



Health and  
Wellness

# Prince Edward Island Guidelines for Antimicrobial-Resistant Organisms (AROs) in Long-Term Care And Community Care Facilities

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Department of Health and Wellness  
Chief Public Health Office

# Antimicrobial-Resistant Organisms

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# Antimicrobial-Resistant Organisms

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## EXECUTIVE SUMMARY

Antimicrobial-Resistant Organisms (AROs) such as methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant *Enterococcus* (VRE), carbapenemase-producing *Enterobacterales* (CPE), and *Candida auris* (*C. auris*) present ongoing challenges in long-term care (LTC) and community care (CC) settings. This guideline provides standardized, evidence-based direction for the prevention, screening, management, and outbreak control of AROs across Prince Edward Island's LTC and CC settings.

The guideline emphasizes Routine Practices and Point-of-Care Risk Assessment (PCRA) as the foundation of care, with Modified Contact Precautions (MCP) applied for direct care when PCRA and resident transmission risk indicate increased risk of transmission. A resident-centered, risk-based approach is prioritized to prevent transmission while preserving dignity, autonomy, and quality of life. The document outlines reporting requirements, screening criteria, specimen collection, resident management, outbreak response, communication protocols, and staff education, aligned with provincial legislation and national infection prevention and control standards.

**The guideline supports, but does not replace, directives issued by the Chief Public Health Office (CPHO), which take precedence during outbreaks or public health events.**

# Antimicrobial-Resistant Organisms

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## 1.0 Introduction

Antimicrobial-resistance is an escalating global challenge in infectious disease management. Antimicrobial-resistant organisms (AROs) have existed for decades, but their prevalence has increased substantially in recent decades. The emergence and spread of organisms such as methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant *Enterococcus* (VRE) underscore the need for strong infection prevention and control (IPAC) measures.

The guideline is issued under the authority of the of the Chief Public Health Office (CPHO) and is intended to support compliance with the Public Health Act and applicable regulations in Prince Edward Island.

Effective IPAC strategies in LTC and CC settings help protect residents, improve health outcomes, and reduce operational burdens on care providers. The guideline emphasizes a proportionate, risk-based application of IPAC measures, guided by Routine Practices and PCRA, to minimize transmission risk.

This document provides standardized, evidence-based guidance for the prevention, screening, and management of AROs across Prince Edward Island's LTC and CC facilities. It applies to all facility operators, health care staff, administrators, and affiliated laboratories. The scope includes MRSA, VRE, and other clinically significant AROs such as carbapenemase-producing *Enterobacteriales* (CPE) and *Candida auris* (*C. auris*).

## 2.0 Background

AROs are pathogens that have developed mechanisms to survive exposure to antimicrobials that would normally eliminate them. Resistance reduces the effectiveness of standard treatments, leading to infections that are harder to manage and increasing the risk of complications, prolonged illness, and further transmission.

The rise of AROs is a significant public health concern, driven by factors such as antimicrobial overuse and misuse, inadequate IPAC practices, and the natural evolution of microorganisms. In LTC and CC settings, residents are particularly vulnerable due to advanced age, underlying health conditions, and frequent interactions with health care environments.

The most commonly encountered AROs in these settings include:

- MRSA (Methicillin-resistant *Staphylococcus aureus*)
- VRE (Vancomycin-resistant *Enterococcus*)

Additional organisms of concern, addressed to a lesser extent in this document, include:

- Carbapenemase-Producing *Enterobacteriales* (CPE) – a subset of carbapenem-resistant *Enterobacteriales* (CRE)
- *Candida auris* (*C. auris*) (drug-resistant)

Effective management of AROs requires a coordinated approach involving surveillance, education, antimicrobial stewardship, and strict adherence to evidence-based IPAC practices. This guidance is intended to support facility policies, procedures, and plans for prevention and management that protect residents, staff, visitors, and volunteers.

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## 2.1 Hierarchy of Controls in IPAC

IPAC strategies are guided by the hierarchy of controls, which prioritizes the most effective measures to reduce transmission risk:

- Administrative controls: Policies, procedures, education, screening, and surveillance
- Engineering controls: Physical environment and infrastructure (e.g., hand hygiene stations, private rooms)
- Personal protective equipment (PPE): Used as the final layer of protection when other controls cannot fully mitigate risk

## 3.0 Reporting Requirements

MRSA, VRE , CPE, and *C. auris* (drug-resistant) are designated notifiable diseases under the *Prince Edward Island Public Health Act* and the *Notifiable Diseases and Conditions and Communicable Diseases Regulations*.

### 3.1 Facility Operators/Staff

Health practitioners and facility administrators must promptly notify the Chief Public Health Officer (CPHO) or their designate by telephone of all laboratory-confirmed cases when identified.

### 3.2 Laboratory

The Provincial Laboratory must promptly notify the Chief Public Health Officer (CPHO) or their designate of all positive laboratory results by telephone, mail, fax, or electronic transfer when the result is known.

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## 4.0 Summary of Antimicrobial-Resistant Organisms (AROs)

### 4.0.1 Definition: Modified Contact Precautions (MCP)

Modified Contact Precautions (MCP) are a targeted, risk-based approach used in LTC and CC settings when PCRA and an individualized resident transmission risk indicate an increased risk of transmission.

MCP are applied to direct care activities and to interactions involving the resident's immediate care environment where there is a reasonable expectation of contact with blood, body fluids, secretions, excretions, or contaminated surfaces.

MCP are not determined by ARO status alone and do not automatically require precautions or private-room placement.

MCP are applied based on the task and anticipated exposure during care, not applied continuously to the resident, and are reassessed regularly. When the increased transmission risk is no longer present, MCP are discontinued and care returns to Routine Practices supported by PCRA.

Direct care (for MCP) includes hands-on care activities such as bathing, turning/positioning, changing clothes or incontinence products, toileting, dressing changes, and care of open wounds or lesions. Activities such as assisting with feeding or pushing a wheelchair are not considered direct care and do not routinely require MCP.

# Antimicrobial-Resistant Organisms

## 4.1. Colonization, Infection and Transmission

Understanding the relationship between colonization, infection and transmission is essential for appropriate IPAC decision-making in LTC and CC setting.

### 4.1.1 Colonization Versus Infection

Colonization is a significant contributor to transmission risk and must be considered in both routine management and outbreak recognition.

- **Colonization:** Presence and growth of AROs on or in a host without causing tissue invasion, symptoms, or disease (e.g., skin, mucous membranes, gastrointestinal tract)
- **Infection:** Invasion of body tissues by an ARO that causes clinical signs and symptoms

This distinction guides clinical management, antimicrobial use, and IPAC measures, including PCRA, and MCP.

