

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Holland Home Breton Rehabilitation & Living Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 2589 44th Street SE Grand Rapids, MI 49512	
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 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** Based on observation, interview, and record review the facility failed to consistently use dignified terms for residents and ensure consistent dignified dining experiences for 10 (Residents #3, 19, 15, 42, 44, 6, 29, 38, 25, & 28) of 45 residents reviewed for dignity resulting in the potential for feelings of shame, embarrassment, and/or decreased meal enjoyment. Findings include Resident #3: Review of Resident #3's admission record, dated 4/30/26, indicated she was an [AGE] year old female with a pertinent diagnosis of dementia (decline in cognitive function). Review of Resident #3's brief interview for mental status, dated 2/26/26, was scored zero which reflected severe cognitive impairment. Review of Resident #3's activity of daily living care plan included an intervention, revised 9/2/25, which stated, EATING: The resident needs total feeding assistance (a level of care where a resident requires complete help with the entire eating/drinking process due to physical, cognitive, or medical impairments). During an observation and interview on 4/29/26 at 8:17 AM, Certified Nurse Aide (CNA) Y was in the hallway just outside of Resident #3's room and stated Resident #3 was a feeder and there were other feeders in the dining room who needed assistance. Resident #3 was inside her room, with the door open, and within hearing distance. Resident #3 was confused and unable to answer questions regarding how the term feeder made her feel. Note: Feeders is an undignified term that refers to residents who require staff assistance with their meals. Resident #19 and #15: Review of Resident #19's self-care care plan included an intervention, revised 4/28/26, that stated, EATING: (Resident #19) requires assistance by one staff to eat. Review of Resident #19's brief interview for mental status, dated 3/30/26, was scored zero which reflected severe cognitive impairment. Review of Resident #15's self-care care plan included an intervention, revised 2/20/26, that stated, EATING: I am usually able to eat independently with set up, and hands on assistance at times. Review of Resident #15's brief interview for mental status, dated 3/13/26, was scored 8 which reflected moderate cognitive impairment. During observations and interviews on 04/30/2026 starting at 8:16 AM, CNA Y was delivering and assisting residents during breakfast service and stated She is a feeder to Registered Nurse X in the hallway just outside of Resident #19's room and Resident #15's room. Residents #19 and #15 were in their rooms, with the doors open, and within hearing distance. On 04/30/2026 at 8:23 AM, CNA Y was observed providing total dining assistance for Resident #19 in her room. On 04/30/2026 at 8:26 AM CNA E was observed providing total dining assistance for Resident #15 in her room. Both Residents #19 and Resident #15 presented with confusion and were unable to answer questions related to how the term feeder made them feel. During an interview on 04/30/2026 at 9:21 AM, CNA Y reported feeder was the term she had used to describe residents who required eating and drinking assistance from staff. CNA Y reported previously she had not known another term to use instead of feeder. Residents #42, #44, #6, #29, #38, #25, & #28: Review of Residents #42, #44, #6, #29, #38, and #25's admission records all had a date of 4/30/26 and a diagnosis of dementia. Review of Resident #28's admission record, dated 4/30/26, included a diagnosis of mild cognitive impairment. During an observation on 04/30/2026 at 8:34 AM, Residents #42, #44, #6, #29, #38, #25, & #28 were in the activity/dining room across from the nurse's station. All 7 residents appeared to be (continued on next page)		

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively impaired and received either meal supervision, total dining assistance, or partial dining assistance from staff. All 7 residents were served their meals (plates, bowls, cups, utensils, napkins, condiments, etc.) on trays on top of the dining tables and their meals remained on the trays for the duration of the meal. During an interview on 04/30/2026 at 8:57 AM, Dining Services Manager (DSM) CC reported the residents (which included Residents #42, #44, #6, #29, #38, #25, & #28) in the activity room/dining room who were served meals on trays needed more attention and feeding assistance. DSM CC reported there was no set reason for meals to be served on trays in the dining room and was not aware of any resident group that had voiced a preference to have their meals remain on trays in the dining room. During an interview on 04/30/2026 at 8:59 AM, Director of Nursing (DON) B reported the residents (which included Residents #42, #44, #6, #29, #38, #25, & #28) eating breakfast in the