North Carolina Department of Labor
Occupational Safety and Health Division

Raleigh, North Carolina

Field Information System Operational Procedure Notice 132E

Subject: Special Emphasis Program for Long Term Care Facilities.

A. **Purpose and Scope.**

This OPN describes the NCDOL Occupational Safety and Health Division - Special Emphasis Program (SEP) for all inspections of Long Term Care (LTC) Facilities in NAICS 623000 (NAICS 623110 - Nursing Care Facilities; 623210 - Residential Mental Retardation Facilities; 623220 - Residential Mental Health and Substance Abuse Facilities; 623311 - Continuing Care Retirement Communities; 623312 – Homes for the Elderly; and 623990 – Other Residential Care Facilities).

The SEP has a primary focus on the major hazards prevalent in LTC facilities, specifically, ergonomic stressors relating to resident handling; exposure to blood and other potentially infectious materials (OPIM); exposure to tuberculosis; slips, trips, and falls; and workplace violence. However, as detailed in the Field Operations Manual (FOM), when the Compliance Safety and Health Officer (CSHO) becomes aware of additional hazards, the scope of the inspection will be expanded to include those hazards. Note that this SEP addresses only enforcement-related procedures. Voluntary guidelines published by OSHA will not be used as a basis for citations issued under this SEP.

B. **Special Emphasis Program History.**

In August 1996, USDOL OSHA implemented a seven state nursing home initiative to address hazards in the LTC industry. This federal initiative was terminated on February 10, 1998. All enforcement policies for the initiative were replaced by a National Emphasis Program (NEP) on nursing and personal care facilities and were addressed by CPL 2 (02-03). The NEP ended on September 30, 2003 and nursing homes were returned to the Site Specific Targeting (SST) Inspection Plan. Federal OSHA initiated a new NEP for nursing and residential care facilities on April 5, 2012. No significant changes were made from the prior program, except that this NEP also addresses workplace violence.

The NCDOL had similar strategic plan goals from 1999 - 2003 and an SEP focused on LTC facilities. The inspection procedures contained in the federal directive were implemented with state-specific changes. While federal OSHA discontinued their NEP, the NCDOL Occupational Safety and Health Division included the SEP for LTC facilities in the Strategic Management Plan for 2004 – 2008 and will continue it for the 2009 – 2013 Strategic Management Plan.

C. **Background.**

Long Term Care facilities had one of the highest injury and illness rates among industries for which nationwide lost workday injury and illness (LWDII) rates were calculated for calendar year 2000 (CY 2000). According to data from the Bureau of Labor Statistics (BLS), the national average LWDII rate for private industry for CY 2000 was 3.0. LTC

facilities experienced an average LWDII rate of 7.9, despite the availability of feasible controls that had been identified to address hazards within this industry.

CY 2000 data from BLS indicated that overexertion and injuries from slips, trips, and falls accounted for a high percentage of total nonfatal occupational injury and illness cases with days away from work in LTC facilities. Taken together, these accounted for 72% of all cases involving days away from work (53.4% from overexertion and 18.6% from slips, trips, and falls). In addition, LTC workers had the potential for exposure to bloodborne pathogens and tuberculosis.

Between 1998 and 2008, there have been significant reductions in the number of injuries in the LTC industry. However, the industry's rates are still double those of the average employer nationwide. Therefore, LTC remains an SEP in the state's Strategic Management Plan.

D. **Definitions.**

Days Away, Restricted, or Transferred (DART) Rate: This case rate includes injuries and illnesses involving days away from work, restricted work activity, and transfers to another job. It is calculated using the formula (N ÷ EH) x (200,000) where N is the number of cases involving days away and/or restricted work activity, and/or job transfer; EH is the total number of hours worked by all employees during the calendar year; and 200,000 is the base number of hours for 100 full-time equivalent employees.

For example: Workers of an establishment including management, temporary, and leased workers worked 645,089 hours at this worksite. There were 22 injury and illness cases involving days away and/or restricted work activity and/or job transfer from the OSHA-300 Log (total of column H plus column I). The DART rate would be (22 ÷ 645,089) x (200,000) = 6.8.