*Table 1 Colonization Vs Infection*

Feature	Colonization	Infection
<b>Definition</b>	Presence of AROs without illness	Invasion and multiplication causing tissue damage and symptoms
<b>Symptoms</b>	None	Present (e.g. fever, inflammation, pain, wound drainage)
<b>Immune Response</b>	Typically absent	Active immune response
<b>Diagnostic Tests</b>	Positive culture without clinical signs	Positive culture with clinical signs
<b>Treatment Required</b>	Usually not required	Required (antimicrobial therapy, supportive care)
<b>Transmission Risk</b>	High (often unrecognized)	High (especially with wounds/devices or uncontained secretions)
<b>Common Sites</b>	Skin, nasal passages, GI tract, urinary tract	Depends on infection site (e.g., lungs, bloodstream, wounds, urinary tract)
<b>IPAC Measures</b>	Screening and surveillance, Routine Practices, MCP (when indicated based on PCRA and resident transmission risk), hand hygiene, environmental cleaning and disinfection, and antimicrobial stewardship	MCP (when indicated based on PCRA and resident transmission risk), treatment, enhanced IPAC measures as required, environmental cleaning and disinfection, and antimicrobial stewardship
<b>Progression Potential</b>	May progress to infection if host defenses are compromised	Already progressed to disease

## Antimicrobial-Resistant Organisms

### 4.1.2 Common AROs – Colonization Sites and Infections

Understanding colonization patterns supports risk assessment and targeted interventions, as colonization can precede infection and may serve as a reservoir for transmission.

**Table 2 Common AROs- Colonization Sites and Infections**

ARO Name	Type	Common Colonization Sites	Common Infections Caused
<b>MRSA (Methicillin-resistant <i>Staphylococcus aureus</i>)</b>	Bacteria	Skin, nasal passages, perianal area, wounds	Skin/soft tissue infections, wounds, UTIs, pneumonia, bloodstream infections, surgical site infections
<b>VRE (Vancomycin-resistant <i>Enterococcus</i>)</b>	Bacteria	GI tract, perineum	UTIs, bloodstream infections
<b>CPE (Carbapenemase-producing <i>Enterobacteriales</i>)</b>	Bacteria	GI tract	Sepsis, pneumonia, UTIs, intra-abdominal infections
<b><i>C. auris</i> (<i>Candida auris</i>) (drug-resistant)</b>	Fungus	Skin (axilla/groin), external ear canal	Bloodstream infections, wound infections, ear infections

### 4.1.3 Transmission

Understanding transmission pathways is essential for effective IPAC. AROs are primarily spread through contact—either direct or indirect—and transmission may be facilitated by invasive procedures if aseptic technique is compromised.

**Table 3 Mode of Transmission**

Mode of Transmission	Description
<b>Direct Contact</b>	Most common route. Spread via hands of healthcare workers or direct contact with colonized/infected individuals. Common in LTC and CC settings where residents are in close proximity. Invasive procedures (e.g., hypodermoclysis insertion, dressing changes) increase risk if aseptic technique is compromised.
<b>Indirect Contact</b>	Transmission via contaminated surfaces, equipment, or shared items (e.g., blood pressure cuffs, thermometers, bed rails, linens). AROs such as <i>C. auris</i> and CPE can persist on surfaces and in the environment for extended periods.

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## 4.2 Methicillin-resistant *Staphylococcus aureus* (MRSA):

MRSA is a strain of *Staphylococcus aureus* that has developed resistance to several commonly used antibiotics, including methicillin, oxacillin, penicillin, and amoxicillin. It is a major cause of healthcare-associated infections (HAIs) and a significant public health concern due to its ability to cause severe illness and its resistance to treatment.

Like non-resistant *S. aureus*, MRSA can colonize individuals without causing symptoms. Colonization typically occurs in the anterior nares, skin, and other mucosal surfaces. While 25–30% of the population may be colonized with *S. aureus*, approximately 1–2% are colonized with MRSA.

Colonized individuals can transmit MRSA to others, particularly in healthcare settings. Colonization may progress to infection when host defenses are compromised, such as through wounds, invasive devices, or immunosuppression.

### Common HAIs Include:

- Skin and soft tissue infections
- Surgical site infections
- Pneumonia
- Bloodstream infections (Bacteremia)
- Urinary tract infections (UTIs)

### Treatment Challenges

MRSA infections are difficult to treat due to resistance to beta-lactam antibiotics. Treatment options include agents such as vancomycin, linezolid, daptomycin, and clindamycin, selected based on infection severity, site, and resident-specific factors. Combination therapy may be considered for complicated infections. Antimicrobial stewardship is essential to prevent further resistance.

## 4.3 Vancomycin-Resistant *Enterococci* (VRE)

*Enterococci* are Gram-positive, facultative anaerobic cocci that naturally inhabit the gastrointestinal tract and may also be found in the anterior urethra, vagina, skin, oropharynx, and bile. While generally harmless, they can colonize wounds, ulcers, and medical devices and are a frequent cause of HAIs.

VRE are strains of *Enterococcus faecalis* and *Enterococcus faecium* that have developed resistance to vancomycin, a key antibiotic for treating serious enterococcal infections. This resistance is primarily due to genetic mutations—most notably the **vanA**, **vanB**, and **vanD** gene clusters—which alter the bacterial cell wall and reduce vancomycin's effectiveness.

### Common HAIs Include:

- UTIs
- Bacteremia
- Endocarditis

### Treatment Challenges

VRE infections are difficult to treat due to limited antibiotic options. Treatment options include agents such as linezolid or daptomycin, with dosing tailored to infection severity and resident-specific factors. Combination therapy with beta-lactams may enhance effectiveness in severe cases.

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## 4.4 Other AROs

Beyond MRSA and VRE, other emerging antimicrobial-resistant organisms pose significant challenges in LTC and CC settings. This section highlights two key organisms—Carbapenemase-Producing *Enterobacterales* (CPE) and *Candida auris* (*C. auris*)—including their clinical relevance and implications for infection prevention and control.

### 4.4.1 Carbapenemase-Producing *Enterobacterales* (CPE)

CPE are a subset of carbapenem-resistant *Enterobacterales* that produce carbapenemase enzymes, which break down carbapenem antibiotics and render them ineffective. This resistance makes CPE highly challenging to treat and a major concern for healthcare facilities.

#### Common species include:

- *Escherichia coli* (*E. coli*)
- *Klebsiella* species
- *Enterobacter* species

#### Common HAIs Include:

- Bacteremia
- Pneumonia
- UTIs
- Intra-abdominal infections

#### Treatment Challenges

CPE infections are extremely difficult to treat due to resistance to nearly all beta-lactam antibiotics, including carbapenems. Options include **ceftazidime-avibactam**, **meropenem-vaborbactam**, or **tigecycline**, often in combination therapy. Strict antimicrobial stewardship and enhanced IPAC measures are essential.

### 4.4.2 *Candida auris* (*C. auris*)

*C. auris* is an emerging multidrug-resistant fungal pathogen capable of colonizing the skin, particularly in warm, moist areas such as the axillae and groin. It can cause severe invasive infections, especially in hospitalized or immunocompromised individuals. *C. auris* spreads easily in healthcare environments and demonstrates resistance to multiple antifungal medications and common disinfectants.

