4. On 5/14/25 at 7:50 AM, V5, Registered Nurse, put on gloves, a protective gown, and entered R22's room to provide a treatment to R22's right buttock pressure ulcer. V5 removed the old dressing dated 5/13/25, changed gloves without hand hygiene in between, cleansed the pressure ulcer with normal saline, changed gloves with hand hygiene, applied calcium alginate, and a dry dressing. (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	R22's Face Sheet, undated, documents that R22 was admitted on [DATE]. 5. On 5/13/25 at 12:53 PM, V8, Wound Nurse Practitioner, was at the nurses' station with the wound treatment cart. V8 is wearing gloves. V8 entered R37's room to provide left heel pressure ulcer treatment. V8 removed R37's shoe, sock, and pressure ulcer dressing. The dressing was dated 5/11/25 and had a moderate amount of brownish drainage on it. V8 rubbed the wound with her gloved hand. V8 retrieved wound cleanser and gauze from the cart and cleansed the pressure ulcer. V8 retrieved a wound ruler from the cart and measured the pressure ulcer. The pressure ulcer in its' entirety measured 5 centimeters (cm) by 4 cm. The middle of the pressure ulcer had a necrotic area that measured 3 cm x 2.5 cm. The pressure ulcer area that was not necrotic had beefy red tissue. V8 retrieved betadine and gauze from the cart and cleansed the pressure ulcer. V8 retrieved calcium alginate with silver, torn off a piece to cover the necrotic area and placed it over the necrotic area, placed the remaining calcium alginate with silver in the packaging and placed it back in the cart. V8 retrieved a gauze roll out of the cart, wrapped R37's left heel, retrieved scissors out of the cart, cut the gauze, placed the remaining gauze in the packaging, and placed it in the cart. V8 removed her gloves, retrieved tape out of the cart, taped R37's gauze wrap, and placed the tape back in the cart. V8 performed hand hygiene. V8 failed to wear a gown while providing the pressure ulcer treatment. R37's Face Sheet, undated, documents R37 was admitted [DATE] and has diagnoses of Diabetes, dependence on Renal Dialysis, and Polyneuropathy. On 5/13/25 at 1:04 PM, V8 was questioned why she went from dirty to clean with the same gloves, V8 stated, It's not a sterile procedure. On 5/13/25 at V1, Administrator, stated hand hygiene should be performed before putting on gloves, between gloves changes, and gloves should be changed when they are dirty. The policy Hand Washing / Hand Hygiene Policy, dated March 2020, documents, 4. When hands are not visibly soiled, employees may use an alcohol - based hand rub (foam, gel, liquid) containing at least 60% alcohol in all of the following situations: a. before direct contact with resident; b. after direct contact with a resident but prior to direct contact with another resident; c. donning gloves; d. before performing any non-surgical invasive procedures; e. before preparing or handling medications; f. before handling clean or soiled dressing, gauze pads, etc. g. before moving from a contaminated body site to a clean body site during resident care; h. before and after putting on and upon removal of PPE (Personal Protective Equipment), including gloves. The Facility policy Enhanced Barrier Precautions dated revised, 3/21/2024 documents it is the practice of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy documents enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities know to be colonized or infected with a Multi Drug Resistant Organism (MDRO) as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). The policy documents implement enhanced barrier precautions for residents with any of the following: wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The policy documents high-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, Device care or use, wound care; any skin opening requiring a dressing.