| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365789 | A. Building<br>B. Wing | 06/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sanctuary at Wilmington Place | 264 Wilmington Avenue<br>Dayton, OH 45420 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to notify a resident's responsible party/power of attorney (POA) of health changes. This affected one (#30) of the three residents reviewed for notification. The facility census was 59.<br><br>Findings include:<br><br>Review of the medical record of Resident #30 revealed an admission date of 04/12/24. Diagnoses included Parkinson's disease, anxiety, hypertension (HTN ), and glaucoma.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #30 had severely impaired cognition. Resident #30's son was listed as the POA.<br><br>Review of a progress note dated 09/23/24 for Resident #30, revealed the resident had a change in condition due to the resident's oxygen saturation being low at 82 percent (%) and was wheezing. The physician was called and ordered for the resident to receive oxygen, a breathing treatment and a chest X-ray. There was no documented evidence of the resident's POA being notified.<br><br>Review of a progress notes dated 02/21/25 for Resident #30, revealed the resident was lethargic, and unable to awaken after receiving medications. There was no documented evidence of the resident's POA being notified.<br><br>Interview with Registered Nurse (RN) #59 on 05/22/24 at 3:00 P.M., verified there was no notification made to Resident #30's POA when the resident had changes in condition on 09/23/24 and 02/21/25.<br><br>Review of the facility policy titled Notification of Change dated 12/2024, revealed family should be notified of changes in physical, mental or psychosocial deterioration of residents.<br><br>This deficiency represents non-compliance investigated under Master Complaint Number OH00164992. |

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 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility policy review, and staff interview, the facility failed to ensure an updated Pre-admission Screening and Resident Review (PASARR) was completed. This affected one (#41) of the two residents reviewed for PASARR. The facility census was 59.<br><br>Findings include:<br><br>Review of the medical record for Resident #41 revealed an admission date of 01/06/23. Diagnoses included Dementia and Schizoaffective disorder bipolar type.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #41 had moderate cognitive impairment as evidenced by a Brief Interview Mental Status (BIMS) of eight.<br><br>Review of the medical record for Resident #41, revealed a PASARR was completed on 01/06/23, indicating Resident #41 had no indications of serious mental illness such as Schizophrenia, mood disorders, delusional disorders, panic or other severe anxiety disorders, somatic symptom disorders, personality disorders, or other psychotic disorders.<br><br>Further review of the medical record for Resident #41, revealed a diagnosis of schizoaffective disorder bipolar type was added on 11/21/23. There were no documented evidence an updated PASARR was completed.<br><br>Interview with Social Service Director (SSD) #70 on 05/29/25 at 3:52 P.M., confirmed the only PASARR Resident #41 had completed was dated for 01/06/23.<br><br>Review of the facility policy titled Resident Assessment, Coordination with PASARR Program, dated 12/2024, revealed any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability (ID) authority for a level II resident review. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to timely develop and implement fall interventions to help reduce and/or eliminate falls. This affected one (#210) of the three residents reviewed for falls. The facility census was 59.<br><br>Findings include:<br><br>Review of the closed medical record for Resident #210 revealed an admission date of 02/11/25 and a discharge date of 02/16/25. Diagnoses included encephalopathy, altered mental status, Type Two diabetes mellitus (DM II) with hyperglycemia, depression, acute respiratory failure with hypoxia, chronic kidney disease, anemia, peripheral vascular disease, visual hallucinations, congestive heart failure (CHF), chronic atrial fibrillation, and obstructive sleep apnea (OSA).<br><br>Review of the admission Assessment initiated on 02/11/25 and completed on 02/16/25, revealed Resident #210 was at risk for falls. The interventions marked were to follow the facility's fall protocol and anticipate the resident's needs.<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #210 was cognitively intact. Resident #210 was assessed to require setup assistance for eating and oral hygiene, substantial/maximal assistance with toileting, bathing, dressing, personal hygiene, and bed mobility, and was dependent for transfers.<br><br>Review of an Incident Report dated 02/15/25, revealed the nurse heard a loud noise, and Resident #210 was found on the floor between the wall and bed. The resident was assessed and noted to have a skin tear on the left elbow, which was treated, and the resident was assisted back to the bed.<br><br>Review of the care plan initiated 02/16/25, revealed Resident #210 was at risk for falls related to other lack of coordination, difficulty walking, morbid obesity, osteomyelitis, and peripheral vascular disease. Interventions included analyze previous resident falls to determine whether a pattern/trend can be addressed, anticipate and meet the resident's needs, ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed, follow the facility's fall protocol, and have commonly used articles within easy reach.