

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER Meadowbrook Skld Nsg & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 320 South 2nd Street Grayville, IL 62844	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714</p> <p>Based on observation, interview, and record review, the facility failed to ensure the MDS (Minimum Data Set) assessment was accurately coded for 1 (R9) of 1 resident reviewed for accuracy of assessments in the sample of 28.</p> <p>Findings Include:</p> <p>R9's Admission Record documented R9 as a 71 -year -old, with an admitted [DATE] to the facility. Diagnoses listed are unspecified atrial fibrillation, type 2 diabetes mellitus, edema, primary osteoarthritis of left knee, obesity, venous insufficiency, poly osteoarthritis, pain in leg, and unspecified osteoarthritis.</p> <p>R9's Illinois PASRR (Preadmission Screening and Resident Review) Summary of Findings, dated 03/22/2024, documented, Level II Outcome- Approved No SS (Specialized Services).</p> <p>R9's MDS with an Assessment Reference Date of 07/02/2024 documented this MDS as being an annual assessment. Section A1500. Preadmission Screening and Resident Review (PASRR) asks Is this resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The answer was documented as a 0 for No. The same MDS section I Active Diagnoses has a checkmark under Psychiatric/Mood Disorder has an X marked next to I5900 Bipolar Disorder, I5950 Psychotic Disorder, and I6000 Schizophrenia indicating these are all active diagnoses for R9.</p> <p>On 05/15/2025 at 11:10 AM, V7 (Licensed Practical Nurse/ MDS) stated he was not the person who completed the July MDS for R9. V7 stated he was not employed at this facility at that time. V7 stated the section A1500 of R9's MDS from 07/02/2024 was not documented appropriately. V7 stated R9 has an annual MDS that he is working on, and will make sure that section is documented appropriately.</p> <p>On 05/15/2025 at 11:54 AM, V1 (Administrator) stated the company does not have a policy for accurately completing MDS assessments. V1 stated the company follows the RAI (Resident Assessment Instrument) Manual for guidance on how to complete the MDS. V1 stated it is her expectation the MDS be coded accurately.</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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619</p> <p>Based on observation, interview, and record review, the facility failed to provide pressure wound treatment per physician's orders for one resident (R31) of three residents reviewed for pressure wounds in the sample of 28.</p> <p>Findings include:</p> <p>R31's Admission Record documented an admitted [DATE], and listed Diagnoses including Chronic Kidney Disease, Polyneuropathy, and Peripheral Vascular Disease.</p> <p>R31's Minimum Data Set, dated dated [DATE], documented R31 had minimum deficits in cognition, and had one stage 3 pressure ulcer.</p> <p>R31's May 2025 Physicians Orders Sheet (POS) documented a 4/25/25 order for, Wound to Right Buttock/Ischium: Cleanse with wound cleanser, apply barrier wipe to peri wound, cover with calcium alginate, cover with bordered gauze every day shift and as needed.</p> <p>R31's May 2025 Treatment Administration Record (TAR) documented an order, Wound to Right Buttock/Ischium, cleanse with wound cleanser, apply barrier wipe to peri wound, cover with calcium alginate. Cover with bordered gauze every day shift, start date 4/25/25. The TAR documented this treatment was done daily from 5/1/25 through 5/14/25.</p> <p>R31's Wound Assessment and Plan Notes, authored by V10, Wound Care Nurse Practitioner, documented the following: 4/25/25: Wound Location: Right Buttock/Ischium. Wound Type: Pressure Injury.</p> <p>Pressure Injury Stage Upon Completion of Visit: 3. Healing Status: Healing .Wound Onset Date: 04/07/2025 Treatment: Cleanse with wound cleanser, apply barrier wipe to periwound, apply calcium alginate to wound bed then cover with bordered gauze dressing every day and as needed. 