activity/dining room, located across from the nurses' station, needed direct supervision or hands on meal assistance. DON B reported there was no facility/resident group he was aware of that had agreed upon a preference/desire to have their meals served on trays in the dining room. Review of the facility's Resident Rights policy, revised 4/2021, stated, Upon admission, residents will be informed of their rights, including-but not limited to-the right to a dignified existence. Review of the facility's Meal Delivery policy, revised 2/2025, stated, A defined meal delivery service is followed to ensure delivery of a dignified dining atmosphere and necessary assistance to promote nutritional health. Review of the Pioneer Network's (A group that advocates for positive culture change for care of elderly residents) resource paper, The Food and Dining Side of the Culture Change Movement: Identifying Barriers and Potential Solutions to furthering Innovation in Nursing Homes, dated 1/28/2010, stated, As part of a dignified dining experience, forward-thinking pioneers questioned, and then simply stopped serving food on trays. What is also becoming a former long term care practice is referring to those needing assistance or to be fed as feeders. Harm was not meant by these ideas, but they have contributed to putting the task, and the goal of efficiency before the person.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was revised to reflect an increased need for assistance for transfers in 1 resident (Resident #6) of 12 residents reviewed for care plans, resulting in the potential for injury and falls. Findings include: Resident #6 Review of an admission Record revealed Resident #6 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, repeated falls, unsteadiness on feet, weakness, and difficulty walking. Review of a Significant Change in Status Minimum Data Set (MDS) assessment for Resident #6, with a reference date of 3/7/26 revealed the Functional Abilities revealed that Resident #6 required substantial/maximal (staff does more than half of the effort) assistance to stand and for all transfers. Review of Resident #6's Care Plan revealed, I have a self-care deficit related to deconditioning, debility, and dementia as evidenced by needs assistance with daily cares and mobility. I require assistance with all my ADLs (activities of daily living) Date initiated: 8/27/25. Revision on: 11/7/25. Goal: (Resident #6) will receive max to total staff assistance to meet her ADL needs. Date initiated: 2/6/26. Revision on: 3/25/26. Interventions: 1/4 enabler rails to HOB (head of bed) for bed mobility, transfers. Date initiated: 8/27/25 .One person assist for transfers, mod-max assist (staff does 50% or more of effort) for bed mobility (rolling from side to side). Date initiated 2/24/26. Revision on: 3/13/26. Toilet Use: Max assist . Dated initiated: 8/27/25. Revision on: 3/13/26. The revisions on 3/13/26 were for an increased assistance level with bed mobility and toilet use but did not include 2-person assistance for bed to chair transfers. The care plan did not include personalized interventions related to Resident #6's inconsistent functional abilities. Review of Resident #6's Kardex (care guide for direct care staff) revealed, .Mobility: 1 assist for transfers .ADL's: Assist .Special instructions: .Fall risk, No socks, only tubi (compression stocking). During an observation on 04/28/2026 at 10:11 AM in Resident #6's room. Certified Nursing Assistant (CNA) D entered the room and prepared to transfer Resident #6 from bed to wheelchair. CNA D placed the wheelchair at the bedside, wrapped a gait belt (used to assist in transferring a resident with limited abilities) around Resident #6's waist and lifted Resident #6 up and sat her in the wheelchair. In an interview on 04/28/2026 at 10:26 AM, Registered Nurse (RN) L reported that Resident #6 did not stand well at all and it takes 2 people to transfer her. During an observation on 04/28/2026 at 10:30 AM in Resident #6's bathroom, RN L was observed lifting Resident #6 up and off the toilet, CNA D quickly pulled the resident's pants up and RN L sat Resident #6 down in her wheelchair. Resident #6's legs were bent during the transfer and she did not bear weight on her feet. In an interview on 04/30/2026 at 7:52 AM, RN L reported that Resident #6 did not stand well or bear weight, but staff was able to do a one person transfer due to Resident #6 being light weight. RN L reported that she was able to revise care plans and was expected to communicate to Nurse Manager (NM) F if a resident declined in their ability to transfer. During an observation on 04/29/2026 at 7:10 AM in Resident #6's room, CNA M entered the room to get the resident out of bed for breakfast. CNA M sat the resident up onto the side of the bed, put her arms underneath Resident #6's arms and wrapped them around the resident's back, then lifted her up and placed her in the wheelchair next to the bed. CNA M did not cue Resident #6 before the transfer, did not use a gait