

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145593	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Avantara Libertyville		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 South Milwaukee Avenue Libertyville, IL 60048	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37232</p> <p>Based on observation, interview, and record review, the facility failed to obtain weights as ordered for residents with congestive heart failure (CHF) for 4 of 24 residents (R38, R66, R244, and R11) reviewed for quality of care in the sample of 24.</p> <p>The findings include:</p> <p>1. R38's Face Sheet showed R38 had the diagnosis of CHF.</p> <p>R38's Order Summary Report showed an order for weekly weights to be done on Friday mornings, starting on 8/9/24</p> <p>R38's Weights and Vitals Summary showed there were no weekly weights for the week of 8/9/24, 8/23/24, 8/30/24, and 9/20/24.</p> <p>R38's Medication Administration Record and Treatment Administration Record did not have any recorded weights.</p> <p>On 09/24/24 at 12:07 PM, R38 said she gets weighed once every few weeks.</p> <p>2. R66's Face Sheet showed R66 had the diagnosis of CHF.</p> <p>R66's Orders showed an order for daily weights.</p> <p>R66's Weight and Vitals Summary and Treatment Administration Record for 9/1/24-9/23/24 showed missing daily weights for 9/4/24, 9/6/24, 9/7/24, 9/9/24, 9/10/24, 9/15/24, 9/16/24, 9/17/24, 9/18/24, 9/21/24 and 9/23/24.</p> <p>On 09/24/24 at 12:09 PM, V13 (Licensed Practical Nurse) said, For residents with CHF, weights are typically done weekly or daily depending on the orders, and weights are done to monitor for fluid gain. V13 added, Weights should be done as ordered.</p> <p>34506</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. R224's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including acute on chronic diastolic congestive heart failure, malnutrition, acute pulmonary edema, acute respiratory failure with hypoxia, and dyspnea.</p> <p>R244's After Visit Summary from the local hospital, dated 9/9/24 shows, Daily weight. R224 was admitted to the local hospital prior to admission to the facility with a diagnosis of acute on chronic congestive heart failure.</p> <p>R244's Order Summary Report, dated September 9/24/24 shows an order entered on 9/15/24 for weight upon admission/readmission, weekly x 4 then monthly.</p> <p>R244's Weights and Vitals Summary shows R244 was weighed on 9/15/24 and 9/23/24. There were no daily weights noted in R244's electronic medical record.</p> <p>R244's Care Plan, initiated 9/18/24, shows R244 is at risk for altered cardiovascular functioning related to congestive heart failure. Obtain labs and weights as ordered.</p> <p>4. R11's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including chronic diastolic congestive heart failure, acute kidney failure, and presence of prosthetic heart valve.</p> <p>R11's Order Summary Report, dated 9/24/24 shows an order was entered on 9/3/24 to monitor weight daily before breakfast. Notify MD of a two pound weight gain in one day or five pound weight gain in one week.</p> <p>R11's Weights and Vitals Summary shows R11 has only been weighed on 9/3/24.</p> <p>On 9/25/24 at 9:47 AM, V9, RN (Registered Nurse), said residents that have congestive heart failure should be weighed everyday so the staff know if the residents are retaining fluid. A weight gain could signify a congestive heart failure exacerbation. V9 said the doctor is notified if a resident has a weight gain.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>37232</p> <p>Based observation, interview, and record review, the facility failed to ensure pressure relieving interventions were in place for 2 of 5 residents (R106 and R30) reviewed for pressure injury in the sample 24.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 09/23/24 at 09:35 AM, R106 was in bed. Hanging on the foot board of the bed was an air mattress pump. The orange standby light was lit up on the air mattress pump. The light next to On was not lit up. <p>R106's Care Plan showed she was at risk for developing a pressure injury. Listed under interventions was to check air mattress for proper functioning.