#### Common HAIs Include:

- Bacteremia
- Wound infections
- Ear infections

#### Treatment Challenges

*C. auris* often exhibits resistance to azoles, polyenes, and sometimes echinocandins. First-line therapy typically involves **echinocandins**, with liposomal amphotericin B reserved for resistant cases. Environmental persistence requires rigorous cleaning and disinfection using products effective against *C. auris*, in accordance with facility policy and IPAC/CPHO guidance.

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## 5.0 Routine Screening for MRSA and VRE

- Routine universal admission screening for MRSA and VRE is not recommended; targeted, risk-based screening should be used
- Routine Practices and PCRA remain the foundation of prevention and are applied consistently for all residents
- Screening must not be used to determine admission, placement, or access to care

### 5.1 Admission Screening for MRSA

#### 5.1.1 Risk Factors for MRSA Colonization/Infection

Screening should be considered for residents with one or more of the following risk factors:

- History of MRSA colonization or infection
- Health care exposure outside Canada within the past 12 months
- Transfer from a unit or facility with a known MRSA outbreak

**Note: When risk factors are present or while awaiting results, apply Routine Practices and PCRA. Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission.**

#### 5.1.2 Specimen Collection for MRSA

Collect specimens from multiple sites for highest yield:

1. Nares
2. Perianal
3. Skin lesions, wounds, ulcers, surgical incisions, or exit sites of indwelling devices (if present)

#### Collection guidelines:

- Maximum of four different sites per resident
- Notify the laboratory if >4 sites require testing
- Always use aseptic technique

Note: Urine specimens are not part of routine MRSA screening. Collect urine only when clinically indicated (e.g., signs/symptoms of urinary tract infection), in accordance with clinical assessment and facility policy.

### 5.2 Admission Screening for VRE

#### 5.2.1 Risk Factors for VRE Colonization/Infection

Screening should be considered for residents with one or more of the following risk factors:

- History of VRE colonization or infection
- Health care exposure outside Canada within the past 12 months
- Transfer from a unit or facility with a known VRE outbreak

**Note: When risk factors are present or while awaiting results, apply Routine Practices and PCRA. Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission.**

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## 5.2.2 Specimen Collection for VRE

Preferred method:

1. Rectal swab with visible stool
2. If a colostomy is present, collect from the colostomy site

**Always use aseptic technique for all specimen collections.**

## 5.3 Ongoing Culturing for MRSA and VRE

Routine re-culturing of residents known to be MRSA or VRE positive is not recommended.

Re-culturing may be considered:

- During outbreak investigations
- Prior to transfer to another facility, if required
- When clinically indicated

An antibiotic-free interval (minimum of 48 hours) is required before testing if the individual has received any of the following antibiotics:

- Vancomycin
- Trimethoprim-sulfamethoxazole (cotrimoxazole)
- Doxycycline
- Ciprofloxacin
- Levofloxacin
- Moxifloxacin

Recolonization can occur at any time, even after documented clearance.

## 5.4 Decolonization for MRSA and VRE in LTC and CC

Routine decolonization for MRSA and VRE is not recommended in LTC and CC settings. The guideline emphasizes IPAC measures rather than routine decolonization strategies.

### Rationale

Routine decolonization is discouraged due to:

- Limited effectiveness and high risk of recolonization
- Potential harm to residents
- For MRSA: Low likelihood of sustained clearance in residents with weakened immune systems and multiple chronic conditions
- For VRE: Eradication attempts can disrupt the gut microbiome and increase antimicrobial-resistance risk

### Shared IPAC Measures

- Rigorous hand hygiene
- Environmental cleaning and disinfection
- MCP when indicated
- Risk-based screening and surveillance
- Antimicrobial stewardship to prevent resistance

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## 5.5 Managing ARO Cases

Once an ARO is identified or suspected, management strategies focus on reducing transmission risk while supporting resident participation in care and daily activities. Effective management relies on Routine Practices and PCRA, with MCP applied for direct care when PCRA and the resident transmission risk indicate increased risk of transmission, rather than organism status alone.

### 5.5.1 General Principles

- Apply Routine Practices for all residents
- Perform PCRA before every interaction
- Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission

### 5.5.2 Accommodation and Precautions

Residents who are colonized or infected with MRSA or VRE do not automatically require precautions.

- Routine Practices and PCRA remain the foundation of care.
- MCP are implemented only when the risk of transmission is assessed as higher, such as:
  - Uncontrolled wound drainage or secretions
  - Inability to maintain hygiene despite assistance
  - Frequent uncontained incontinence
  - Behavioural or cognitive challenges affecting containment
- A private room is preferred or required based on transmission risk, not ARO status alone.
- When single rooms are unavailable:
  - Cohort residents with the same organism, or
  - Place with a lower-risk roommate as defined in Appendix F1: Technical Reference / Management of ARO-Positive Residents
- Dedicate resident-specific equipment where possible or clean and disinfect between uses
- Post signage only when MCP are in place

### 5.5.3 Environmental Cleaning

- Resident rooms and bathrooms are cleaned and disinfected at least daily, with high-touch surfaces cleaned and disinfected more frequently based on risk, environmental contamination, or outbreak direction
- Ensure shared equipment and common areas are cleaned and disinfected after use
- Use hospital-grade disinfectants effective against MRSA and VRE
- For *C. auris*, use disinfectants effective against *C. auris* in accordance with IPAC/CPHO guidance and facility policy

### 5.5.4 Communication and Transfer Protocols

- Notify receiving facilities of ARO status prior to transfer
- Document organism status clearly in the resident's health record
- Provide education to staff, residents, and families about Routine Practices and MCP if in place

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## 5.5.5 Outbreak Management

Outbreak management for AROs is conducted in collaboration with the CPHO and IPAC.

Facilities must follow the procedures outlined in Appendix G1: Technical Reference / ARO Outbreak Management in LTC and CC, including:

- Outbreak triggers and reporting requirements
- Immediate and enhanced IPAC measures
- Screening and surveillance
- Environmental cleaning and auditing
- Criteria for outbreak closure

See Appendix F1: Technical Reference / Management of ARO-Positive Residents and Appendix F2: Quick Reference Poster / Management of ARO-Positive Residents for detailed technical and PCRA guidance.

## 6.0 Outbreak Management for AROs

Outbreak management in LTC and CC settings requires a coordinated, risk-based approach that prioritizes resident safety, continuity of care, and timely intervention to prevent transmission.

During outbreaks or public health events, directives issued by the CPHO take precedence over this guidance. All outbreak identification, management, and closure activities must be undertaken in collaboration with the CPHO.

Outbreak measures should be guided by Routine Practices and PCRA, with MCP implemented when the risk of transmission is increased. ARO colonization and infection both contribute to transmission risk and must be considered in outbreak recognition and response.

See Appendix G1: Technical Reference / ARO Outbreak Management in LTC and CC and Appendix G2: Quick Reference Poster / ARO Outbreak Management for detailed outbreak management guidance and visual reference tools.