E. **Program Procedures.**

LTC assignments will be generated through accidents, complaints, referrals, SST and general schedule criteria. The assignments will have priority based upon instructions in the FOM.

F. **Inspection Procedures.**

Inspections initiated under this SEP will be scheduled and conducted in accordance with provisions of the FOM, except as noted below. Unprogrammed inspections will be expanded to cover the elements of a LTC inspection (bloodborne pathogens; tuberculosis; ergonomics; slips, trips and falls; and workplace violence) and any apparent violations observed during the inspection. The scope of programmed LTC inspections will be comprehensive and will always include these elements.

1. Privacy

   a. Resident Privacy and Medical Records:

      i. Respect for resident privacy must be a priority during each inspection. Under no circumstances may a CSHO enter resident rooms or other areas where resident privacy could be compromised without the consent of the resident or their next-of-kin or guardian.

ii. In evaluating resident handling or other hazards, do **not** review any resident records that include personally identifiable health information, including diagnoses, laboratory test results, etc., provided by the employer without the consent of the resident or their next-of-kin.

iii. Evaluations of workplace health and safety issues in this SEP may involve assessment of resident handling. Resident handling activities may take place in resident rooms, restrooms, shower and bathing areas or other areas where the privacy of residents could be compromised. Documenting resident handling activities by videotaping or photography requires the resident's informed, written consent. Family members or guardians may give consent for those residents who are incapable of giving informed consent (see Appendix A).

b. Employee Medical Records:

i. If employee medical records are needed that are not specifically required by an OSHA standard (e.g., the results of medical examinations, laboratory tests, medical opinions, diagnoses, first aid records, reports from physicians or other health care providers), they must be obtained and kept in accordance with FOM Chapters III, XIII, and XVI.

ii. Health and Human Services' Standards for Privacy of Individually Identifiable Health Information 45 CFR 164.512 (b)(1)(v), state that an employer (or its health care provider) can disclose and use confidential employee health information when conducting or evaluating workplace medical surveillance; or to evaluate whether an employee has a work-related illness or injury; or to comply with OSHA requirements under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose.

2. Recordkeeping:

Recordkeeping issues must be handled in accordance with OSHA Instruction CPL 02-00-135, Recordkeeping Policies and Procedures Manual, CPL 02-02-069 (CPL 2-2.69) - Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, or other relevant field guidance. For LTC assignments coming from an SST listing, a partial walkthrough may be conducted to confirm and verify the injury and illness experience. Any serious violations that are observed in the vicinity or brought to the attention of the CSHO must be investigated and may be cited.

3. Ergonomic Risk Factors Relating to Resident Handling:

Ergonomic evaluations, as they relate to risk factors associated with resident handling, shall be conducted in accordance with the FOM instructions in Chapter XVII – Ergonomics Inspection Procedures. Using those guidelines helps to identify case outcomes as early as possible in the inspection process in order to conserve Department resources.

Evaluations will begin with a determination of the extent of resident handling, its hazards, and the manner in which the hazards are addressed. Then the CSHO will assess the establishment incidence and severity rates, determine whether the rates are increasing or decreasing over a three-year period, and evaluate whether the establishment has implemented a process to address these conditions in a manner that can be expected to have a useful effect. When assessing an employer's efforts to address these conditions, the CSHO should evaluate program elements, such as the following:

a. Program Management:

i. Whether there is a system for hazard identification and analysis.
ii. With whom the responsibility and authority for compliance with this system resides.
iii. Whether employees have input in the development of the establishment's lifting procedures.
iv. Whether there is a system for monitoring compliance with the establishment's policies and procedures and following up on deficiencies.
v. If there have been recent changes in policies/procedures and what effect they have had (positive or negative) on injuries and illnesses.

b. Program Implementation:

i. How resident mobility is determined.
ii. What decisions are made for using lift assist devices, and under what circumstances manual lifts occur.
iii. With whom does the decision on how to lift patients reside.
iv. Whether there is an adequate quantity and variety of appropriate lift assist devices available and operational. Note that no single lift assist device is appropriate in all circumstances.
v. Whether there are an adequate number of slings for lift assist devices, double handled gait belts, or other transfer assist devices (such as, but not limited to: slip sheets, pivot transfer devices) available and maintained in a sanitary condition.
vi. Whether the policies and procedures are appropriate to reduce exposure to the lifting hazards at the establishment.