</p> <ol style="list-style-type: none"> On 09/23/24 at 10:25 AM, R30 was in bed. Hanging on the foot of the bed was an air mattress pump. The lights on the pump were not lit up. The air mattress pump's power cord was not plugged into an outlet. <p>R30's care plan showed R30 had cerebral palsy, paraplegia, limited mobility, and was at risk for skin alterations. Listed under interventions was to check air mattress for proper functioning.</p> <p>On 09/24/24 at 11:04 AM, V12 (Wound Care Nurse) said R106 and R30 are at risk for pressure injuries. V12 said air mattresses are a pressure relieving intervention, and R106 and R30 should have working air mattresses.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>33760</p> <p>Based on observation, interview, and record review, the facility failed to provide catheter care to prevent urinary tract infection to 1 of 6 residents (R113) reviewed for catheter care in the sample of 24.</p> <p>The findings include:</p> <p>On 9/23/24 at 10:05 AM, V14 (Certified Nursing Assistant-CNA) provided catheter care to R113. V14 (CNA) removed R113's incontinent pad, then took disposable wipes and wiped R113's perineal area, then applied a new incontinent brief. V14 did not provide any cleansing to R113's catheter tubing, and did not provide any cleansing to R113's frontal area/genitals area.</p> <p>On 9/24/24 at 9:40 AM, V2 (Director of Nursing) said staff should provide thorough incontinence care, including the catheter tubing when providing pericare to prevent infection. R113 has history of UTIs (urinary tract infections).</p> <p>The facility policy entitled Urinary Catheter. 16. For male residents Use wash cloth with warm waster and soap to cleanse around the meatus .17. Use clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>33760</p> <p>Based on observation, interview, and record review, the facility failed to provide individualized activities for a resident with dementia for 1 of 3 residents (R76) reviewed for dementia care in the sample of 24.</p> <p>The findings include:</p> <p>R76's facility assessment, dated 7/19/24, show R76 is severely cognitively impaired.</p> <p>R76's electronic medical record shows R76 has diagnosis of dementia.</p> <p>R76's care plan, dated 2/18/24, shows, (R76) demonstrate movement behavior of wandering, pacing or roaming. Intervention include: remain safely engaged in activity focused care, a meaningful intervention or social interaction. Engage (R76) with walking movement/keeping busy/exercise program.</p> <p>On 9/23/24 during the initial tour on 2nd floor, R76 was noted to be walking and pacing aimlessly from her room towards the nurses station, then by the elevator, then back to the nurses station then hallways. R76 was being repeatedly told to go back to her room. There was no activity being provided to R76.</p> <p>On 9/23/24 at 10 AM, R76 was coming out form her room. V15 (Certified Nursing Assistant-CNA Supervisor) went to R76 and said, You need to go back to your room.</p> <p>At 11 AM, R76 was coming out of her room. V11 (Infection Control Nurse) hurriedly went to R76, provided her a walker and redirected R76 to her room. R76 continued to walk around the nurses station, then near the elevator, then to her room. R76 would sit down in her bed for a short time then wander again. At 12:15PM, R76 was coming out of her room. V14 (CNA) said to R76, Stay in your room.</p> <p>The facility presented this surveyor the Activity Calendar for September 2024 that shows (All) Activities on 3rd floor. There were no staff noted to bring R76 to 3rd floor on 9/23/24 (Monday)</p> <p>On 9/24/24 at 9:20 AM, R76 was walking towards an office on 2nd floor. V15 again told R76 to go back to her room. R76 continued to wander from her room to the nurses station. At 10 AM, R76 was in her room sitting in her bed watching TV. R76 said, Hi, hello, and thank you, then got up and took her walker and walked towards the nurses station.</p> <p>At 12:50 PM, V16 (Licence Practical Nurse/LPN) said, This is (R76's) routine, being redirected all day. (R76) paces and wanders back and forth. Due to dementia, (R76) rarely speaks in English, and now speaks in Russian. Both V16, LPN, and V15 (CNA Supervisor) confirmed all the facility activities were done on 3rd floor. There was no activity being provided to R76 at this time.