belt and/or enabler bar for the transfer and Resident #6 was not wearing any socks. In an interview on 04/29/2026 at 7:37 AM, CNA M reported that she had forgotten to use a gait belt. CNA M stated, (Resident #6) recently started to not stand on her legs. before she was able to help more. In an interview on 04/29/2026 at 12:39 PM, Physical Therapist (PT) V reported that Resident #6 was doing therapy to get stronger but was not motivated to participate. PT V reported that Resident #6 was a max (maximum) assist, which meant that 2 staff needed to do 75% of the effort to transfer. PT V reported that Resident #6 was at a high risk for falling, required 2 people, a gait belt, non-skid socks, and a wheelchair close by for all (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers. Review of Resident #6's Physical Therapy Notes dated 4/21/26 revealed, .Sit to stand transfer training with walker in the front 5x (five times), Max A (maximum assistance) of 2 person required.increased challenge with tasks.Review of Resident #6's Physical Therapy Notes dated 4/15/26 revealed, .Sit to stand transfer training with walker in the front 8x, Max A of 2 person required.required extra time to process new information.Review of Resident #6's Physical Therapy Notes dated 4/8/26 revealed, .Sit to stand transfer training with walker in the front 10x, Max A of 2 person required.required extra time to process new information.Review of Resident #6's Physical Therapy Notes dated 3/23/26 (first visit) revealed, .seen for functional transfer training including sit to stand, bed mobility including supine to sit, sit to supine, chair transfer with RW (rolling walker) with cue for hand placement, weight shift and sequencing. Pt (patient) required max A of 2 to dep (dependent) for all functional transfers and mobility.In an interview on 04/30/2026 at 8:57 AM, NM F reported that Resident #6's functional abilities fluctuated; on good days Resident #6 was able to transfer with one-person assistance and other days she required two-person assistance. NM F reported that a significant change in Resident #6's condition was identified about a month ago and therapy services were started. NM F reported that the therapy department normally communicated with the nursing staff when there were recommendations about transfer status and then the resident's care plan should be updated. NM F was not sure if she had received any communication from therapy recently regarding Resident #6.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe transfers were performed and the comprehensive care plan was updated with therapy recommendations in 1 resident (Resident #6) of 3 residents reviewed for accidents/falls, resulting in the potential for injury and falls due to unsafe transfers. Findings include: Resident #6 Review of an admission Record revealed Resident #6 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, stage 4 pressure ulcer of sacral region (coccyx, tailbone area), repeated falls, unsteadiness on feet, weakness, and difficulty walking. Review of a Significant Change in Status Minimum Data Set (MDS) assessment for Resident #6, with a reference date of 3/7/26 revealed the Functional Abilities revealed that Resident #6 required substantial/maximal (staff does more than half of the effort) assistance to stand and for all transfers. Review of Resident #6's Fall Risk Evaluation dated 4/15/26 revealed, .If the score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. 1-2 falls in the past 3 months. Disoriented x 3 at all times. Chairbound/incontinent. Fall Risk Score: 17. Review of Resident #6's Care Plan revealed, I have a self-care deficit related to deconditioning, debility, and dementia as evidenced by needs assistance with daily cares and mobility. I require assistance with all my ADLs (activities of daily living) Date initiated: 8/27/25. Revision on: 11/7/25. Goal: (Resident #6) will receive max to total staff assistance to meet her ADL needs. Date initiated: 2/6/26. Revision on: 3/25/26. Interventions: 1/4 enabler rails to HOB (head of bed) for bed mobility, transfers. Date initiated: 8/27/25. Up daily in high back wheelchair, foot buddy across leg rests. Date initiated: 3/13/26. One person assist for transfers, mod-max assist for bed mobility (rolling from side to side). Date initiated 2/24/26. Revision on: 3/13/26. Toilet Use: Max assist . Dated initiated: 8/27/25. Revision on: 3/13/26. The revisions on 3/13/26 were for an increased assistance level with bed mobility and toilet use but did not include 2-person assistance for bed to chair transfers. The care plan did not include personalized interventions related to Resident #6's inconsistent functional abilities. Review of Resident #6's Kardex (care guide for direct care staff) revealed, .Mobility: 1 assist for transfers .ADL's: Assist .Special instructions: .Fall risk, No socks, only tubi (compression stocking). During an observation on 04/28/2026 at 10:11 AM in Resident #6's room. Certified Nursing Assistant (CNA) D entered the room and