c. Employee Training:

i. Whether employees have been trained in the recognition of hazards associated with resident handling.
ii. Whether there is early reporting of injuries.
iii. Whether management has an effective process for abating those hazards.

d. Occupational Health Management:

i. Whether processes are established to ensure that ergonomic disorders are identified and treated early to prevent the occurrence of more serious problems.

ii. Whether this process includes restricted or accommodated work assignments.

Citation Guidance: After evaluating the facility's incidence and severity rates and the extent of the employer's program, a decision will be made as to the need to continue the ergonomic portion of the inspection. Where there is a need to address these issues, the CSHO will refer to the FOM in Chapter XVII – Ergonomics Inspection Procedures and other OSHA reference documents prior to proceeding with citation or hazard alert letter issuance.

4. Slips, Trips, and Falls:

a. Evaluate the general work environments (i.e., kitchen, hallways, laundry, bathing areas, and egress) and document hazards likely to cause slips, trips, and falls such as but not limited to:

i. Slippery or wet floors; uneven floor surfaces; cluttered or obstructed work areas/ passageways; poorly maintained walkways; broken equipment; or inadequate lighting (especially for night shift).
ii. Unguarded floor openings and holes.
iii. Damaged or inadequate stairs and/or stairways.
iv. Elevated work surfaces that do not have standard guardrails.
v. Inadequate aisles for moving residents.
vi. Improper use of ladders and stepstools.

b. Note any policies, procedures and/or engineering controls used to deal with wet surfaces. These would include but are not limited to ensuring spills are reported and immediately cleaned up, posting signs/barriers alerting employees to wet floors, passageways/aisles kept clear of clutter, and using appropriate footgear. Where appropriate, evaluate the use of no-skid waxes or other types of coated surfaces designed to enhance surface friction.

Citation Guidance: Where hazards are noted, the CSHO should cite the applicable standard (subparts D and J of 29 CFR 1910). If employees are exposed to falling hazards while performing various tasks including maintenance from elevated surfaces, then determine the applicability of 29 CFR 1910.23(c)(1), (c)(3) and 1910.132(a).

5. Bloodborne Pathogens (BBP) Inspection and Citation Guidance.

In order to conduct inspections and prepare citations for occupational exposure to blood and other potentially infectious materials (OPIM), CSHOs should refer to OSHA Instruction CPL 02-02-069 (CPL 2-2.69), Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens. In addition, outreach and educational materials for employers are available at www.nclabor.com and www.osha.gov.

In accordance with CPL 02-02-069, the compliance officer should ensure that the following items are addressed during this portion of the LTC inspection:

a. Evaluate the employer's written Exposure Control Plan (ECP) to determine if it contains all the elements required by the standard.

b. Assess the implementation of appropriate engineering and work practice controls.

    1. Determine which procedures require the use of a sharp medical device (e.g., syringe administration of insulin) and determine whether the employer has evaluated, selected and is using sharps with engineered sharps injury protection (SESIPs) or needleless systems.

    2. Confirm that all tasks involving sharps have been evaluated for the implementation of safer devices. For example, does the employer require safety-engineered needles for pre-filled syringes and single-use blood tube holders?

    3. Determine whether the employer solicited feedback from non-managerial employees responsible for direct resident care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation and selection of effective engineering and work practice controls and whether the employer documented solicitation in the ECP.

c. Ensure that proper work practices and personal protective equipment are in place.

d. Assess whether containment of regulated waste is performed properly.

e. Evaluate and document the availability of handwashing facilities. If immediate access to handwashing facilities is not feasible, ascertain whether skin cleansers are used (e.g., alcohol gels).

f. Assess the use and availability of appropriate personal protective equipment in appropriate sizes.

g. Ensure that a program is in place for the immediate and proper clean-up of spills and disposal of contaminated materials, specifically for spills of blood or other body fluids.

