

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Canton Christian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2550 Cleveland Avenue NW Canton, OH 44709	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the medical record, self-reported incident (SRI) review, review of the police incident report, personnel file review, interviews facility policy review, the facility failed to ensure Resident #43 was treated with dignity while care was being provided. This affected one (Resident #43) of one resident reviewed for dignity. The facility census was 49. Findings include: Review of the medical record for Resident #43 revealed an admission date of 07/16/25. Diagnoses included hypo-osmolality and hyponatremia, adult failure to thrive, hypertensive chronic kidney disease and personal history of urinary tract infections. Review of the 10/01/25 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #43 revealed intact cognition. The resident required maximum assistance from staff for transfers and was dependent upon staff for toileting. Review of Resident #43's care plan with a revision date of 10/09/25 revealed an activity of daily living (ADL) self-care performance and mobility deficits related to weakness, hypertension, and atrial fibrillation. Interventions included transfers and walks with one assist with wheeled walker and gait belt during the day. Use the sit-to-stand lift with one assist for transfers and toileting in the evening. Review of the 10/10/25 physician order for Resident #43 revealed an order for sit-to-stand lift with one assist for transfers and toileting at night. Review of the 10/11/25 skin incident report for Resident #43 revealed the resident was leaning to the right in the wheelchair. The certified nursing assistant (CNA) moved the call light from the resident before positioning. After repositioning, there was a skin tear to the resident's right elbow which was at wheelchair level. Review of the 10/13/25 skin incident report for Resident #43 revealed the resident reported to her son via phone call that a staff member was entering her room and not doing what the resident wanted her to do. The resident stated the staff member pinched the skin of her left forearm, and she was fearful of the staff member. Resident #43's son reviewed the video surveillance from her room camera and reported no indication of pinching or harm to Resident #43. Skin was assessed with no new bruising or redness noted. The incident report noted a previously documented skin tear to bilateral elbow, and upper arm areas. Review of the certified nurse practitioner (CNP) note dated 10/13/25 for Resident #43 revealed she was having increased urinary symptoms and reporting urinary frequently which was worse at night. Resident #43 stated she had to go to the bathroom multiple times throughout the night. Medications for overactive bladder were offered but Resident #43 declined. Resident #43 had an unwitnessed fall on 10/09/25, was found on the floor with her back against the bed frame. Vitals signs were stable. New onset of a skin tear to the left upper extremity. Evaluated today and there is bruising to the site. Likely sarcopenia due to advanced age and 93. Resident #43 has a skin tear from a wheelchair to the right extremity. There was also concern regarding an incident regarding the left forearm being pinched by staff. No noted bruising or new onset skin tear to the left upper or lower extremity. Resident #43 is denying any pain to the left forearm region today. Review of the 10/15/25 wound nurse note revealed bilateral skin tears to arms and was thought to be from arms rubbing against doorway leading into her bathroom. Geri (protective) sleeves were initiated. Review of the facility SRI tracking #266581 dated 10/20/25 timed at 1:44 P.M. revealed an allegation of abuse from Resident #42 towards CNA #220. The summary of the incident revealed (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 - Few	Resident #43 called her son in the middle of the night (time unknown) of 10/19/25 into 10/20/25 and stated she was afraid. Resident #43's son came to the facility to report this concern to the Director of Nursing (DON) on 10/20/25. The DON reported the concerns to the Administrator, physician and police department. Review of the first video provided by Resident #43's from the room camera dated 10/20/25 timed at 1:57 A.M. revealed CNA #220 entering Resident #43's room and speaking with Resident #43 who was lying in bed. CNA #220 was observed leaning in and over the resident, shaking her hands up and down and spread her arms out in an intimidating and aggressive manner. Mannerisms appear to show signs of frustration by CNA #220. Review of the second video provided by Resident #43's from the room camera dated 10/20/25 timed at 1:58 A.M. revealed CNA #220 applying the vest for the sit-to-stand machine quickly, pulling Resident #43 toward her without giving Resident #43 an opportunity to sit up on her