<br><br>Interview on 06/02/25 at 4:25 P.M. with MDS Coordinator #59, revealed the admission Assessment transfers over to the care plan when completed, and verified there were no fall interventions care planned for Resident #210 until 02/16/25.<br><br>Review of the undated facility policy titled Fall Prevention Program revealed the nurse would initiate fall interventions on the resident's baseline care plan.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00162762. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure oxygen tubing was changed as ordered. This affected one (#05) of the two residents reviewed for oxygen therapy. The facility census was 59.<br><br>Findings include:<br><br>Review of the medical record for Resident #05 revealed an admission date of 02/01/22 with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and a history of pulmonary embolism.<br><br>Review of a physician order for Resident #05 dated 10/27/22, revealed the resident was ordered to have oxygen applied continuously at two liters per minute (LPM) via nasal cannula at bedtime. An additional physician order dated 08/17/23, revealed for staff to change the oxygen tubing weekly on Sundays.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #05 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14.<br><br>Observation of Resident #05's room on 05/28/25 at 12:31 P.M., revealed an oxygen concentrator next to the bed with oxygen tubing dated 05/11/25. Interview with Resident #05 during the observation, revealed she wears oxygen at bedtime.<br><br>Interview on 05/28/25 at 12:36 PM with Certified Nursing Assistant (CNA) #106 verified the date on Resident #05's oxygen tubing being 05/11/25.<br><br>Review of the facility policy titled Oxygen Administration, dated 2025, revealed the staff shall perform hand hygiene and apply gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include changing oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews, and policy review, the facility failed to ensure medications were administered by the nurse who prepared the medications. This affected one (#15) of the seven residents investigated for medication administration. This had the potential to affect all twelve Residents (#08, #11, #15, #20, #21, #22, #25, #28, #31, #32, #38, and #47) on 200-hall. The facility census was 59.<br><br>Findings include:<br><br>Review of the medical record for Resident #15 revealed an admission date of 04/22/25. Diagnoses included chronic obstructive pulmonary disease (COPD), cerebral infarction (stroke) and dementia.<br><br>Review of the five-day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 had moderate cognitive impairment. Resident was dependent on staff for medications.<br><br>Observation of medication administration on 05/27/25 from 5:06 P.M. through 5:09 P.M. with Licensed Practical Nurse (LPN) #53, revealed LPN #53 pulled and prepared medications from the medication cart for Resident #15. LPN #53 handed the medicine cup of medications to LPN #42, who took the medications into the resident's room and administered them to Resident #15.<br><br>Interview on 05/27/25 at 5:09 P.M. with LPN #53, verified she pulled and prepared medications for Resident #15 and handed the medications to LPN #42 to administer to the resident. LPN #53 stated the nurse who prepared the medications should be the same one who administered them.<br><br>Interview on 05/27/25 at 5:14 P.M. with LPN #42, verified she administered medications to Resident #15 that LPN #53 prepared.<br><br>Review of the undated facility policy titled Medication Administration policy, revealed medications are administered by licensed nurses in accordance with standards of practice and then the nurse signs the medication administration record after administration. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and interview with contracted pharmacy staff, the facility failed to implement pharmacy recommendations agreed upon by the facility's physician. This affected one (#15) of the five residents reviewed for unnecessary medications. The facility census was 59.<br><br>Findings include:<br><br>Review of the medical record for Resident #15 revealed an admission date of 04/22/25 with diagnoses of dementia, chronic obstructive pulmonary disease (COPD), cerebral infarction (stroke).<br><br>Review of a New admission Review by the contracted pharmacy dated 04/25/25, revealed a recommendation by the pharmacist for the ordered Lidocaine Patch (topical pain medications applied in a patch) as needed (PRN) every twelve hours to be changed to one Lidocaine patch daily. Additional recommendations included discontinuing Oxybutynin (for overactive bladder) and change Xarelto (anticoagulant) to Eliquis (anticoagulant). The physician reviewed the recommendations (undated) and ordered the Lidocaine Patch to be changed to apply one patch daily, discontinue Xarelto and start Eliquis five milligrams (mg) two times daily.<br><br>Further review of the medical record for Resident #15, revealed the pharmacy recommendations dated 04/25/25, were never implemented after the facility physician approved the changes.<br><br>Review of the five-day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 had moderate cognitive impairment. Resident was dependent on staff for medications.<br><br>Interview on 05/29/25 at 9:02 A.M. with Minimum Data Set (MDS) Nurse #59, verified the pharmacy recommendations dated 04/25/25 were approved by the physician and the facility never implemented the orders. MDS Nurse #59 stated Resident #15 was receiving Hospice services, and they should have addressed the pharmacy's recommendations.<br><br>Interview on 05/29/25 at 11:27 A.M. with the Director of Nursing (DON), verified the facility did not have any documentation related to the 04/25/25 pharmacy recommendations being implement for Resident #15 after they were approved by the facility physician.