### 6.1 Outbreak Definition

An outbreak is:

- A significant increase in cases of colonization or infection with an ARO above the expected baseline for the facility within a defined time period
- Includes epidemiologically linked cases (e.g., same unit or care area)
- Includes both colonized and infected residents, as colonization can contribute to transmission

#### Key Points

Outbreak thresholds may vary by facility size, resident population, and local epidemiology. Typically, two or more epidemiologically linked cases in the same unit or care area may trigger outbreak protocols. A single case involving a higher-risk ARO (e.g., CPE or *C. auris*) may also trigger outbreak response measures, as directed by IPAC/CPHO.

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## 6.2 Outbreak Closure Criteria

All criteria must be met, in consultation with the CPHO and IPAC:

### 1. Epidemiological Criteria

- No new cases (colonization or infection) for **≥14 days** after the last positive case was identified and placed on appropriate precautions

### 2. Enhanced Measures Completed

- Environmental cleaning audits demonstrate compliance
- Hand hygiene audits show sustained adherence
- Staff education and competency verification completed

### 3. Communication & Documentation

- Outbreak line list updated and finalized
- CPHO (or designated authority) confirms outbreak closure

### 4. Risk Assessment Supports Closure

- No pending laboratory results or unresolved contacts
- Cohorting and MCP can be safely discontinued, based on PCRA and resident transmission risk

### 5. Ongoing Surveillance

- Continue active surveillance and hand hygiene audits until the outbreak is officially declared over
- Maintain vigilance for recurrence

### 6. Resident-Specific Precautions

- For residents who continue to have increased transmission risk on assessment, MCP may remain in place based on PCRA and resident transmission risk, as directed by IPAC/CPHO

## 7.0 Communication and Reporting Protocols

- **Routine Cases:**
  - Document ARO status in the resident's health record
  - Communicate required measures to the care team and environmental services.
    - Routine Practices and PCRA apply at all times
    - Apply MCP for direct care when PCRA and the resident transmission risk indicate increased risk of transmission
- **Transfers:**
  - Notify the receiving facility of ARO status prior to transfer, including whether MCP are currently in place
- **Outbreaks:**
  - Report suspected or confirmed outbreaks to the CPHO immediately
  - Provide regular updates to staff, residents, and families, as appropriate
- **CPHO Collaboration:**
  - Follow CPHO directives for outbreak declaration and closure, and for any additional IPAC measures

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## 8.0 Roles and Responsibilities

### Facility Operators and Administrators

- Ensure IPAC policies are implemented, including Routine Practices and PCRA
- Ensure staff are trained and competent in hand hygiene, PCRA, specimen collection, and the risk-based use of MCP
- Maintain communication with the CPHO and the IPAC team during suspected or confirmed outbreaks

### Healthcare Staff

- Apply Routine Practices and perform PCRA before every interaction
- Follow screening, specimen collection, and documentation protocols
- Apply MCP for direct care when PCRA and resident transmission risk indicate increased risk of transmission, and discontinue when no longer indicated

### IPAC Team

- Provide guidance on resident transmission-risk assessment, MCP application, cohorting/placement considerations, and outbreak management in collaboration with CPHO
- Monitor and support compliance with hand hygiene and environmental cleaning, including audit and feedback as needed

### Laboratories

- Promptly report positive ARO results to the CPHO or designate, in accordance with notifiable disease reporting requirements
- Support outbreak investigations with timely testing and reporting of results

## 9.0 Education and Training

### Facilities must ensure:

- Annual IPAC education for all staff, including Routine Practices, hand hygiene, PCRA, task-based PPE selection, and environmental cleaning and disinfection
- Competency validation for specimen collection and outbreak response, including application of MCP for direct care when PCRA and resident transmission risk indicate increased risk of transmission
- Resident and family education on AROs, hand hygiene, and the purpose of MCP when in place, including what to expect during outbreaks

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Appendix A: Hand Hygiene

# HAND HYGIENE

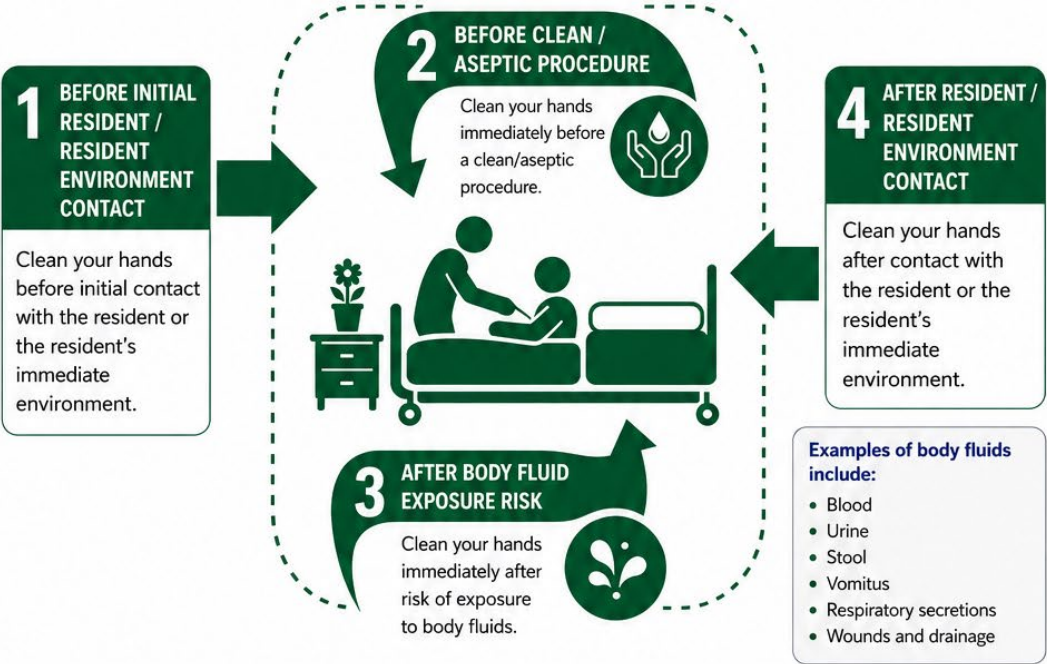
## The 4 Moments for Hand Hygiene

*Clean hands. Safe care. Every time.*





Hand hygiene is the single most important way to **prevent the spread of infections**. Clean your hands with soap and water or use alcohol-based hand rub (ABHR) at the **4 Moments**.




### HOW TO CLEAN YOUR HANDS



**Use alcohol-based hand rub (ABHR) when hands are not visibly soiled.**

- ✓ Apply a dime-sized amount to palm of hand.
- ✓ Rub all surfaces of hands and fingers until dry (15–30 seconds).
- ✓ Do not rinse or wipe off.



**Use soap and water when hands are visibly soiled.**

- ✓ Wet hands with warm water.
- ✓ Apply soap and lather.
- ✓ Scrub all surfaces for at least 20 seconds.
- ✓ Rinse well and dry with paper towel.



**REMEMBER**

- ✓ Perform hand hygiene at the 4 Moments for every resident interaction.
- ✓ Use the correct technique and allow hands to dry completely.
- ✓ Healthy hands provide safe care. Thank you!