own. When the sit-to-stand machine was brought to the bedside, it appeared CNA #220 hit the bed and shifted the bed backwards. When CNA #220 applied the lift strap, the video showed the resident was jerked forward towards the machine. CNA #220 lifted and moved Resident #43 by yanking the straps on the sling forward forcefully to attach them to the sit to stand machine. Review of the third video provided by Resident #43's from the room camera dated 10/20/25 timed at 1:59 A.M. revealed as soon as Resident #43 was standing, CNA #220 quickly turned the sit-to-stand machine to the right and swung it around swiftly and pushed it toward the bathroom. Review of the skin assessment dated [DATE] for Resident #43 revealed a skin tear on the back of the upper left and right arms, a yellow area with a purple line on the left lower back, a purple nickel sized area on the left lower leg, a two nickel sized purple areas on the left lower right leg, and a purple, red and yellow area on the front lower leg. Review of the undated statement from Resident #43 revealed she (CNA #220) got very upset saying Resident #43 goes to the bathroom too much and because upset with her. Resident #43 stated she was throwing her arms around like she was very angry. Resident #43 stated she was scared but was not scared anymore. Review of police incident report #25-10866 dated 10/20/25 timed at 3:43 P.M. revealed the reporter (Administrator) reported one of her employees was seen on the camera being physically rough with the elderly victim causing the victim to fear for her safety. Interview on 12/09/25 at 2:53 P.M. with the Director of Nursing (DON) revealed following review of the videos, she felt CNA #220 did not treat Resident #43 with respect during care. Counseling was attempted with CNA #220, but the employee was not receptive. CNA #220 stood up as if to leave and was told her employment was terminated. Interview on 12/10/25 at 11:10 A.M. with Resident #43's son revealed his mother called him during the night and stated an aide was rough with her when assisting her to the bathroom and she was afraid. After reviewing the video footage from the early hours of the morning of 10/20/25, he took the videos to the DON. Resident #43's son stated the CNA appeared to be frustrated and did not feel his mother was treated respectfully. Interview on 12/11/25 at 11:20 A.M. with the DON revealed Resident #43 uses the sit-to-stand machine at night. On 10/20/25, Resident #43's son reported his mother had called him during the night. After reviewing the videos, he brought them in for the DON to review. Resident #43's son stated he felt the aide was rough with her and appeared to be frustrated. Review of the employee file for CNA #220 revealed a date of hire of 05/30/24 and a termination date of 10/21/25 following the incident. Review of the 03/22/2022 revised facility policy called; Quality of Life-Dignity revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. Staff are expected to treat cognitively impaired residents with dignity and sensitivity; for example: addressing the underlying motives or root causes for behavior and not challenging or contradicting the resident's beliefs or statements.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on medical record review, interview and facility policy review, the facility failed to ensure a baseline care plan was completed as required for Resident #52. This affected one (Resident# 52) of nine residents reviewed for baseline care plans. The facility census was 49. Findings include: Review of the medical record for Resident #52 revealed an admission date of 10/01/25 and a discharge date of 10/17/25. Diagnoses included but were not limited to sepsis, morbid obesity, stage IV chronic kidney disease and liver cell carcinoma. Review of the 10/07/25 admission Minimum Data Set (MDS) 3.0 assessment for Resident #52 revealed intact cognition. Resident #52 was noted to require moderate assistance to being fully dependent upon staff for activities of daily living (ADL). Interview on 12/10/25 at 3:00 P.M. with the Director of Nursing (DON) confirmed she was unable to provide evidence of a baseline care plan for Resident #52. Review of the 11/22/16 facility policy titled: Resident Directed Care Planning Policy and Procedure revealed the interdisciplinary team (IDT) shall develop a baseline care plan for each resident that includes the instructions needed to provide effective and resident-directed care of the resident that meets professional standards of care. The baseline care plan shall be developed within 48 hours of a resident's admission.