prepared to transfer Resident #6 from bed to wheelchair. CNA D placed the wheelchair at the bedside, wrapped a gait belt (used to assist in transferring a resident with limited abilities) around Resident #6's waist and lifted Resident #6 up and sat her in the wheelchair. CNA D did not cue Resident #6 to place her feet on the floor or to stand. Resident #6 was wearing thick gray socks with very minimal grip on the bottom. Resident #6's feet slid across the floor, and she did not bear any weight. In an interview on 04/28/2026 at 10:26 AM, Registered Nurse (RN) L reported that Resident #6 did not stand well at all and it took 2 people to transfer her. During an observation on 04/28/2026 at 10:30 AM in Resident #6's bathroom, Nurse Manager (NM) F and CNA D were with the resident as she was sitting on the toilet. RN L entered the bathroom and NM F exited the room. RN L was observed lifting Resident #6 up and off the toilet, CNA D quickly pulled the resident's pants up and RN L sat Resident #6 down in her wheelchair. Resident #6's legs were bent during the transfer and she did not bear weight on her feet. In an interview on 04/30/2026 at 7:52 AM, RN L reported that Resident #6 did not stand well or bear weight, but staff were able to do a one person transfer due to Resident #6 being light weight. RN L reported that she was able to revise care plans and was expected to communicate to NM F if a resident declined in ability to transfer. RN L reported that Resident #6's transfer status had not changed recently. During an observation on 04/29/2026 at 7:10 AM in Resident #6's room, CNA M entered the room to get the resident out of bed for breakfast. CNA M sat the resident up onto the side of the bed, put her arms underneath Resident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#6's arms and wrapped them around the resident's back, then lifted her up and placed her in the wheelchair next to the bed. CNA M did not cue Resident #6 before the transfer, did not use a gait belt and/or enabler bar for the transfer and Resident #6 was not wearing any socks. In an interview on 04/29/2026 at 7:37 AM, CNA M reported that she had forgotten to use a gait belt. CNA M stated, (Resident #6) recently started to not stand on her legs before she was able to help more. In an interview on 04/29/2026 at 12:39 PM, Physical Therapist (PT) V reported that Resident #6 was doing therapy to get stronger but was not motivated to participate. PT V reported that Resident #6 was a max (maximum) assist, which meant that 2 staff needed to do 75% of the effort to transfer. PT V reported that Resident #6 was at a high risk for falling, required 2 people, a gait belt, non-skid socks, and a wheelchair close by for all transfers. PT V reported that Resident #6 was able to make the motion for walking but did not bear weight on her legs. Review of Resident #6's Physical Therapy Notes dated 4/21/26 revealed, .Sit to stand transfer training with walker in the front 5x (five times), Max A (maximum assistance) of 2 person required. increased challenge with tasks. Review of Resident #6's Physical Therapy Notes dated 4/15/26 revealed, .Sit to stand transfer training with walker in the front 8x, Max A of 2 person required. required extra time to process new information. Review of Resident #6's Physical Therapy Notes dated 4/8/26 revealed, .Sit to stand transfer training with walker in the front 10x, Max A of 2 person required. required extra time to process new information. Review of Resident #6's Physical Therapy Notes dated 3/23/26 (first visit) revealed, .seen for functional transfer training including sit to stand, bed mobility including supine (lying on back) to sit, sit to supine, chair transfer with RW (rolling walker) with cue for hand placement, weight shift and sequencing. Pt (patient) required max A of 2 to dep (dependent) for all functional transfers and mobility. In an interview on 04/29/2026 at 1:24 PM, Director of Nursing (DON) B reported that staff were expected to use a gait belt with all transfers. DON B reported that he was not aware that Resident #6 was not bearing weight during transfers. In an interview on 04/30/2026 at 8:57 AM, NM F reported that Resident #6's functional abilities fluctuated; on good days Resident #6 was able to transfer with one-person assistance and other days she required two-person assistance. NM F reported that a significant change in Resident #6's condition was identified about a month ago and therapy services were started. NM F reported that the therapy department normally communicated with the nursing staff when there were recommendations about transfer status and then the resident's care plan should be updated. NM F was not sure if she had received any communication from therapy recently regarding Resident #6, but that direct care staff had not reported any need for further assistance. NM F reported that direct care staff should be cueing Resident #6 before attempting to transfer and if the resident is not bearing weight, then they need to get a second person.		