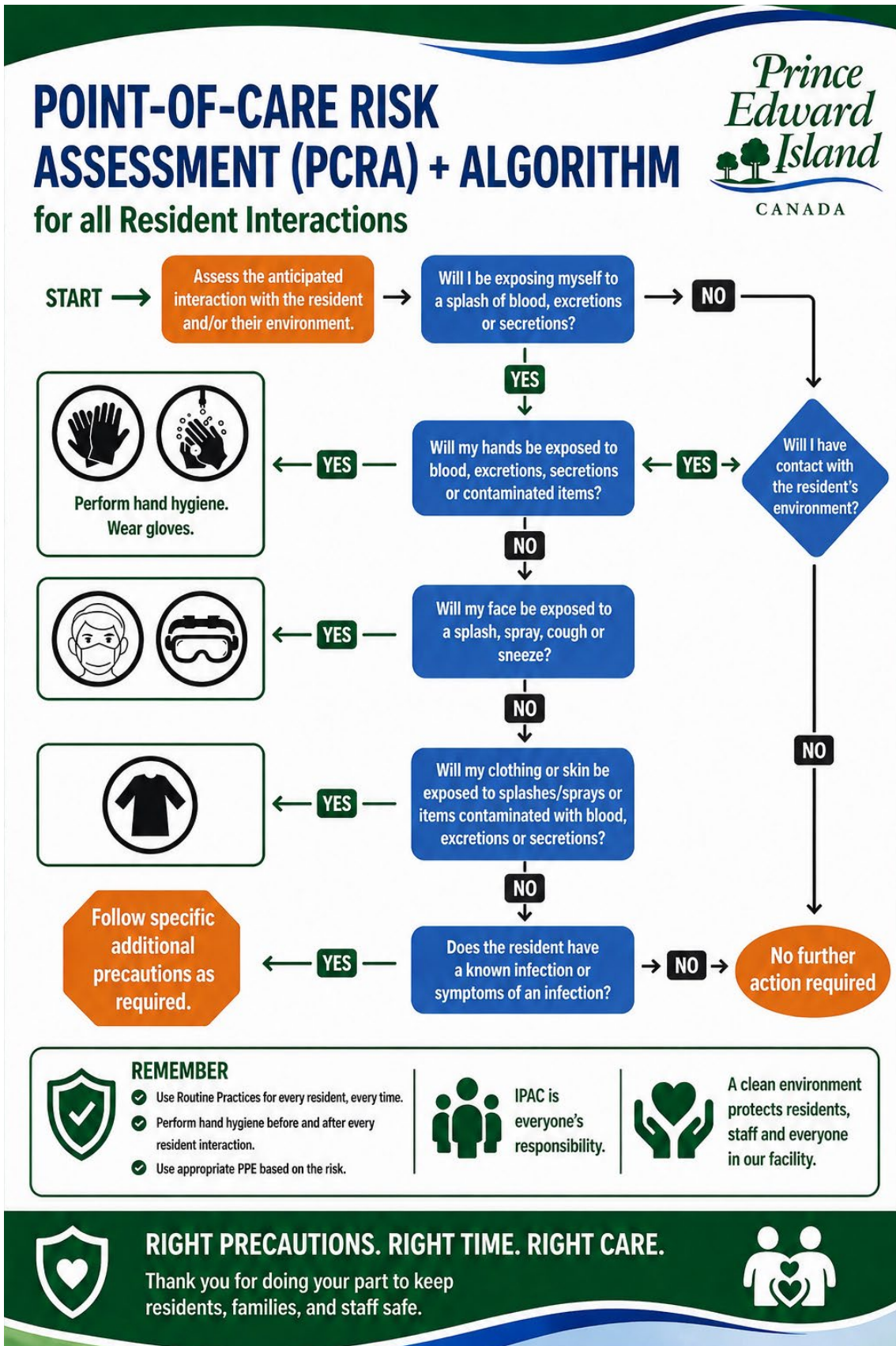




**RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.**

Thank you for doing your part to keep residents, families, and staff safe.





Appendix C: Modified Contact Precautions (MCP)

# MODIFIED CONTACT PRECAUTIONS (MCP)



**Targeted. Risk-Based. Person-Centred.**  
**Protect residents. Protect each other.**

	<b>Modified Contact Precautions (MCP)</b> are a targeted, risk-based approach used in long-term care (LTC) and community care (CC) settings when Point-of-Care Risk Assessment (PCRA) and an individualized resident transmission-risk assessment indicate an <b>increased likelihood of spread by direct or indirect contact</b> .
	MCP are applied to <b>direct care activities</b> and to interactions involving the resident's <b>immediate care environment</b> when there is a reasonable expectation of contact and an <b>increased risk of contamination</b> (e.g., uncontained body fluids, uncontrolled drainage, or frequent contamination of surfaces).
	MCP are <b>not</b> determined by ARO status alone and <b>do not automatically</b> require precautions or private-room placement.
	MCP are <b>reassessed regularly</b> and <b>discontinued</b> when the increased transmission risk is no longer present, returning the resident to <b>Routine Practices</b> supported by PCRA.

**✓ DIRECT CARE (for MCP)**

**Hands-on care such as:**

- Bathing
- Turning/positioning
- Changing clothes or incontinent products
- Toileting
- Dressing changes
- Care of open wounds/lesions

**✗ NOT DIRECT CARE**

**Examples:**

- Assisting with feeding
- Pushing a wheelchair

Use your Point-of-Care Risk Assessment (PCRA) and clinical judgment to determine if MCP are needed.

**REMEMBER**

- Use Routine Practices for every resident, every time.
- Perform hand hygiene before and after every resident interaction.
- Use appropriate PPE based on the risk.

IPAC is everyone's responsibility.


A clean environment protects residents, staff and everyone in our facility.

**RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.**  
 Thank you for doing your part to keep residents, families, and staff safe.

## Appendix D: Resident Risk Assessment for AROs

# RESIDENT RISK ASSESSMENT FOR AROs

(MRSA, VRE, CPE, *Candida auris*)



**RESIDENT INFORMATION**

First Name:

Last Name:

Date of Birth (yyyy-mm-dd):

Medical Record Number (MRN):


**ASSESSOR INFORMATION**

First Name:

Last Name:








Position:


Date (yyyy-mm-dd):


 Routine Practices and Point-of-Care Risk Assessment (PCRA) are the foundation of care for all residents, including those known to be ARO-positive.

A “Yes” response **does not automatically** require Modified Contact Precautions (MCP) and must be interpreted in conjunction with the Risk of Transmission Assessment (see Appendix F, Table 1).