h. Determine that the facility has chosen an appropriate EPA-approved disinfectant to clean contaminated work surfaces and that the product is being used in accordance with the manufacturer's recommendations.

i. Determine that all employees with occupational exposure to blood and OPIM have been offered the hepatitis B virus (HBV) vaccine series within 10 days of initial assignment at no cost. For employees who declined the vaccine series, determine that declinations have been properly documented.

j. Ensure that healthcare workers who have contact with residents or blood and are at ongoing risk for percutaneous injuries have been offered an antibody test for the HBV surface antigen in accordance with U.S. Public Health Service guidelines.

k. Evaluate the ECP for procedures for post-exposure evaluation and follow-up and that the procedures have been implemented.

1. Determine that establishment-specific post-exposure protocols specify where and when to report exposure incidents.

2. Determine whether medical attention is immediately available, including administration of a rapid HIV test, in accordance with U.S. Public Health Service guidelines.

l. Determine whether employees have received training in accordance with the BBP standard.

m. Evaluate the employer's sharps injury log. Ensure that injuries recorded on the sharps injury log have also been recorded on the OSHA 300 log and that they have been recorded as privacy concern cases.

6. Tuberculosis (TB) Inspection and Citation Guidance.

Determine whether the establishment has had a suspected or confirmed TB case within the previous 6 months prior to the date of the opening conference. If not, do not proceed with this section of the inspection. If a case has been documented or suspected, proceed with inspection according to the guidance document, CPL 02-00-106 (CPL 2.106), Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis.

7. Workplace Violence Inspection and Citation Guidance.

Through employee interviews and a review of OSHA 300 logs, CSHOs conducting inspections in long term care facilities should identify any instances that were the result of workplace violence to employees in these facilities. In accordance with the OSH Workplace Violence Memo dated 10/24/2011, OSHA directive CPL 02-01-052 will be used as guidance for determining the applicability of citing the General Duty Clause and any associated OSH standards for failure to establish a workplace violence prevention program.

8. Other Hazards.

When additional hazards come to the attention of the compliance officer, the scope of the inspection may be expanded to include those hazards. Unprotected occupational exposure to MRSA and other multi-drug resistant organisms, exposure to hazardous chemicals, and other hazards should be investigated when the compliance officer is made aware of their existence.

a. Methicillin-resistant *Staphylococcus aureus* (MRSA) and other multi-drug resistant organisms (MDROs).

Nursing and residential care facilities are among the settings at increased risk of potential transmission of MRSA and other MDROs. Recommendations for standard precautions and contact precautions to reduce or eliminate exposure to MRSA and other MDROs are outline in CDC guidelines, including *Guidelines for Isolations Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007.* Appendix C provides an example of language that may be used in an Alleged Violation Description (AVD) for unprotected occupational exposure to MRSA specific to nursing and residential care facilities.

Note: Violations of applicable OSHA standards (e.g., PPE standards) must be documented in accordance with the FOM. In General Duty Clause citations the recognized hazard must be described in terms of the danger to which employees are exposed, e.g., the danger of being infected by MRSA, not the lack of a particular abatement method. Feasible abatement methods that are available and like to correct the hazard must be identified.

b. Hazard Communication.

Employee exposures to hazardous chemicals, such as sanitizers, disinfectants and hazardous drugs, may be encountered in nursing and residential facilities. Employers are required to implement a written program that meets the requirements of the Hazard Communication Standard (HCS) to provide worker training, warning labels and access to (Material) Safety Data Sheets ((M)SDSs).

Note: Refer to OSHA Instruction CPL 02-02-038, Inspection Procedures for the Hazard Communication Standard for inspection and citation guidance.

G. **Outreach.**

The outreach efforts of Education, Training and Technical Assistance (ETTA) and the Consultative Services Bureau (CSB) will be in accordance with the goals set forth in the Occupational Safety and Health Division Strategic Management Plan. Training marketing mailings will be sent when directed by the LTC SEP to all known employers in NAICS 623XXX (formerly SIC 805X) in order to provide outreach materials to all applicable employers.