5/2/25:Wound Location: Right Buttock/Ischium Wound Type: Pressure Injury. Pressure Injury Stage Upon Completion of Visit: 3. Healing Status: Healing .Wound Onset Date: 04/07/2025. (New) Treatment order: Cleanse with wound cleanser, apply collagen to open areas bed then cover with bordered gauze dressing three times per week and as needed.</p> <p>On 05/14/25 at 02:33 PM, V9 (Licensed Practical Nurse) was observed providing wound care for R31. R31 had a stage 3 pressure wound, with 2 visible open areas to the area of the Right Buttock/Right Ischium. V9 cleansed the wound with wound cleanser, applied a skin barrier agent to the peri-wound area, applied calcium alginate to both open wound beds, and covered the area with a bordered gauze dressing.</p> <p>On 05/15/25 at 12:50 PM, V2 (Director of Nurses), stated he is the staff member responsible for adding new orders to the POS and the TAR, and V2 acknowledged the new 5/2/25 treatment order had not been changed on the TAR and POS.</p> <p>On 05/16/25 at 8:13 AM, V10 stated she would be meeting with V2 to review the process by which her orders are entered into the medical record.</p> <p>(continued on next page)</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>A Pressure Ulcer Prevention, Identification, and Treatment Policy, dated 10/16/23, documented, It is the responsibility of the Charge Nurse/Designee to care for pressure areas, and provide treatments as ordered.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714</p> <p>Based on interview and record review, the facility failed to provide range of motion services to 1 (R9) of 1 resident reviewed for range of motion in the sample of 28.</p> <p>Findings Include:</p> <p>R9's Admission Record documented R9 as a 71 -year -old with an admitted [DATE] to the facility. Diagnoses listed are unspecified atrial fibrillation, type 2 diabetes mellitus, edema, primary osteoarthritis of left knee, obesity, venous insufficiency, poly osteoarthritis, pain in leg, and unspecified osteoarthritis.</p> <p>R9's Physician's orders, with a print date of 05/15/2025, do not document an order for any range of motion or restorative nursing program.</p> <p>R9's Quarterly MDS (Minimum Data Set), with a date of 03/26/2025, noted R9's BIMS (Brief Interview of Mental Status) of 15, which indicates R9 is cognitively intact. Section GG documents for functional limitation in range of motion that R9 has impairment on both sides of lower extremities. Section GG for self-care documents R9 requires substantial / maximum assist for upper body dressing. Section GG documents R9 is dependent for toileting hygiene, shower / bathe, lower body dressing, putting on taking off footwear, and personal hygiene. Section O of the same MDS documents R9 received 0 days of active range of motion and 0 days of passive range of motion (with a look back period of 7 days.)</p> <p>Review of Care Plan, with a start date of 02/23/2024, documents a focus area of R9 Self-Care Deficit as evidenced by needs assistance with activities of daily living. Interventions listed are assist with toileting / peri care as needed, assist with bed mobility as needed, assist with bathing two times weekly, assist with transfers and ambulation as needed.</p> <p>On 05/15/2025 at 11:29 AM, V2 (Director of Nursing) stated, We do not have a restorative CNA (Certified Nursing Assistant). If the resident is supposed to receive range of motion, the Certified Nurse Assistants would chart it in tasks in the electronic medical record. V2 stated he does not see any charting in R9's electronic medical record to indicate he is receiving range of motion. V2 stated R9 has pain in his lower extremities.</p> <p>On 05/15/2025 at 11:48 AM, V8 (Director of Therapy) stated R9 has been verbally screened by therapy, but has never been on therapy services while at the facility. R9 stated he is not aware of R9 receiving and range of motion.</p> <p>On 05/16/2025 at 8:38 AM, V1 (Administrator) stated R9 will be screened by therapy today to see if he needs any services or range of motion programs.</p> <p>Review of Policy titled Range of Motion Procedure with no date, documented, If there is no order for treatment, contact the attending physician to obtain treatment orders.