

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Edgewood Manor of Lucasville I		STREET ADDRESS, CITY, STATE, ZIP CODE 10098 Big Bear Creek Rd Lucasville, OH 45648	

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 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** 42728</p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure interventions to prevent skin breakdown were implemented as appropriate. This affected one (Resident #45) of four residents reviewed for pressure ulcers. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including spina bifida, dementia with behavioral disturbance, and contractures of the left and right hand.</p> <p>Review of the active physician's orders for Resident #45 revealed an order dated 01/03/23 for staff to apply bilateral palm shields with finger separators which should be removed for range of motion and hygiene.</p> <p>Review of the active physician's orders for Resident #45 revealed an order dated 01/12/23 for Prevalon boots to bilateral lower extremities at all times.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #45 dated 03/19/23 revealed the resident was cognitively impaired and had limitation in functional range of motion to the left and right upper extremities and was at risk the development of pressure ulcers.</p> <p>Review of the care plan for Resident #45 revised 07/14/23 revealed the resident had the potential for injury. Interventions included to utilize palm shields to bilateral hands with finger separators daily and to remove at night for range of motion and hygiene.</p> <p>Review of the care plan for Resident #45 revised 11/02/23 revealed the resident was at risk for impairment to skin integrity. Interventions included to provide Prevalon boots as ordered.</p> <p>Observation on 05/05/24 at 11:38 A.M. revealed Resident #45 was lying in bed sleeping. There were no palm shields with finger separators in place to the resident's hands or Prevalon boots in place on the resident's feet.</p> <p>Observation on 05/06/24 at 10:15 A.M. revealed Resident #45 was lying in bed sleeping. There were no palm shields with finger separators in place to the resident's hands or Prevalon boots in place on the resident's feet.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/06/24 at 2:30 P.M. revealed Resident #45 was lying in bed sleeping. No palm shields with finger separators were in place on the resident's hands. Licensed Practical Nurse (LPN) #405 opened Resident #45's bed side drawer to reveal several palm shields were being stored inside the drawer.</p> <p>Interview with on 05/06/24 at 2:30 P.M. with LPN #405 confirmed Resident #45 did not have palm shields with finger separators placed on the resident's hands and confirmed the palm shields were being stored in the resident's drawer.</p> <p>Observation on 05/07/24 at 10:30 A.M. revealed Resident #45 was lying in bed sleeping and did not have Prevalon boots in place to the feet as ordered.</p> <p>Observation on 05/07/24 at 4:05 P.M. revealed Resident #45 was lying in bed and did not have Prevalon boots in place to the feet as ordered.</p> <p>Interview on 05/07/24 at 4:05 P.M. with State tested Nursing Assistant (STNA) #305 confirmed Resident #45 did not have Prevalon boots in place to the feet. STNA #305 stated he was unsure as to whether the resident should be wearing Prevalon boots.</p> <p>Review of the facility policy titled Pressure Ulcers/Skin Breakdown revised April 2018 revealed the physician would order pertinent wound treatments including pressure reduction devices.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on medical record review, observation, resident interview, staff interview, and review of facility policy, the facility failed to timely assess, treat and report increased pain to the physician. This affected one (Resident #65) of one residents reviewed for pain. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses including unspecified severe protein calorie malnutrition, bipolar disorder, chronic pain, peripheral vascular disease, carpal tunnel syndrome of left and right upper extremities, polyneuropathy, post-traumatic stress disorder (PTSD) and history of alcohol, cannabis, and opioid abuse.