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the medical record, interviews and facility policy review, the facility failed to ensure bathing was provided and documented as requested and required for Resident #29. This affected one (Resident #29) of one resident reviewed for bathing. The facility census was 49. Findings include: Review of the medical record for Resident #29 revealed an admission on [DATE]. Diagnoses included but were not limited to Parkinson's disease, obesity, dementia and generalized anxiety disorder. Review of the 11/04/25 quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #29 revealed intact cognition. Resident #29 was noted to require moderate staff assistance with bathing and shower transfer. Review of the 11/15/25 bathing assessment for Resident #29 revealed she preferred a tub bath twice a week on day shift. Review of the care plan for Resident #29 revealed it was last reviewed on 11/17/25. Resident #29 was noted to have activities of daily living (ADL) performance and mobility deficits related to muscle weakness, debility and difficulty walking. Interventions listed were staff assistance with bathing or showering weekly and as needed. Review of the facility shower schedule for Resident #29 revealed bathing was scheduled on Sundays and Thursdays on day shift. Review of the Resident #29's Minimum Data Set (MDS) 3.0 Bathing Documentation Survey Report for September 2025 revealed one refusal on 09/25/25. Review of the bathing documentation for October 2025 revealed a refusal on 10/05/25, and bathing was provided on 10/23/25. Review of the bathing documentation for November 2025 revealed a refusal on 11/02/25, a bath was provided on 11/06/25 and 11/27/25. Review of the shower task for Resident #29 for the past 30 days revealed bathing was indicated as not applicable on 11/17/25 and 11/20/25, bath on 11/23/25, not applicable on 11/24/25, bath on 11/27/25, refused on 12/01/25, and a bath on 12/04/25. Review of the documentation from the MDS Bathing Survey Report and the bathing task revealed out of 28 opportunities for bathing between 09/01/25 and 12/07/25 for Resident #29, evidence was provided for five baths and four refusals. Interview on 12/09/25 at 1:42 P.M. with the Director of Nursing (DON) revealed the facility does not use shower sheets. The nurse is supposed to complete a progress note in the medical record and indicate bathing was completed on the Medication Administration Record (MAR). Staff follow the bathing preferences assessment as to the frequency and times for bathing. The DON confirmed Resident #29's bathing preference was two days a week on day shift, and bathing was not completed as requested per resident preference for Resident #29. Interview on 12/10/25 at 12:18 P.M. with Shower Aide #276 revealed there was a shower book which lists the days and shifts for resident bathing. Shower Aide #276 stated Resident #29 was able to make her needs known, required one assist for bathing, got bathed twice a week, and does not usually refuse bathing. Shower Aide #276 confirmed the bathing schedule recently changed due to some of the floor aides thought the shower aide was doing all of the showers and were not completing their scheduled showers. Review of the 10/2022 revised facility policy titled Policy and Procedure for Bathing revealed each resident and/or family will be questioned upon admission as to their choices for bathing. Quarterly, each resident will be questioned if there are any changes to preferences.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure the treatment to Resident #8's right heel was completed as ordered. This affected one (Resident #8) out of one resident reviewed for wound care. The facility census was 49. Findings include: Review of the medical record revealed Resident #8 was admitted on [DATE] with diagnoses that included but not limited to chronic pain, protein calorie malnutrition, and anxiety. A plan of care dated 08/29/25 revealed Resident #8 had a pressure ulcer to right heel. Interventions included but not limited to treatments to be administered as ordered and to monitor for effectiveness. The quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated cognitive impairment. The MDS also revealed Resident #8 had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) that was not present upon admission. A physician order dated 11/26/25 at 12:43 P.M. revealed Resident #8's right heel wound was to be cleansed with Vashe (wound cleanser used to gently clean, debride, and remove microorganisms from wounds), patted dry, Skin Prep (protective barrier) applied to the peri wound, Medihoney (wound gel that promotes healing by creating a moist environment, fights bacteria, reduces inflammation, and helps lift dead tissue) applied to the wound bed, and a Vashe moistened gauze applied to the wound bed only, an abdominal pad (ABD) applied, and then wrapped with rolled gauze daily and as needed if soiled and dislodged. An observation on 12/09/25 at 2:11 P.M. of treatment to Resident #8's right heel by Registered Nurse (RN) #283 revealed the dressing was dated 12/05/25. RN #283 verified the dressing was to be completed daily on the 7:00 P.M. to 7:00 A.M. shift. RN #283 verified the dated dressing revealed the treatment was not completed on 12/06/25, 12/07/25, and 12/08/25.		