<br><br>Interview on 05/29/25 at 11:33 A.M. with Hospice Registered Nurse (RN) #123 revealed, Hospice was never contacted when the facility's physician approved the pharmacy's recommendations for Xarelto to be changed to Eliquis or Lidocaine patch order to be changed from PRN to daily. RN #123 stated the DON contacted her today to discuss the concern with her and if Hospice had known, they would have contacted the hospice physician and the approval department. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, the facility failed to administer medications per physician orders. This affected one (#15) of the seven residents investigated for medication administration. The facility census was 59.<br><br>Findings include:<br><br>Review of the medical record for Resident #15 revealed an admission date of 04/22/25 with diagnoses of chronic obstructive pulmonary disease (COPD), cerebral infarction (stroke) and dementia.<br><br>Review of the five day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 had moderate cognitive impairment.<br><br>Review of the May 2025 Medication Administration Record (MAR) revealed the following:<br><br>a) On 05/15/25 at 11:00 A.M., Rivaroxaban 20 mg for Deep Vein Thrombosis (DVT) was not administered due to being out of stock.<br><br>b) On 05/23/25 at 10:19 A.M., Rivaroxaban 20 mg was not administered due to being out of stock and the pharmacy was notified.<br><br>c) On 05/24/25 at 8:55 A.M., Rivaroxaban 20 mg was not administered due to medication being unavailable and a reorder was sent to the pharmacy.<br><br>d) On 05/27/25 at 10:46 A.M., Rivaroxaban 20 mg was not administered due to medication being on order and the pharmacy was notified.<br><br>Interview on 05/28/25 at 3:34 P.M. with the Director of Nursing (DON), verified there was no documented evidence Resident #15 received Rivaroxaban on 05/15/25, 05/23/25, 05/24/25, and 05/27/25 and the MAR indicated the medication was not available.<br><br>Review of the undated facility policy titled Medication Administration, revealed medications are administered as ordered by the physician and in accordance with standards of practice. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and policy review, the facility failed to ensure medications were stored properly. This affected one (#30) of the 12 residents who resided on the 400-hall and received medications. The facility census was 59.<br><br>Findings include:<br><br>Review of medical record for Resident #30 revealed the resident was admitted on [DATE]. Diagnoses included open angle glaucoma, hypertension, Parkinson's Disease, and chronic kidney disease<br><br>Review of the May 2025 active physician orders for Resident #30, revealed the resident was ordered Rhopressa Ophthalmic solution (for open angle glaucoma) 0.02 percent (%) one drop instilled in both eyes daily.<br><br>Observation of the 400-hall medication cart on 05/29/25 at 08:01 A.M., with Licensed Practical Nurse (LPN) #39, revealed an open container of Rhopressa 0.02 % Ophthalmic Solution for Resident #30 with no open date. Interview with LPN #39 at the same time, verified the container of Rhopressa was opened and undated. Interview with Licensed Practical Nurse (LPN) #39 at the time of the observation, verified the bottle was opened, not dated and should have been dated when it was opened.<br><br>Review of online resources from Medsccape.com (https://reference.medscape.com/drug/rhopressa-netarsudil-1000159#11), revealed the an open bottle of Rhopressa could be stored up to six weeks.<br><br>Review of facility's policy titled Medication Storage revealed all medications will be stored in the pharmacy and/or medication rooms according to the manufacturer recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Review of the undated facility form titled Legionella Environmental Assessment Form with Maintenance Supervisor (MS) #58, revealed the facility's WMP included monthly chlorine testing and visual inspections for biofilm. The Legionella Assessment form did not include a description or diagram of the facility's water system.<br><br>Interview on 06/02/25 at 2:29 P.M. with MS #58, verified there was no description or diagram of the facility's water system. MS #59 stated he had no documentation related to biofilm inspections or chlorine testing because they had not been completed.<br><br>Review of the facility's undated Water Management Program revealed the facility would establish a WMP for reducing risk of pathogens in the facility's water systems. The policy indicated a variety of control measures may be used, such as visual inspections and disinfectant level control. The policy also stated testing protocols and control limits would be established, and individuals responsible for testing or conducting visual inspections would record the information.<br><br>Review of online resources from CDC, (https://www.cdc.gov/control-legionella/php/healthcare/index.html) dated 03/15/24, revealed healthcare facilities should develop and implement comprehensive WMP to reduce the risk of Legionella growth and transmission. Developing and maintaining a WMP is a multi-step process that requires continuous review. The seven steps to building an effective Legionella water management program are briefly described as the following:<br><br>1.<br><br>Establish a WMP team<br><br>2.<br><br>Describe the building water systems<br><br>3.<br><br>Identify areas where Legionella could grow and spread<br><br>4.<br><br>Decide where to apply and how to monitor control measures<br><br>5.<br><br>Establish interventions when control limits aren't met<br><br>6.<br><br>Make sure the program runs as designed and is effective<br><br>7.