</p> <p>Review of the plan of care for Resident #65 initiated on 11/11/22 and revised on 02/16/24 revealed the resident had the potential for pain related to opioid abuse with opioid induced mood disorder, chronic obstructive pulmonary disease (COPD), polyneuropathy, severe carpal tunnel bilateral upper extremities, neuropathy to bilateral lower extremities and peripheral vascular disorder. Interventions included the following: administer pain medication per orders, anticipate the resident's need for pain relief and respond immediately to any complaints of pain, encourage and assist to elevate extremities, evaluate the effectiveness of pain interventions every shift and as needed, review for alleviating of symptoms, dosing schedules and resident's satisfaction with results, notify physician if interventions were unsuccessful.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #65 dated 04/09/24 revealed the resident was cognitively intact and dependent on staff assistance with activities of daily living (ADLs.)</p> <p>Review of the monthly physician's orders for Resident #65 dated May 2024 revealed an order dated 04/17/24 for Norco 7.5 milligrams (mg) by mouth routinely four times daily and orders dated 05/04/24 to admit to hospice care and give morphine sulfate 0.25 milliliters (ml) by mouth every four hours as needed for pain, an order dated 05/06/24 to increase morphine sulfate to 0.05 ml. by mouth every four hours as needed for pain.</p> <p>Review of the Medication Administration Record (MAR) for Resident #65 dated May 2024 revealed the resident received Norco four times daily as ordered from 05/01/24 to 05/06/24. Resident #65 received as needed morphine sulfate 0.25 ml on the following dates and times: on 05/05/24 at 2:00 P.M. with pain rated 7 of 10 on a scale of 1 to 10 with 10 being the worst pain, on 05/05/24 at 7:00 P.M. for pain rated 9 of 10, on 05/05/24 11:00 P.M. with pain rated 9 of 10, on 05/06/24 at 3:00 A.M. with pain rated 9 of 10, and 05/06/24 at 7:00 A.M. with pain rated 9 of 10. Further review of the MAR for Resident #65 dated May 2024 revealed the resident received morphine sulfate 0.5 ml on the following dates and times: 05/06/24 at 11:05 A.M. with pain rated at 5 of 10, 05/06/24 at 10:00 P.M. with pain rated 5 of 10.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress notes for Resident #65 dated 04/09/24 through 05/06/24 revealed there was no documentation related to increased pain, notifying the physician or NP, and no documentation of behaviors related to pain and/or nonpharmacological interventions offered for pain.</p> <p>Observation on 05/05/24 at 10:53 A.M. revealed Resident #65 was up in geri chair in the common area and was crying.</p> <p>Interview on 05/05/24 at 10:53 A.M. of Resident #65 confirmed she was having pain.</p> <p>Interview on 05/05/24 at 10:54 A.M. with Stated tested Nursing Assistant (STNA) #318 confirmed Resident #65 was crying and was having pain. STNA #318 stated it was not time yet for the resident's pain medication. STNA #318 did not inform the nurse of Resident #65's pain.</p> <p>Interview on 05/05/24 at 11:15 A.M. with Licensed Practical Nurse (LPN) #413 confirmed she was going to get Resident #65's pain medication, even though it was not due until 12:00 P.M. LPN confirmed she had not notified Resident #65's physician of the resident's pain which had been increasing over the past couple of months. LPN #413 administered Resident #65's routine dose of Norco pain medication but did not assess the resident's pain level or offer non-pharmacological interventions.</p> <p>Observation on 05/06/24 at 9:45 A.M. of Resident #65 revealed the resident was up in her geri chair in the main sitting area and was crying. An STNA approached Resident #65 and offered to reposition Resident #65 and told her it was not time for her medication. The STNA told Resident #65 she would let the nurse know the resident was having pain.</p> <p>Observation on 05/06/24 at 10:25 A.M. of Resident #65 the resident remained up in geri chair in sitting area by the nurses' station and was continuing to cry out in pain.</p> <p>Interview on 05/06/24 at 11:00 A.M. with LPN #413 confirmed Resident #65's pain medication was not due again until 11:00 A.M. LPN #413 stated she had called hospice about increasing Resident #65's morphine sulfate. At no time did LPN #413 address Resident #65, assess her for increased pain, or offer nonpharmacological interventions.</p> <p>Observation on 05/06/24 at 12:45 P.M. revealed Resident #65 was lying in bed, moaning and crying out in pain.</p> <p>Interview on 05/07/24 at 1:11 P.M. with LPN #407 confirmed if a resident complained of pain the nurse would assess the pain, try nonpharmacological interventions, and check to see if resident had an order for as needed pain medication. If the pain was not controlled, the LPN stated she would notify the physician and inform physician of the problem.