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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 record review, review of self-reported incident (SRI) tracking #264837, interviews, observations and facility policy review, the facility failed to ensure Resident #61 was not outside the facility without adequate supervision. This affected one (Resident #61) out of one resident reviewed for accidents. The facility census was 49. Findings include: Review of the medical record revealed Resident #61 was admitted on [DATE] and discharged on 09/16/25 with diagnoses that included chronic atrial fibrillation, dementia, major depressive disorder, generalized anxiety, insomnia, restlessness and agitation, and chronic pain. A care plan dated 01/01/23 revealed Resident #61 was at risk for injury related to dementia. Resident #61 wanders looking for wife, has impaired safety awareness, and short attention span. Interventions included wander management system to wrist or leg and checked every shift, attempt to redirect when focused on leaving the facility unassisted or without supervision, if the resident attempts to exit, the staff should try to move the resident to a safe area away from the mode of exiting the facility, and notify the charge nurse or supervisor immediately if an attempt to leave the facility should occur out the doors or elevator unassisted or unsupervised. A WanderGuard (wander management system) and Exit Seeking evaluation dated 03/04/25 revealed Resident #61 was a candidate for the wander management system. Resident #61 was at risk for unintentional exiting from the building due to visits to wife on and off the unit. An order dated 04/24/25 at 4:05 P.M. revealed a wander management bracelet (Roam Alert) was in place on Resident #61. The placement was to be checked by the nurse every shift to ensure function to maintain surveillance on a 24-hour basis. The quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated cognitive impairment. The MDS also revealed Resident #61 had wandering behavior for one to three days during the seven-day assessment period. A health status note dated 09/03/25 at 7:00 P.M. by Licensed Practical Nurse (LPN) #200 revealed Resident #61 was observed by staff on the patio at the east entrance. Resident #61 stated he was going home. One-on-one supervision was started, and the Director of Nursing (DON) was notified. Review of SRI tracking #264837 revealed on 09/03/25 at 6:54 P.M. Resident #61 was found by staff sitting unsupervised outside of the entrance in his wheelchair. Resident #61 was brought to the nurse and received an assessment with no injury noted. Resident #61 was at baseline and had no complaints of pain. During the investigation, it was noted that the monitoring system was operational, and the doors were operating properly. Staff reported that the resident appeared agitated the night of the incident and was re-directed multiple times. Review of the facility investigation revealed a typed statement by LPN #222 revealed on 09/03/25 at 7:00 P.M. LPN #222 responded to an alarm at the east entrance (located at assisted living). LPN #222 was unaware a resident had exited the facility without an escort. This nurse silenced the alarm and continued with shift duties. A handwritten note (no date) by LPN #200 revealed Resident #61 stated he was going home. Resident #61 was offered fluids and food, which he refused and redirection was not effective. A handwritten statement (no date) by Certified Nursing Assistant (CNA) #201 revealed Resident #61 was agitated. CNA #201 offered Resident #61 food and drinks, but the resident refused. CNA #201 found Resident #61 sitting outside on the patio at the east entrance. Resident #61 was brought back into the facility, and the nurse was notified the resident had been found outside the facility. A handwritten statement dated 09/03/25 by CNA #203 revealed Resident #61 was leaving the dining room. Resident #61 stated his wife yelled at him and he was going home. Resident #61 proceeded to get his clothes and bible and tried to find the exit. CNA #203 notified the nurse of Resident #61's behavior. A handwritten statement dated 09/03/25 by Registered Nurse (RN) #205 revealed after giving report they saw Resident #61 moving towards the exit door. RN #205 closed the door (fire doors between the nursing facility and assisted living facility) and turned the resident back towards his (continued on next page)		