H. **Recording and Tracking.**

1. For all unprogrammed inspections conducted in conjunction with a LTC Facilities SEP inspection, the OSHA-1 forms must be marked as "unprogrammed" in "Inspection Type" with the appropriate unprogrammed activity identified (accident, complaint, referral, etc).

2. For programmed inspections, the OSHA-1 forms must be marked as "programmed planned" in "Inspection Type" with the appropriate activity identified (SST, Health GS list, Safety GS list, etc).

3. Other Applicable Codes for the OSHA-1.

   a. Mark the "National Emphasis" box with the value "NURSING".
   b. Select 'Strategic Plan Activity' and enter the value "LONG TERM CARE FACILITIES".

c. OSHA-1 Optional Information, Item 42 codes, as follows:

Code	Information
S-16	General Duty Ergonomic Citation Issued
S-17	Ergonomic Hazard Alert Letter Issued
N-02-BLOOD	Bloodborne Pathogen Related Inspection
N-02-TB	TB Related Enforcement Inspection
N-03 -UED	Upper Extremity Disorders
N-03-BACK	Back Disorders
N-03-ERGO-CIT	Nursing NEP Inspection - 5(a)(1) Ergo. Citation Issued
N-03-ERGO-LTR	Nursing NEP Inspection - Ergo Hazard Alert Letter Issued
N-03-OTHER	Other Ergonomic Disorders

d. Optional codes for workplace violence and slips, trips and falls are not necessary and have not been developed.

I. **Program Evaluation.**

BLS data will be reviewed to determine the effectiveness of the program.

J. **Effective Date.**

OPN 132D is canceled. This OPN is effective on the date of signature. It will remain in effect until revised or canceled by the director.

Signed on Original
J. Edgar Geddie
SEP Team Leader

Signed on Original
Allen McNeely
Director

6/21/2012
Date of Signature

Appendix A: Resident Consent and Release

I hereby consent and release to the N.C. Department of Labor, Occupational Safety and Health (OSH) Division, the right to use my picture and sound being videotaped or photographed during an OSH inspection of _____ (name of facility) commenced on _____(date). I understand that this videotape or photograph will be used solely to document employee safety and health conditions at the facility, and may be used as evidence in legal proceedings related to those conditions.

_____ _____
Signature of Resident Date of Signature

In the event that there has been a medical or legal determination that a resident can not give informed consent to be videotaped or photographed, the following shall be used:

On behalf of _____ (name of resident), I hereby grant to the OSH Division, the right stated above.

_____
Printed name of person authorized to give informed consent on resident's behalf

_____ _____
Signature of Authorized Person Date of Signature

_____ _____
Signature of Witness Date of Signature

Appendix B: Resources

Title 29 Code of Federal Regulations Part 1904.

Title 29 Code of Federal Regulations Part 1910.

North Carolina Field Operations Manual.

OSHA Notice 09-05 (CPL 02), Site-Specific Targeting 2009 (SST-09), July 20, 2009 (or most current revision).

OPN 124 – most current revision.

Occupational Injuries and Illnesses; Recording and Reporting Requirements, published in the Federal Register on January 19, 2001 (66 FR 5915) and following years.

OSHA Instruction CPL 02-00-135, Recordkeeping Policies and Procedures Manual (RKM), December 30, 2005 (or most current revision).

OSHA Instruction CPL 02-00-051, Enforcement and Limitations under the Appropriations Act, December 12, 2009.

Bureau of Labor Statistics (BLS), Table 1. Incidence Rates of Nonfatal Occupational Injuries and Illnesses by Industry and Selected Case Types, 2000, and following years.

OSHA Instruction CPL 02-00-106, Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis, February 9, 1996.

OSH Field Information System (FIS) Memorandum WPV 1, October 24, 2011 with attached CPL 02-01-052. Subject: Workplace Violence Inspections.

OSHA Instruction CPL 02-02-038, Inspection Procedures for the Hazard Communication Standard, March 20, 1998.

OSHA Instruction CPL 02-02-069, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens Standard, 29 CFR 1910.1030, includes revisions mandated by the Needlestick Safety and Prevention Act (November 27, 2001).

OSHA Instruction CPL 03-00-016, National Emphasis Program – Nursing and Residential Care Facilities (NAICS 623110, 623210 and 623311), April 5, 2012.