</p> <p>Interview on 05/07/24 at 1:19 P.M. with LPN #413 confirmed Resident #65 had complaints of pain two to three times per day on her shift. Resident #65 had pain upon admission once in a while. The pain had increased and changed in the last few months.</p> <p>Interview on 05/07/24 at 1:45 P.M. with STNA #309 confirmed Resident #65 had complaints of pain frequently which had increased over the last couple of months. STNA #309 stated Resident #65 had behaviors including yelling out in pain which should be documented by the nurses.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview 05/07/24 at 2:00 P.M. with Nurse Practitioner (NP)#4 confirmed Resident #65's pain was not well controlled, and the expectation was for the nurse to notify him or the physician about the changes in pain, increased pain or new pain.</p> <p>Review of the facility policy titled Pain Assessment and Management dated March 2020 revealed staff should identify pain in the resident and should develop interventions that were consistent with the resident's goals and needs and that address the underlying causes of pain. The pain management program was based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and the resident's choices related to pain management. Pain management was a multidisciplinary care process that included the following: assessing the potential for pain, recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the pain, developing and implementing approaches to pain management, monitoring for the effectiveness of interventions and modifying approaches as necessary. Comprehensive pain assessments were conducted upon admission, quarterly, whenever there was a significant change in condition and when there was onset of new pain or worsening of existing pain. Acute pain or significant worsening of chronic pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief was obtained.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure pharmacy recommendations were addressed by the physician in a timely manner. This affected four (Residents #32, #43, #77, and #78) of five residents reviewed for unnecessary medications. The facility census was 90 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including end stage renal disease, hypertension, and unspecified psychosis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #43 dated 03/11/24 revealed the resident had intact cognition.</p> <p>Review of the pharmacy recommendation for Resident #43 dated 09/18/23 revealed a recommendation for a gradual dose reduction of Lexapro (an antidepressant.) The recommendation was signed and dated as being reviewed by the physician on 10/23/23 which was 35 days after the recommendation was made.</p> <p>Interview on 05/08/24 at 10:00 A.M. with Regional Director of Clinical Operations (RCDO) #500 confirmed the facility failed to ensure Resident #43's pharmacy recommendation dated 09/18/23 was addressed by the physician in a timely manner. RDCO #500 confirmed pharmacy recommendations were to be addressed by the physician no later than 30 days after they were made in accordance with facility policy.</p> <p>2. Review of the medical record for Resident #78 revealed the resident was admitted to the facility on [DATE] with diagnoses including psychosis, dementia with other behavioral disturbances, and insomnia.</p> <p>Review of the pharmacy recommendation for Resident #78 dated 02/13/24 revealed recommendations for a gradual dose reduction of melatonin (a sleep supplement.) The recommendation was signed and dated as being reviewed on 04/01/24, 48 days after the recommendation was made.</p> <p>Review of the quarterly MDS assessment for Resident #78 dated 03/18/24 revealed the resident was cognitively impaired.</p> <p>Interview with RCDO #500 on 05/08/24 at 10:00 A.M. confirmed the facility failed to ensure the physician addressed Resident #78's pharmacy recommendation dated 02/13/24 in a timely manner.</p> <p>33023</p> <p>3. Review of the medical record for Resident #77 revealed an admitted [DATE] with diagnoses including protein-calorie malnutrition, Parkinson's disease, chronic lymphocytic leukemia, traumatic compartment syndrome, emphysema, anemia, and metabolic encephalopathy.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of pharmacy recommendation for Resident #77 dated 02/13/24 revealed a recommendation was made for a gradual dose reduction of Gabapentin. The recommendation was signed and dated as being reviewed by the physician on 03/27/24, over 30 days after the recommendation was made.</p> <p>Review of the MDS assessment for Resident #77 dated 03/12/24 revealed the resident was mildly cognitively impaired.