<br><br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Document and communicate all the activities<br><br>Based on staff interview, record review, observation and review of the Centers for Medicare and Medicaid Services (CMS) guidance for Enhanced Barrier Precautions (EBPs) in nursing homes, review of online resources from the Centers for Disease Control and Prevention (CDC), and review of the facility's Water Management Plan (WMP), the facility failed to ensure EBPs were utilized during a resident's chronic pressure ulcer dressing change. The facility also failed to ensure the appropriate infection control techniques were performed during a resident's pressure ulcer dressing change. This affected one (#24) of the two residents observed for dressing changes of pressure ulcers. The facility also failed to develop and implement a Water Management Program (WMP) to reduce the risk of Legionella (a type of bacteria which causes Legionnaires' disease and poses a significant risk in nursing homes due to their complex water systems and vulnerable resident populations). This had the potential to affect all residents in the facility. The facility census was 59.<br><br>Findings include:<br><br>1) Review of the medical record for Resident #24 revealed the resident was admitted on [DATE] with diagnosis including pressure ulcer on sacrum and buttocks, Type II Diabetes Mellitus (DM II), hypertension, heart failure, and anemia.<br><br>Review of the May 2025 active physician orders for Resident #24, revealed there were no orders for the resident to be in EBP. The physician orders revealed for the resident to have his pressure ulcer on sacrum and buttocks cleansed twice daily and as needed (PRN) with normal saline, iodine applied, peri-guard barrier applied and covered with an abdominal (ABD) dressing pad.<br><br>Interview with Resident #24 on 05/27/25 at 10:37 A.M., revealed he was receiving treatment twice a day and as needed for a pressure ulcer that he was admitted with.<br><br>Observation of Resident #24's dressing change on 05/28/25 at 1:26 P.M. with Licensed Practical Nurse (LPN) #54 and LPN #42, revealed no EBP signage or personal protective equipment (PPE) cart outside the resident's room. LPN #54 and LPN #42 announced they were there to conduct a dressing change and entered the resident's room. The dressing change supplies were placed on a rolling bedside table and both nurses washed hands and applied gloves. Resident #24 independently rolled to the left side and LPN #42 removed the resident's pants, incontinent brief, the old dressing, and disposed of the incontinence brief and the old dressing. LPN #42 washed hands and applied new gloves. LPN #54 poured normal saline (NS) into small cup, submerged a cotton wipe and washed from the outside of the wound towards the center of the wound. LPN #42 submerged a second cotton wipe in the NS, and the wound was again cleansed from the outside of the wound towards the center of the wound. LPN#54 then applied iodine to the wound using two gauze four by fours (4x4s). LPN #54 washed hands and applied new gloves, opened an ABD pad and applied peri-guard barrier cream using a tongue depressor. LPN #54 applied the ABD pad to the wound and was assisted by LPN#42 with pulling up Resident#24's incontinent brief and pants. Both LPNs removed and disposed of gloves and washed hands.<br><br>Interview with LPN #54 on 05/28/25 at 1:45 P.M., verified Resident #24 had a pressure ulcer to his sacrum and buttocks and the resident should have been in EBP. LPN #54 verified she and LPN #42 didn't follow the EBP guidelines by wearing gowns during the resident's dressing change procedure. LPN #54 also verified she cleansed the pressure ulcer from the outside towards the center instead of from the center towards the outside of the pressure ulcer.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365789 | A. Building<br>B. Wing | 06/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sanctuary at Wilmington Place | 264 Wilmington Avenue<br>Dayton, OH 45420 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of online resources from CDC (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html) dated 06/28/24, revealed EBPs are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBPs involves at minimum gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical device. EBP expands the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on the use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. EBPs are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard Precautions still apply while using EBPs. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBPs for all residents with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized. Preventing infection by cleaning a wound from the center to the outer edges helps to remove bacteria and debris from the wound and minimize the chance of introducing microorganisms from the surrounding skin back into the wound bed. A moistened gauze pad can be used or other suitable cleaning material, starting at the center of the wound and wiping or dabbing outwards in concentric circles. Discard the used gauze pad or cloth and use a fresh one for each subsequent wipe as you work your way outwards<br><br>Review of CMS QSO Memorandum [QSO-24-08-NH] dated 03/20/24, revealed new guidance for Long Term Care (LTC) facilities on the use of EBPs to align with nationally accepted standards. EBP refers to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove use during high contact resident care activities. EBP recommendations now include the use of EBPs for residents with chronic wounds (e.g., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers) or indwelling medical devices during high-contact resident care activities regardless of their MDRO status. |