**RISK-BASED ASSESSMENT FOR ARO TRANSMISSION**


Risk Factor	Yes	No
 History of MRSA colonization or infection	<input type="checkbox"/>	<input type="checkbox"/>
 History of VRE colonization or infection	<input type="checkbox"/>	<input type="checkbox"/>
 History of CPE or other multidrug-resistant organism (MDRO)	<input type="checkbox"/>	<input type="checkbox"/>
 Presence of wounds, ulcers, psoriasis (if open/active), or invasive devices (e.g., urinary catheter, vascular access device, feeding tube)	<input type="checkbox"/>	<input type="checkbox"/>
 Immunocompromised (e.g., cancer chemotherapy, transplant, biologic or high-dose steroid therapy)	<input type="checkbox"/>	<input type="checkbox"/>
 Health care exposure outside Canada	<input type="checkbox"/>	<input type="checkbox"/>
 Exposure to a unit or setting with a known ARO outbreak	<input type="checkbox"/>	<input type="checkbox"/>


 **IF ALL RESPONSES = NO**

 **Continue Routine Practices and PCRA**


**No MCP required**


 **IF ANY RESPONSE = YES**


 Perform an individualized Risk of Transmission assessment (Appendix F, Table 1).

 **Implement MCP only if transmission risk is increased, such as:**


- Uncontrolled drainage or secretions
- Inability to maintain personal hygiene
- Frequent or uncontained incontinence
- Cognitive or behavioural challenges affecting infection control practices


 **Ensure dedicated equipment and supplies if Modified Contact Precautions are required.**

 **Consider screening cultures only if clinically indicated, in consultation with IPAC.**


 **Notify the IPAC team for guidance as needed.**


**DOCUMENTATION AND COMMUNICATION**

 Document assessment findings and required precautions in the resident's health record and plan of care.

 Communicate risk status and precautions to:


- Nursing and interprofessional care team
- Environmental and support services

 Reassess and update precautions as the resident's condition or risk factors change.

 Clear communication supports safe, consistent care for every resident.

**RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.**


Thank you for doing your part to keep residents, families, and staff safe.



## Appendix E: Specimen Collection

# SPECIMEN COLLECTION FOR AROs (MRSA, VRE)

Accurate collection supports timely diagnosis  
and appropriate infection prevention and control.



GENERAL PRINCIPLES

 Perform hand hygiene before and after collection.	 Perform Point-of-Care Risk Assessment (PCRA) before every interaction.	 Use aseptic technique at all times.	 Label specimens immediately at bedside.	 Collect from all indicated sites for highest yield.
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MRSA

VRE

**PRIMARY SITES**

- Anterior nares
- Perianal

---

**ADDITIONAL SITES (if present)**

- Wounds, ulcers, incisions
- Device exit sites
- Groin/perineum  
(Maximum total: 4 sites)

---

**SWAB TYPE**

- Sterile flocked swab

---

**COLLECTION STEPS**

1. Insert swab 1–2 cm into nostril.
2. Rotate swab while maintaining contact for 3–5 seconds.
3. Repeat in other nostril using same swab.
4. Swab perianal area.
5. Swab additional sites as indicated.

**PRIMARY SITE**

- Rectal swab  
(must have visible stool)

---

**ALTERNATIVE**

- Stool specimen
- Colostomy site (if present)

---

**SWAB TYPE**


- Sterile flocked swab

---

**COLLECTION STEPS**

1. Insert swab 1–2.5 cm beyond anal sphincter.
2. Rotate swab while maintaining contact for 3–5 seconds.
3. Ensure visible fecal material is present on swab.

STORAGE




  
**MRSA**  
 Refrigerate within ≤24 hours.

  
**VRE**  
 Room temperature if ≤48 hours, or refrigerate if longer.

LABELLING – Include:

- Resident ID (Name, MRN, DOB)
- Site
- Date and Time of Collection

BEST PRACTICES


 Perform hand hygiene before and after collection.	 Use PPE as per PCRA based on risk and resident care needs.	 Use sterile technique and limit 1:1 contact.	 Use approved containers.	 Transport promptly to the lab.	 Do not reuse swabs or collection materials.
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- Follow laboratory requisition instructions.
- Transport to laboratory as soon as possible according to laboratory requirements.
- Contact the laboratory for any questions.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Thank you for doing your part to keep residents, families, and staff safe.



# Antimicrobial-Resistant Organisms

## Appendix F1: Technical Reference / Management of ARO-Positive Residents

**Cross-link to poster:** This technical appendix supports the visual quick reference poster, Appendix F: Management of ARO-Positive Residents. The poster is intended for point-of-care use. This appendix provides detailed guidance for clinical decision-making, audit, and policy reference.

### Purpose

- Provide standardized, risk-based guidance for the management of residents identified with antimicrobial-resistant organisms (AROs) in LTC and CC settings.
- Support safe care while preserving resident dignity, autonomy, participation, and quality of life.

### Core Principles

<b>Risk-based, not organism-based</b>	Routine Practices and PCRA apply to all residents.
<b>Targeted use of MCP</b>	MCP are applied for direct care when PCRA and resident transmission risk indicate increased risk of transmission.
<b>Resident-centred and proportionate</b>	Care approaches should balance infection prevention with quality of life and be reassessed regularly.

### Risk of Transmission and Placement

Risk Level	Clinical Indicators	Precautions	Placement Guidance
<b>Lower risk</b>	Able to perform or accept hand hygiene; secretions, excretions, and wound drainage are contained; no uncontrolled drainage.	Routine Practices + PCRA. MCP is not required based on ARO status alone.	Private room is not required based on ARO status alone. Room sharing may be appropriate when risk is low.
<b>Higher risk</b>	Uncontrolled wound drainage or secretions; inability to maintain personal hygiene; frequent incontinence not contained by products; cognitive or behavioural factors affecting containment.	Routine Practices + MCP are applied for direct care when PCRA and resident transmission risk indicate increased risk of transmission.	Private room is recommended when risk cannot be mitigated. Cohorting may be considered based on IPAC guidance.

# Antimicrobial-Resistant Organisms

## Resident Participation in Activities

Risk Level	Participation	Additional Measures
Lower risk	No restriction from activities solely due to ARO status.	Support hand hygiene as needed. Ensure affected areas are covered or contained when applicable.
Higher risk	Participation is conditional and based on current risk assessment.	Restrict participation only when transmission risk cannot be reasonably mitigated. Reassess regularly.

## Accommodation and Room Sharing

Scenario	Guidance
Private room	Use is based on risk of transmission, not ARO status alone. Consider resident preference, clinical needs, roommate vulnerability, and ability to contain secretions or excretions.
Shared room	Permitted when risk is low and care needs can be safely managed. If applicable, residents with the same organism may share a room when clinically appropriate.
Key consideration	Ensure secretions, excretions, and wound drainage are contained. Reassess if the resident condition changes.

## Precautions and Care Practices

Element	Requirement
Routine Practices	Apply to all residents, for all care, at all times.
PCRA	Complete before each interaction to determine anticipated exposure and required controls.
MCP	Apply for direct care when PCRA and resident risk indicate increased risk of transmission.
PPE	Select according to anticipated exposure to blood, body fluids, secretions, excretions, contaminated items, or environmental contamination.
Signage and communication	Follow organizational and IPAC guidance where signage or additional communication is required.

# Antimicrobial-Resistant Organisms

## Environment and Equipment

Area	Standard
Shared equipment	Clean and disinfect between residents and between uses according to manufacturer instructions and organizational procedures.
Non-cleanable items	Do not share items that cannot be cleaned and disinfected, such as some books, electronics, or personal items.
Environmental cleaning	Follow routine cleaning protocols. Increase attention to high-touch surfaces and shared areas when risk is increased.
Supplies and storage	Store clean supplies to prevent contamination. Avoid bringing excess supplies into the resident care area.