</p> <p>At 1:40 PM, V16 (LPN), V17 and V10 (both CNAs) were all trying to redirect R76 from the elavator to go to her room.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/24/24 at 2PM, V20 (R76's husband) said he tries to come everyday, weather permitting, to visit R76. V20 said R76 used to work in the beauty department that provided facial and skin treatments. (R76) loves to talk about those things.</p> <p>R76's Activity Assessment, dated 7/26/2,4 under behaviors of wandering, leaves area -NO</p> <p>The same Activity Assessment under past and present interests listed family contact and watching TV (did not include R76's interests with beauty treatments per husband.)</p> <p>On 9/24/24 at 9:45 AM, V1 (Administrator) V2 (Director of Nursing) and V18 (Activity Director) said they are in the process of working together to provide activities to R76, who has dementia.</p> <p>The Facility Policy entitled Dementia Care undated shows, 3.Therapeutic diversional activities are provided consistent to the residents level of functioning, individualized activity preferences consistent to interests and customary routines. Activities are provided either in a small groups or 1:1 setting in accordance to the level of functioning and level of activity performance.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45540</p> <p>Based on observation, interview, and record review, the facility failed to store and prepare food in a sanitary manner. This has the potential to affect all 122 residents residing in the facility.</p> <p>The findings include:</p> <p>The CMS 671 form, dated 9/23/24, list the resident census as 122.</p> <p>On 9/23/2024 at 10:10AM, small white circular containers were seen unlabeled in the freezer. Frozen pizza was observed in the corner of the freezer in an open box, uncovered, and open to air.</p> <p>On 9/24/2024 at 10:55AM, V6, Cook, was observed using a spatula to scoop taco meat into the blender to puree. V6 set the spatula down in a strainer pan over the sink that was visibly soiled with yellow, white, and brown food debris. V6 then removed the spatula in the strainer and used it to scoop rice out of a pan into the blender.</p> <p>On 9/23/2024 at 11:40AM, V7, Dietary Director, said, Foods should be prepared and labeled with the date. This way staff know when it was made and when to toss it out. Foods should be covered in the freezer.</p> <p>On 9/24/2024 at 12:29PM, V7 said a spatula that has touched a dirty surface shouldn't be placed back into food for residents. V7 said residents are placed at risk for food borne illnesses from being contaminated with bacteria.</p> <p>The facility's Kitchen policy, revised 7/23/2023, states, refrigerated food should be covered, dated, labeled and shelved to allow air circulation.</p> <p>The facility's Food Handling policy, revised 7/26/2024, states, This facility recognizes that the critical factors implicated in foodborne illness are contaminated equipment.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on observation, interview, and record review, the facility failed to wear PPE (Personal Protective Equipment) for residents with Enhanced Barrier Precautions (EBP), failed to place a resident on Enhanced Barrier Precautions, and failed to change their gloves and perform hand hygiene in a manner to prevent cross contamination for four of 24 residents (R233, R232, R113, R66) reviewed for infection control in the sample of 24.</p> <p>The findings include:</p> <p>1. R233's Admission Record shows he was admitted to the facility on [DATE], with diagnoses including Gout, malignant melanoma of skin, heart failure, pneumonia, end stage renal disease, bacteremia, and gastrostomy status.</p> <p>On 9/24/24 at 9:37 AM, R233 had a sign on his door that showed Enhanced Barrier Precautions. V5, RN (Registered Nurse), went into R233's room to administer medications via R233's PEG (Percutaneous Endoscopy Gastrostomy) tube. V5 did not wear a gown.</p> <p>On 9/25/24 at 9:47 AM, V9, RN, said gown and gloves should be worn in a residents room with Enhanced Barrier Precautions when administering medications via PEG tube. V9 said the gown and gloves are worn to protect the resident from infections.