</p> <p>Interview on 05/08/24 at 10:00 A.M. with RDCO #500 confirmed the facility failed to ensure the physician addressed Resident #77's pharmacy recommendation dated 02/13/24 in a timely manner.</p> <p>34299</p> <p>4. Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses including fracture of unspecified right femur, hypertension, chronic obstructive pulmonary disorder, depression and anxiety.</p> <p>Review of the pharmacy recommendation for Resident #32 dated 02/13/24 revealed a recommendation to reevaluate the medicinal need of Dexilant for gastrointestinal disorder. The physician reviewed and signed the recommendation on 04/01/24 over 30 days after the recommendation was made.</p> <p>Review of the quarterly MDS assessment for Resident #32 dated 03/11/24 revealed the resident was cognitively impaired.</p> <p>Review of the pharmacy recommendation for Resident #32 dated 02/13/24 revealed a recommendation to reevaluate the medicinal need of Dexilant for gastrointestinal disorder. The physician reviewed and signed the recommendation on 04/01/24 over 30 days after the recommendation was made.</p> <p>Interview on 05/08/24 at 10:00 A.M. with RCDO #500 confirmed the facility did not ensure the physician addressed Resident #32's pharmacy recommendation dated 02/13/24 in a timely manner.</p> <p>Review of the facility policy titled Medication Regimen Review Policy undated revealed the attending physician or designee should ideally respond to the facility within seven to 14 days of the pharmacist's recommendation date, but no longer than the next regularly scheduled physician visit (30 days).</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on medical record review and staff interview the facility failed to ensure appropriate indications for prescribing antibiotic medications to residents. This affected three (Residents #28, #50 and #62) of three residents reviewed for antibiotic stewardship. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including Parkinson's disease, atrial fibrillation, bilateral osteoarthritis of hip, chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, bladder neck obstruction, benign prostatic hyperplasia with lower urinary tract symptoms and chronic obstructive pulmonary disorder.</p> <p>Review of the Medication Administration Record (MAR) for Resident #28 dated December 2023 revealed an order dated 12/23/23 for Bactrim (an antibiotic) by mouth once daily for a urinary tract infection (UTI) with a stop date of 12/28/24.</p> <p>Review of the nursing progress note for Resident #28 dated 12/23/23 timed at 6:53 P.M. revealed the resident had new or worsening incontinence and was urinating more frequently. The recommendation per the physician was to dip test the resident's urine and start Bactrim for five days.</p> <p>Review of the infection report form for Resident #28 dated 12/23/23 revealed the resident had acute dysuria, suprapubic pain, new or marked incontinence and increase in urgency. Staff did a dip test of Resident #28's urine and it was positive for leukocytes. Infection Preventionist (IP) #333 documented Resident #28 did not meet surveillance criteria. The facility did not do a urinalysis or culture and sensitivity to ensure the correct medication was administered.</p> <p>Interview 05/09/24 at 10:03 A.M. with IP #333 confirmed Resident #28 received an antibiotic without appropriate indication. IP #333 stated Resident #28 should have had a urinalysis and culture and sensitivity.</p> <p>2. Review of the medical record for Resident #62 revealed an admitted [DATE] with diagnoses including paraplegia, mood disorder, generalized edema, hyperlipidemia, peripheral vascular disorder, anxiety disorder and depression.</p> <p>Review of the MAR for Resident #62 dated October 2023 revealed the resident received Macrobid (an antibiotic) by mouth twice daily for five days for a UTI. Macrobid was started on 10/17/23 and end date was 10/22/23.</p> <p>Review of a progress note for Resident #62 dated 10/17/23 timed at 12:00 AM per Nurse Practitioner (NP) #4 revealed nursing staff reported the resident was exhibiting confusion which was consistent with a UTI for the resident. NP # 4 ordered Macrobid by mouth two times daily for five days. The NP did not order any diagnostic testing.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the infection report form for Resident #62 dated 10/17/23 revealed the resident had acute dysuria, suprapubic pain, altered mental status, and new or marked incontinence. IP #333 documented Resident #62 did not meet surveillance criteria. The facility did not do a urinalysis or culture and sensitivity to ensure the correct medication was administered.