## Acute Care vs. LTC and CC Context


Context	Guidance
Acute care practices	Practices such as strict precautions or prolonged room restriction are generally not appropriate for LTC and CC unless specifically indicated.
LTC and CC focus	Use Routine Practices and PCRA, targeted MCP when indicated, and interventions that preserve dignity, autonomy, and quality of life.

## Documentation and Care Planning Requirements

- Document ARO status and current transmission risk in the resident record according to organizational process.
- Document precautions and any additional measures clearly in the plan of care.
- Reassess risk regularly and when the resident condition, hygiene, wound drainage, continence, or behaviour changes.
- Communicate required precautions to relevant staff while maintaining resident privacy and dignity.

## Consultation

- Consult IPAC or CPHO when risk assessment is unclear, placement decisions are complex, or ongoing transmission concerns exist.







# MANAGEMENT OF ARO-POSITIVE RESIDENTS

in all Long-Term Care (LTC) and Community Care (CC) settings

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### KEY PRINCIPLES

 <b>RESIDENT-CENTRED CARE</b> LTC and CC settings are the resident's home. Care must support dignity, autonomy, and quality of life.	 <b>RISK-BASED APPROACH</b> Infection prevention measures must be proportionate, risk-based, and balanced with quality of life.	 <b>ARO STATUS ALONE DOES NOT REQUIRE MCP</b> ARO status alone is not automatically require MCP.	 <b>SEEK EXPERT GUIDANCE</b> When placement or ongoing care planning is challenging, consult IPAC or CPHO for guidance.
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#### ADMISSION & RESIDENCE

- ARO status alone must not determine admission, re-admission decisions in LTC or CC.
- LTC and CC settings are the resident's home. Infection prevention measures must be proportionate, risk-based, and balanced with quality of life.
- When placement or ongoing care planning is challenging, consult IPAC or CPHO for guidance.

#### INDICATORS OF INCREASED TRANSMISSION RISK





- Uncontrolled wound drainage or secretions
- Inability to maintain personal hygiene
- Frequent incontinence (episode not contained by continence products)
- Cognitive or behavioural challenges affecting adherence to hygiene or containment measures

MCP are implemented only when the risk of transmission is increased, based on risk assessment and professional judgement.



#### TESTING

- Routine admission screening for AROs (e.g., MRSA, VRE, CPE) etc.) is not recommended.
- ARO testing is performed only when clinically indicated, not for placement, transfer, or discontinuation decisions.



#### 1 RISK OF TRANSMISSION & PLACEMENT

 <b>LOWER RISK</b>	<ul style="list-style-type: none"> <li>• Able to follow hygiene</li> <li>• Routine Practices</li> <li>• Routine Practices + PCRA</li> <li>• No MCP required</li> <li>• Private room preferred (not required)</li> </ul>	
 <b>HIGHER RISK</b>	<ul style="list-style-type: none"> <li>• Uncontained fluids</li> <li>• Hygiene challenges</li> <li>• Routine Practices + MCP</li> <li>• Private room strongly considered</li> </ul>	



#### 2 RESIDENT PARTICIPATION IN ACTIVITIES

 <b>LOWER RISK</b>	<ul style="list-style-type: none"> <li>• Full participation</li> <li>• Routine Practices</li> <li>• Hand hygiene as needed</li> </ul>
 <b>HIGHER RISK</b>	<ul style="list-style-type: none"> <li>• Consider modifications</li> <li>• Balance risk and benefit</li> <li>• Maintain inclusion</li> <li>• Monitor regularly</li> </ul>



#### 3 ACCOMMODATION & ROOM SHARING

 <b>PRIVATE ROOM</b> (preferred for ARO when able)	<ul style="list-style-type: none"> <li>• Preferred option in ARO cases</li> <li>• Facilitates care and infection prevention</li> </ul>
 <b>SAME ORGANISM</b> (when private room not available)	<ul style="list-style-type: none"> <li>• Room share as considered appropriate</li> </ul>

#### 4 PRECAUTIONS & CARE PRACTICES

 <b>ROUTINE PRACTICES</b>	<ul style="list-style-type: none"> <li>• Foundation of care</li> <li>• Apply to all residents, at all times</li> </ul>
 <b>MCP</b>	<ul style="list-style-type: none"> <li>• Use when risk of transmission is increased</li> <li>• Based on point-of-care risk assessment</li> </ul>




#### 5 ENVIRONMENT & OPERATIONAL PRACTICES

 <b>SHARED ITEMS</b>	<ul style="list-style-type: none"> <li>• Clean between each resident use</li> <li>• Clean and disinfect before resident use</li> </ul>
 <b>CLEANING</b>	<ul style="list-style-type: none"> <li>• Routine cleaning; enhanced cleaning when clinically indicated</li> <li>• Follow outbreak cleaning guidance as directed above</li> </ul>







#### 6 ACUTE CARE vs. LTC & CC

MCP in acute care settings may differ from LTC/CC. Decisions are based on risk assessment, ARO epidemiology, and setting.

In LTC and CC:

 Maintain resident dignity and inclusion	 Balance safety and quality of life	 Planning aligns with resident goals of care
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### BEST PRACTICE SUMMARY


	Perform hand hygiene before and after every interaction.		Apply Routine Practices + PCRA based on risk.		Reassess risk regularly and adjust as needed.		Communicate clearly with resident, family, and team.		Document care decisions and rationale.		Seek guidance when uncertain or complex.
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**!**

- Follow laboratory requisition instructions.
- Transport to laboratory as soon as possible according to laboratory requirements.
- Contact the laboratory for any questions.

### RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Thank you for doing your part to keep residents, families, and staff safe.



# Antimicrobial-Resistant Organisms

## Appendix G1: Technical Reference / ARO Outbreak Management in LTC and CC

**Cross-link to poster:** This technical appendix supports the visual quick reference poster, Appendix G: ARO Outbreak Management. The poster is intended for point-of-care use. This appendix provides detailed guidance for outbreak management, audit, and policy reference.

### Purpose

- Provide standardized, risk-based guidance for the management of ARO outbreaks in LTC and CC
- Support safe care while preserving resident dignity, autonomy, participation, and quality of life.