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619</p> <p>Based on observation, interview, and record review, the facility failed to monitor weights and meal intakes for a resident with significant weight loss for 1 (R45) of 5 residents reviewed for weight loss in the sample of 28.</p> <p>Findings include:</p> <p>R45's Admission Record documented an admitted [DATE], and listed Diagnoses including early onset Alzheimers Disease and Osteoarthritis.</p> <p>R45's Minimum Data Set, dated dated [DATE], documented R45 had severe deficits in cognition, and required at least partial or moderate assistance for eating.</p> <p>R45's May 2025 Physicians Orders Sheet (POS) documented an order for regular diet with puree texture and thin liquids. This POS also documented an order for weekly weights, with an order date of 4/17/25.</p> <p>R45's Care Plan, dated 2/3/25, documented a problem area, (R45) is at risk for altered nutrition.</p> <p>R45's Meal Documentation Report for April 2025 showed missing documentation of at least one meal on the following dates: 4/1/25, 4/2/25, 4/7/25, 4/8/25, 4/12/25, 4/14/25, 4/16/25, 4/18/25, 4/21/25, 4/22/25, 4/23/25, 4/25/25, 4/26/25, 4/27/25, 4/28/25, and 4/30/25. There was no documentation to indicate if R45 refused these meals.</p> <p>R45's Meal Documentation Report for May 2025 showed missing documentation of at least one meal on the following dates: 5/1/25, 5/3/25, 5/4/25, 5/5/25, 5/6/25, 5/8/25, 5/9/25, 5/10/25,5/11/25, 5/13/25, 5/14/25, and 5/15/25.</p> <p>There was no documentation to indicate if R45 refused these meals.</p> <p>R45's Weight Summary documented the following:</p> <p>4/1/25 160.8 Lbs. (pounds) -10.0% change, comparison weight 01/30/2025, 184.0 lbs, -12.6%,.</p> <p>03/06/2025 173.5 Lbs</p> <p>02/24/2025 176 Lbs</p> <p>02/06/2025 179.5 Lbs</p> <p>02/02/2025 183.5 Lbs</p> <p>02/01/2025 184 Lbs</p> <p>01/31/2025 184 Lbs</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>01/30/2025 184 Lbs</p> <p>V6, Registered Dietician, authored the following:</p> <p>2/10/25 Admission/Mini Nutrition Assessment (MNA) Note: MNA score of 9 on 2/4/25 indicating a risk for malnutrition related to decreased intakes, stress, Dementia. Weight stable since admit weigh slight loss. Admit weight on 1/30/25 184 pounds. BMI (Body Mass Index) 28.1. IBW (Ideal Body Weight) 148 pounds. Resident averages 50 percent (meal intake) and is refusing some. Resident is on a regular diet with puree texture. (V6) recommending to start (trade name supplement) 90 milliliters three times daily to help with weight maintenance. Diagnoses: Alzheimers Disease/Dementia, Osteoarthritis, B Complex Vitamin Deficiency. Medications and chart reviewed. Resident has confusion and noted agitation. Resident appears well nourished, requires assist/dependent with most meals. Walks with assist. No labs to assess. No skin issues noted. (V6) will continue to monitor oral intake, weight, skin, and need for additional nutrition interventions.</p> <p>4/30/25: Weight Loss Note: Resident is triggering for significant weight loss with 4/1/25 weight of 160.8lb, -7.3 percent from 3/6/25 weight of 173.5lb, -12.6 percent from admit weight of 184lb. Weight is trending down since admit weight of 184lb. BMI (Body Mass Index) 25.2, IBW (Ideal Body Weight) 148lb. Resident averages 26-75 percent (meal intake) and refusing some meals. Resident continues on regular diet with puree texture. Resident continues on (trade name liquid supplement) 90 milliliters three times daily to help with weight maintenance. Resident requires assist/dependent with most meals. (V6) recommending to add fortified cereal with breakfast and fortified pudding with lunch and dinner.(V6) will monitor oral intake, weight, skin, and need for additional nutritional interventions.