45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy, Subpart E - Privacy of Individually Identifiable Health Information, Section 164.512.

13 NCAC 7A.0900, Access to Employee Medical Records, March 1, 2010.

Publications:

NIOSH, Musculoskeletal Disorders and Workplace Factors, 2nd printing, US DHHS, CDC, NIOSH Pub No. 97-141.

Back Injury Prevention Guide in the Health Care Industry for Health Care Providers, Cal OSHA (11/97).

NIOSH, Elements of Ergonomic Programs: A Primer based on Workplace Evaluations of Musculoskeletal Disorders, DHHS/NIOSH Pub. No. 97-117.

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA publication # 3148.

Web links:

NIOSH Home Page
http://www.cdc.gov/niosh/homepage.html

OSHA Nursing Home E-Tool
http://www.osha.gov/SLTC/etools/nursinghome/index.html

OSHA Safety and Health Topics: Nursing Homes and Personal Care Facilities
http://www.osha.gov/SLTC/nursinghome/index.html

OSHA Safety and Health Topics: Tuberculosis
http://www.osha.gov/SLTC/tuberculosis/index.html

OSHA Safety and Health Topics: Workplace Violence
http://www.osha.gov/SLTC/workplaceviolence/index.html

Ergonomic Web links:

NIOSH Publication No. 2006-117: Safe Lifting and Movement of Nursing Home Residents
http://www.cdc.gov/niosh/docs/2006-117/

Best Practices for Nursing Homes
http://www.orosha.org/pdf/ergo/nursingbp.pdf

A Back Injury Prevention Guide for Health Care Providers
http://www.dir.ca.gov/dosh/dosh_publications/backinj.pdf

Safe Patient Handling in Washington State
http://www.washingtonsafepatienthandling.org/

Beyond Getting Started: A Resource Guide for Implementing a Safe Patient Handling Program in the Acute Care Setting
http://www.aohp.org/About/documents/GSBeyond.pdf

OSHA Safety and Health Topics: Ergonomics
http://www.osha.gov/SLTC/ergonomics/index.html

Guidelines for Nursing Homes, Ergonomics for the Prevention of Musculoskeletal Disorders
http://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html

NIOSH Ergonomics & Musculoskeletal Disorders Page
http://www.cdc.gov/niosh/topics/ergonomics/

VA Resource Guides (the following two links are part of the VA info)
http://www.visn8.med.va.gov/patientsafetycenter/resguide/

Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement (pt 1)

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http://www.visn8.med.va.gov/patientsafetycenter/resguide/ErgoGuidePtOne.pdf

Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement (pt 2)
http://www.visn8.med.va.gov/patientsafetycenter/resguide/ErgoGuidePtTwo.pdf

Appendix C: Sample NCGS 95-129(1) AVD for MRSA Exposure

Refer to the FOM and other OSH reference documents prior to proceeding with citation issuance. The following is provide ONLY as an example of the language that may be used in an Alleged Violation Description AVD) for unprotected occupational exposure to MRSA.

General duty clause, N.C. General Statute 95-129(1) – refer to the CDC guidelines: *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007,* which recommends standard precautions and contact precautions to reduce or eliminate exposure to MRSA. Abatement would include handwashing, cohorting of patients/residents, device and laundry handling.

The General Duty Clause.

North Carolina General Statute 95-129(1) of the Occupational Safety and Health Act of North Carolina: The employer did not furnish each of his employees conditions of employment and a place of employment free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to communicable diseases:

(a) Location – Address:

On or about *Date* employees were exposed to drug-resistant infections while providing care to residents with infections such as, but not limited to, Methicillin-Resistant *Staphylococcus aureus* (MRSA).

Abatement

Feasible means of abatement include, but are not limited to: a) providing training on all routes of transmission of infectons, the proper personal protective equipment to be used, and infection control practices to be utilized; b) notifying employees about the status of any resident with infection prior to beginning care assignments for every shift; c) cohorting patients/residents; and d) using administrative controls, such as limiting access to patients/residents with MRSA infections by non-essential personnel.