### Core Principles

<b>Risk-based, not organism-based</b>	Outbreak response is guided by transmission risk, not organism alone
<b>Routine Practices and PCRA</b>	Apply to all residents at all times
<b>Targeted use of MCP</b>	MCP are applied for direct care when PCRA and resident transmission risk indicated increased risk of transmission
<b>Resident-centered and proportionate</b>	Balance infection prevention with quality of life; reassess regularly
<b>Least restrictive approach</b>	Avoid unnecessary restrictions whenever possible
<b>Consultation</b>	Consult IPAC or CPHO as needed

### Outbreak Triggers

Trigger Indicator	What This Means	Required Actions
<b>≥2 linked cases</b>	Possible transmission	Initiate outbreak response
<b>Increase above baseline</b>	Unusual rise	Notify CPHO and engage IPAC
<b>High-risk organism</b>	Increased concern	Begin enhanced surveillance

# Antimicrobial-Resistant Organisms

## Immediate Response


Category	Guidance	Details
<b>Infection Prevention</b>	Routine Practices + PCRA	Implement MCP; signage if indicated
<b>Placement &amp; Cohorting</b>	Based on risk	Private room; cohort residents/staff
<b>Environment</b>	Enhance cleaning	High-touch surfaces; shared equipment
<b>Surveillance</b>	Initiate monitoring	Line list; active case finding

## Ongoing Management

Category	Guidance	Details
<b>Screening</b>	Risk-based	Screen contacts per IPAC/CPHO
<b>Staff &amp; Communication</b>	Ongoing	Reinforce PPE; communicate
<b>Operations</b>	Maintain care	Restrict admissions if directed
<b>Resident Activities</b>	Risk-based	Encourage low risk; restrict higher risk

## Outbreak Closure

Criteria	Requirements
<b>No new cases</b>	≥14 days
<b>Screening</b>	Completed
<b>Approval</b>	IPAC or CPHO







# MANAGEMENT OF ARO-POSITIVE RESIDENTS

in all Long-Term Care (LTC) and Community Care (CC) settings

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### KEY PRINCIPLES

 <b>RESIDENT-CENTRED CARE</b> LTC and CC settings are the resident's home. Care must support dignity, autonomy, and quality of life.	 <b>RISK-BASED APPROACH</b> Infection prevention measures must be proportionate, risk-based, and balanced with quality of life.	 <b>ARO STATUS ALONE DOES NOT REQUIRE MCP</b> ARO status alone is not automatically require MCP.	 <b>SEEK EXPERT GUIDANCE</b> When placement or ongoing care planning is challenging, consult IPAC or CPHO for guidance.
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#### ADMISSION & RESIDENCE

- ARO status alone must not determine admission, re-admission decisions in LTC or CC.
- LTC and CC settings are the resident's home. Infection prevention measures must be proportionate, risk-based, and balanced with quality of life.
- When placement or ongoing care planning is challenging, consult IPAC or CPHO for guidance.

#### INDICATORS OF INCREASED TRANSMISSION RISK





- Uncontrolled wound drainage or secretions
- Inability to maintain personal hygiene
- Frequent incontinence (episode not contained by continence products)
- Cognitive or behavioural challenges affecting adherence to hygiene or containment measures

MCP are implemented only when the risk of transmission is increased, based on risk assessment and professional judgement.



#### TESTING

- Routine admission screening for AROs (e.g., MRSA, VRE, CPE) is not recommended.
- ARO testing is performed only when clinically indicated, not for placement, transfer, or discontinuation decisions.



#### 1 RISK OF TRANSMISSION & PLACEMENT

 <b>LOWER RISK</b>	<ul style="list-style-type: none"> <li>• Able to follow hygiene</li> <li>• Routine Practices</li> <li>• Routine Practices + PCRA</li> <li>• No MCP required</li> <li>• Private room preferred (not required)</li> </ul>	
 <b>HIGHER RISK</b>	<ul style="list-style-type: none"> <li>• Uncontained fluids</li> <li>• Hygiene challenges</li> <li>• Routine Practices + MCP</li> <li>• Private room strongly considered</li> </ul>	



#### 2 RESIDENT PARTICIPATION IN ACTIVITIES

 <b>LOWER RISK</b>	<ul style="list-style-type: none"> <li>• Full participation</li> <li>• Routine Practices</li> <li>• Hand hygiene as needed</li> </ul>
 <b>HIGHER RISK</b>	<ul style="list-style-type: none"> <li>• Consider modifications</li> <li>• Balance risk and benefit</li> <li>• Maintain inclusion</li> <li>• Monitor regularly</li> </ul>



#### 3 ACCOMMODATION & ROOM SHARING

 <b>PRIVATE ROOM</b> (preferred for ARO when able)	<ul style="list-style-type: none"> <li>• Preferred option in ARO cases</li> <li>• Facilitates care and infection prevention</li> </ul>
 <b>SAME ORGANISM</b> (when private room not available)	<ul style="list-style-type: none"> <li>• Room share as considered appropriate</li> </ul>

#### 4 PRECAUTIONS & CARE PRACTICES

 <b>ROUTINE PRACTICES</b>	<ul style="list-style-type: none"> <li>• Foundation of care</li> <li>• Apply to all residents, at all times</li> </ul>
 <b>MCP</b>	<ul style="list-style-type: none"> <li>• Use when risk of transmission is increased</li> <li>• Based on point-of-care risk assessment</li> <li>• Follow Alberta Health MCP guidance</li> </ul>




#### 5 ENVIRONMENT & OPERATIONAL PRACTICES

 <b>SHARED ITEMS</b>	<ul style="list-style-type: none"> <li>• Clean between each resident use</li> <li>• Use Alberta Health guidance</li> <li>• Clean and disinfect before resident use</li> </ul>
 <b>CLEANING</b>	<ul style="list-style-type: none"> <li>• Routine cleaning; enhanced cleaning when clinically indicated</li> <li>• Follow outbreak cleaning guidance as directed above</li> </ul>







#### 6 ACUTE CARE vs. LTC & CC


MCP in acute care settings may differ from LTC/CC. Decisions are based on risk assessment, ARO epidemiology, and setting.

In LTC and CC:

 Maintain resident dignity and inclusion	 Balance safety and quality of life	 Planning aligns with resident goals of care
--	---	--

### BEST PRACTICE SUMMARY


 Perform hand hygiene before and after every interaction.	 Apply Routine Practices + PCRA based on risk.	 Reassess risk regularly and adjust as needed.	 Communicate clearly with resident, family, and team.	 Document care decisions and rationale.	 Seek guidance when uncertain or complex.
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- Follow laboratory requisition instructions.
- Transport to laboratory as soon as possible according to laboratory requirements.
- Contact the laboratory for any questions.

### RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.


Thank you for doing your part to keep residents, families, and staff safe.





# OUTBREAK NOTICE





For Long-Term Care (LTC) and  
Community Care (CC) Settings






## OUTBREAK IN PROGRESS


- Follow all posted precautions.
- Follow staff direction.

**REQUIRED PRACTICES**


	<b>HAND HYGIENE</b>	Clean your hands on entry and exit.
	<b>PPE</b>	Wear required PPE as posted.
	<b>VISITORS</b>	Follow restrictions. Check with staff before entering.
	<b>STAFF DIRECTION</b>	Follow all instructions from staff.

**ADDITIONAL MEASURES**

	<b>SHARED ITEMS</b>	Do not share personal items. Use dedicated equipment when possible.
	<b>MOVEMENT</b>	Follow unit/room restrictions as directed.
	<b>QUESTIONS</b>	Speak with a staff member.



These measures are in place to protect residents, families, and staff.  
Restrictions are temporary and risk-based.



**RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.**  
Thank you for doing your part to keep residents, families, and staff safe.