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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 observation, interview, and record review, the facility failed to effectively implement Enhanced Barrier Precautions (EBP) per facility policy and Centers for Disease Control and Prevention (CDC) guidance, in 1 resident (Resident #6) of 12 residents reviewed for infection control, resulting in the potential for cross-contamination and the development and spread of infection to a vulnerable population. Findings include: Resident #6 Review of an admission Record revealed Resident #6 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, stage 4 pressure ulcer of sacral region (coccyx, tailbone area). Review of Resident #6's current Care Plan revealed, .I have an Indwelling Catheter: due to urinary retention and stage 4 pressure ulcer. Review of Resident #6's current Physician Orders revealed, Indwelling urinary catheter. d/t (due to) wound contamination. During an observation on 04/28/2026 at 10:11 AM in Resident #6's room. Certified Nursing Assistant (CNA) D entered the room and prepared to transfer Resident #6 from bed to wheelchair. CNA D did not put a gown or gloves on. CNA D lifted Resident #6 up and sat her in the wheelchair. There was a sign outside of Resident #6's room indicating to use EBP with all high contact activities including transferring, providing hygiene, changing briefs or assisting with toileting, catheter care or use, and wound care. During an observation on 04/28/2026 at 10:30 AM in Resident #6's bathroom, Nurse Manager (NM) F and CNA D were with the resident as she was sitting on the toilet. NM F and CNA D were not wearing gowns, but CNA D was wearing gloves. RN L entered the bathroom and NM F exited the room. RN L was not wearing a gown. RN L was observed lifting Resident #6 up and off the toilet, CNA D quickly pulled her pants up and RN L sat Resident #6 down in her wheelchair. CNA D removed her gloves and pushed Resident #6 in her wheelchair, out of the bathroom. CNA D did not perform hand hygiene. CNA D placed a footrest on the resident's wheelchair and clipped the chair alarm to the resident's shirt. CNA D wheeled Resident #6 out into the hall, stopped and used hand sanitizer and proceeded down the hall. In an interview on 04/30/2026 at 7:52 AM, RN L reported that it was only required to wear a gown when working directly with Resident #6's catheter and/or wounds. During an observation on 04/29/2026 at 7:03 AM in Resident #6's room Director of Nursing (DON) B was completing wound care. A stage 4 pressure wound was observed on Resident #6's coccyx (upper buttocks, tailbone area), multiple wounds were observed on the resident's legs and feet, and a urinary catheter was in place. During an observation on 04/29/2026 at 7:10 AM in Resident #6's room, CNA M entered the room and put a gown and gloves on. CNA M changed Resident #6's urinary catheter bag to a day-time bag that strapped to her leg, cleansed the resident's genitals, groin and buttocks, and applied a clean brief. CNA M then retrieved clothes from Resident #6's dresser and got her dressed. CNA M still had the same gloves on. Then CNA M sat the resident up onto the side of the bed, put her arms underneath Resident #6's arms and wrapped them around the resident's back, then lifted her up and placed her in the wheelchair next to the bed. When CNA M put socks on Resident #6's feet, a large wound bandage rolled up and almost fell off; CNA M reattached the bandage using her soiled gloves. CNA M then took care of the linens and removed her gloves but did not perform hand hygiene. CNA M applied the foot pedals and a foot pad to Resident #6's wheelchair, clipped the chair alarm to the resident's shirt and wheeled her out into the hallway. CNA M took her gown off in the hallway, put it in a bin and used the hand sanitizer in the hallway. CNA M did not change gloves after providing incontinence care, touched surfaces in the resident's room, and did not remove her gown prior to exiting Resident #6's room. In an interview on 04/29/2026 at 7:37 AM, CNA M reported that she did not take her gloves off until after Resident #6 was in her wheelchair and that she should have discarded the gown in the resident's bathroom. In an interview on 04/29/2026 at 1:24 PM, DON B reported that staff were expected to wear a gown and gloves prior to providing any direct care to Resident #6, including incontinence care and transfers. Review of the facility policy Categories of Transmission Based Precautions dated July 2025 revealed, .Implement (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 - Few	Enhanced Barrier Precautions: 1. For SNF (skilled nursing facility) residents with chronic wounds or indwelling devices. 4. High contact activities include: dressing, bathing/showering, providing hygiene, transferring, toileting/changing briefs, changing linens, device care or use (such as catheters), wound care for chronic wounds. 5. [NAME] (put on) gloves and gown prior to performing high contact activities. 7. Remove and discard gloves, gown and mask prior to exiting room; perform hand hygiene. Review of the CDC (Centers for Medicare & Medicaid Services) Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum (Ref: QSO-24-08-NH) with an effective Date of April 1, 2024 revealed, .The new guidance related to EBP is being incorporated into F-880 Infection Prevention and Control .GUIDANCE Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) 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 to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, .Wound care: any skin opening requiring a dressing .		