</p> <p>2. R232's Order Summary Report, dated 9/24/24, shows he was admitted to the facility on [DATE], with diagnoses including cellulitis of right lower limb, acute kidney failure, emphysema, local infection of the skin, and specified soft tissue disorder.</p> <p>R232's Care Plan, initiated 9/17/24, shows R232 is on Enhanced Barrier Precautions due to the presence of bilateral lower extremity wounds.</p> <p>On 9/23/24 at 9:53 AM, V3 and V4, CNAs (Certified Nursing Assistants), provided peri care for R232. There was urine and stool in R232's incontinence brief. V4, CNA, wiped R232's front peri area, then touched R232's body to help him to turn onto his right side. V4 then wiped R232's buttocks, removed R232's dirty sheets, placed clean sheets onto R232's bed, placed R232's clean brief on him, and touched R232's bed controls. V4 did not change her gloves or perform hand hygiene.</p> <p>On 9/25/24 at 9:46 AM, V8, CNA, said, Gloves should be changed after you touched a dirty incontinence brief and before you touch clean items so that the dirty is not transferred onto clean items.</p> <p>The facility's Hand Hygiene Policy, revised 7/30/24, shows, Hand hygiene is important in controlling infections. Hand Hygiene using alcohol based hand rub is recommended during the following situations: Before moving from work on soiled body site to a clean body site on the same resident.</p> <p>33760</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. R113's careplan, dated 6/1/24, shows, (R113) is on EBP due to presence of indwelling catheter with interventions that include: ensure that gown and gloves are used during high-contact resident care activities like .changing briefs, or assisting in toileting, .device care-urinary catheter.</p> <p>R113's door had a sign posted that show, STOP, Enhance Barrier Precaution (EBP) . Everyone must: .Wear gloves and gown for the following High Contact Resident Care Activities: Changing brief, device care use . urinary catheter.</p> <p>On 9/23/24 at 10:05 AM, V14 (CNA) entered R113's room with just gloves on, and emptied R113's catheter bag. Then V14 proceeded to provide incontinence care and catheter care to R113, again just wearing gloves. When it was time to transfer R113 to his wheelchair, V15 (CNA Supervisor), wearing gloves and gown, handed a gown to V14. V14 stated, What is this for? I thought (R113) was just an a regular isolation.</p> <p>37232</p> <p>4. On 09/25/24 at 09:35 AM, R66 was in bed. R66 had an intravenous access in his right upper arm. R66 also had dressings to his feet. There was no Enhanced Barrier Precautions sign outside of R66's room.</p> <p>On 09/23/24 at 12:59 PM, V19 (Certified Nursing Assistant) repositioned R66 in bed by placing her hands on R66's shoulders and moved him to the center of the bed. V19 did not have on any personal protective equipment (no gloves or gown) while repositioning R66. There was still no Enhanced Barrier Precaution signs outside of R66's room.</p> <p>On 09/24/24 at 11:00 AM, V11 (Infection Control Nurse) said, Any resident with an implanted medical device or wounds should be on enhanced barrier precautions. Staff were to wear gloves and gowns when providing high contact care. Repositioning a resident is considered high contact care. Staff know what residents are on Enhanced Barrier Precautions by a sign outside of the resident's room.</p> <p>R66's orders showed R66 had an implanted medical device of an intravenous access.</p> <p>On 09/24/24 at 11:04 AM, V12 (Wound Care Nurse) said R66 had wounds to his legs.</p> <p>The facility's Enhanced Barrier Precaution policy showed enhanced barrier precautions involves the use of gowns and gloves to reduce the transmission of resistant organisms during high contact resident care activities for residents known to be colonized or infected with multidrug-resistant organism as well as residents with wounds and/or indwelling medical devices. Enhanced barrier precautions require the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of extensively drug resistant organisms to staff hands and clothing. The same policy showed providing device care/use is considered a high-contact care activities.</p>		