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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 record review, observation, interview and facility policy review, the facility failed to ensure staff followed standard infection control precautions during medication administration. This affected one (Resident #16) of four residents observed during medication administration. The facility also failed to maintain proper infection control practices while providing wound care for Resident #8. This affected one (Resident #8) of one resident observed for wound care. The facility census was 49. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of 10/16/25 with diagnoses including dementia, chronic kidney disease and diabetes mellitus. Review of the physician's orders for Resident #16 for December 2026 revealed she had an orders for Buspirone 10 milligrams (mg) three times a day for anxiety dated 10/16/25, Gabapentin 300 mg twice daily for nerve pain dated 10/16/25, Memantine 10 mg twice daily for dementia dated 10/16/25, Senna Plus 8.6-50 mg two tablets twice daily for constipation dated 10/16/25, Amlodipine 5 mg once daily for hypertension dated 10/17/25, Glipizide 5 mg in the morning for diabetes mellitus dated 10/17/25, Januvia in the morning for diabetes mellitus dated 10/17/25, Vistaril 25 mg twice daily for anxiety dated 11/05/25, Depakote 125 mg twice daily for anxiety dated 11/11/25, Cholecalciferol 2,000 units in the morning for supplement dated 11/29/25, Oxybutynin Chloride Extended Release 10 mg in the morning for overactive bladder dated 11/29/25, Pioglitazone 45 mg in the morning for diabetic neuropathy dated 11/29/25 and Sertraline 100 mg in the morning for depression dated 12/01/25. Observation on 12/09/25 at 7:48 A.M. of Licensed Practical Nurse (LPN) #233 at the medication cart on hallway B revealed she was popping the medications out of medication cards into her hand and then placing the medications in the medication cup. She had placed all of Resident #16's morning medications into the medication cup. LPN #233 was questioned as to why she was popping the pills into her bare hand and then placing them in the medication cup. She stated she had not realized she had touched the pills. She stated she was afraid of dropping the medications on the floor. LPN #233 verified she should not have touched Resident #16's medications with her bare hands and this was an infection control concern. 2. Review of the medical record revealed Resident #8 was admitted on [DATE] with diagnoses that included but not limited to chronic pain, protein calorie malnutrition, and anxiety. A health status note dated 08/22/25 at 4:00 P.M. revealed therapy notified the nurse Resident #8 had a blister on the back of the (right) heel. A plan of care dated 08/29/25 revealed Resident #8 had a pressure ulcer to right heel. Interventions included but not limited to treatments to be administered as ordered and to monitor for effectiveness. A physician order dated 10/15/25 at 9:02 A.M. revealed Resident #8 was ordered enhanced barrier precautions (EBP) related to a chronic wound. The quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated cognitive impairment. The MDS also revealed Resident #8 had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) that was not present upon admission. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Canton Christian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2550 Cleveland Avenue NW Canton, OH 44709	
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	An observation on 12/09/25 at 2:11 P.M. revealed a laminated sign on the outside of Resident #8's door that revealed Resident #8 had EBP in place. An observation of Registered Nurse (RN) #283 completing the treatment to Resident #8's heel revealed RN #283 wore gloves during the dressing change but did not wear a gown. RN #283 verified she had a gown in the treatment cart but forgot to put it on. The policy and procedure updated 02/25/25 revealed the use of EBP for wounds or indwelling medical devices help prevent the spread of multidrug-resistant organisms (MDRO) in accordance with the centers for disease control (CDC). EBP will be implemented with any elder in the nursing home with an indwelling medical device or wound as an intervention to reduce transmission of MDRO's through gown and glove use. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds that require a dressing and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for EBP included wound care (any skin opening requiring a dressing).		