</p> <p>5/5/25 Nutrition Risk Assessment, Quarterly: MNA score of 9 indicating at risk for malnutrition related to decreased intakes, stress, Dementia. Current weight 160.8lb, BMI 25.2, within normal limits. Triggers for significant weight loss-7.3 percent in one month, -12.6 percent in three months. Resident meal intakes vary 25-75 percent. Resident is on a regular diet with puree texture with (trade name liquid supplement) 90 milliliters three times daily, super cereal one time daily, and fortified pudding at lunch and dinner. Diagnoses: Alzheimer's Disease/Dementia, Osteoarthritis, B Complex Vitamin Deficiency. Medications/chart reviewed. Resident has confusion and noted agitation, resident appears wellnourished, requires assist/dependent with most meals. Walks with assist. No labs to assess. No skin issues noted. (V6) will continue to monitor oral intake, weight, skin, and need for additional nutritional interventions.</p> <p>On 05/13/25 at 12:28 PM, R45 was observed being fed with 100 percent staff assistance. R45 was alert only to self.</p> <p>On at 05/14/25 at 01:13 PM,V6 stated R45 has experienced significant weight loss as outlined above. V6 stated he did not order the weekly weights, and he assumed the Primary Care Physician did in light of the significant weight loss. V45 stated staff should weigh residents as ordered and document each meal intake, V6 stated if residents refuse a meal, it should be charted as such, not left blank.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Weight Assessment and Intervention Policy, dated 11/22/24, stated, Policy Statement: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. 7. The threshold for significant unplanned and undesired weight loss will be based on the following criteria:</p> <ul style="list-style-type: none"> a. 1 month - 5% (percent) weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. <p>Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619</p> <p>Based on observation, interview, and record review, the facility failed to follow enhanced barrier infection control precautions for two residents (R31, R42) of six residents reviewed for infection control in the sample of 28.</p> <p>Findings include:</p> <p>1. R31's Admission Record documented an admitted [DATE], and listed Diagnoses including Chronic Kidney Disease, Polyneuropathy, and Peripheral Vascular Disease.</p> <p>R31's Minimum Data Set, dated dated [DATE], documented R31 had one stage 3 pressure ulcer.</p> <p>On 05/14/25 at 2:33 PM, on R31's door was a sign stating, Enhanced barrier precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities: Wound care-any skin opening requiring a dressing. At that time V9, Licensed Practical Nurse, was observed entering the room to provide wound care for R31. V9 donned gloves, but no gown.</p> <p>2. R42's Admission Record documented an admitted [DATE], and listed Diagnoses including Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, and Traumatic Brain Injury.</p> <p>R42's Minimum Data Set, dated dated [DATE], documented R42 had one unstageable pressure ulcer.</p> <p>On 05/15/25 at 10:36 AM, on R42's door was a sign stating, Enhanced barrier precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities: Wound care-any skin opening requiring a dressing. At that time, V9 was observed entering the room to provide wound care for R42. V9 donned gloves, but no gown. At the conclusion of care, V9 stated R31 and R42 are on enhanced barrier precautions due to having pressure wounds, and that staff are to don gown and gloves before entering the room to provide care.</p> <p>On 05/15/25 at 12:50 PM, V2, Director of Nurses, confirmed in both of the above referenced observations, V9 should have donned a gown in addition to gloves prior to wound care treatment.</p> <p>An Enhanced Barrier Precautions Policy, dated 12/10/24, documented, Policy interpretation and implementation: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE(Personal Protective Equipment) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (Multi Drug Resistant Organisms) to staff hands and clothing. EBP are indicated for residents with any of the following: Infection or colonization with a CDC(Centers for Disease Control)-targeted MDRO when Contact Precautions do not otherwise apply; or, wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.</p>		