</p> <p>Interview 05/09/24 at 10:03 A.M. with IP #333 confirmed Resident #62 received an antibiotic without appropriate indication. RN #333 stated Resident #62 should have had a urinalysis and culture and sensitivity.</p> <p>3. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including schizophrenia, generalized anxiety disorder, hypertension, osteoarthritis and diabetes mellitus type two.</p> <p>Review of the MAR for Resident #50 dated December 2023 revealed Resident #50 received Bactrim by mouth every 12 hours for UTI for seven days. The start date was 12/07/23 and end dated was 12/14/23.</p> <p>Review of progress note dated 12/07/23 timed at 11:59 P.M. per NP #4 revealed Resident #50 exhibited acute dysuria or pain, new or marked increase in urgency. Resident #50 was started on Bactrim by mouth every 12 hours UTI for seven days.</p> <p>Review of the infection report form for Resident #50 dated 12/07/23 revealed resident had acute dysuria, suprapubic pain, new or marked incontinence and increase in urgency. Staff did a dip test of Resident #50's urine and it was positive for nitrates. IP #333 documented Resident #50 did not meet surveillance criteria. The facility did not do a urinalysis or culture and sensitivity to ensure the correct medication was administered.</p> <p>Interview 05/09/24 at 10:03 A.M. with IP #333 confirmed Resident #50 received an antibiotic without appropriate indication. IP #333 stated Resident #50 should have had an urinalysis and culture and sensitivity.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34299</p> <p>Based on observation, staff interview and review of the facility policy the facility failed to implement enhanced barrier precautions (EBP) for residents when appropriate. This affected 11 facility-identified (Residents #13, #23, #29, #39, #43, #54, #60, #70, #77, #92, #337) who were appropriate for EBP and had to potential to affect all of the residents residing in the facility. The facility census was 90.</p> <p>Findings include:</p> <p>Observations on from 05/05/24, 05/06/24, 05/07/24, 05/08/24 and 05/09/24 revealed there were no rooms with signage indicating residents were on EBP.</p> <p>The facility identified 11 residents with a higher risk of infections who were appropriate for EBP: five residents with indwelling Foley catheters (Residents #13, #29, #60, #92, #337), one with a dialysis port (Resident #43), three residents with draining wounds that required a dressing (Residents #13, #39, #60) , two residents with ostomies (Residents #43, #60), five residents with enteral feeding tubes (Residents #23, #43, #54, #70, #77).</p> <p>Interview on 05/08/24 at 10:35 A.M. with State tested Nursing Assistant (STNA) #309 confirmed there were residents with wounds and Foley catheters on her hall. STNA #309 stated she did not know what EBP were and had not received any education on them.</p> <p>Interview on 05/09/24 at 10:30 A.M. with Activity Director (AD) #411 confirmed she did not know what EBP were and had not received any education on them.</p> <p>Interview on 05/09/24 at 10:35 A.M. with Infection Preventionist (IP) #333 confirmed the facility had not implemented EBP. IP #333 stated she knew about EBP but had been waiting on instructions from the corporate office to proceed with implementation.</p> <p>Interview on 05/09/24 at 11:00 A.M. with Licensed Practical Nurse (LPN) #413 confirmed she provided care daily for residents with wounds, Foley catheters, feeding tubes and ostomies. LPN #413 stated she did not know what EBP were and had not received education on them.</p> <p>Review of the facility policy titled Enhanced Barrier Precautions undated revealed all staff would receive training on enhanced barrier precautions, training on high-risk activities and common organisms that required enhanced barrier precautions. An order for enhanced barrier precautions would be obtained for residents with wounds including chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers, and /or residents with indwelling medical devices such as central lines, urinary catheters, feeding tubes and tracheostomy/ventilator tubes even if the resident was not known to be infected or colonized with a multi drug resistant organism (MDRO). Staff should make gowns and gloves available immediately near or outside of the resident's room. Staff should also use face protection if performing activity with risk of splash or spray such as wound irrigation or tracheostomy care. EBP should also be implemented for an any resident with an identified MDRO infection.</p>		