



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 9, 2026

Administrator
Glenoaks Senior Living Campus
100 GLEN OAKS DRIVE
NEW LONDON, MN 56273

RE: CCN:245360

Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 10, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 10, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245360		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER GLENOAKS SENIOR LIVING CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE , NEW LONDON, Minnesota, 56273			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/10/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Glenoaks Senior Living Campus was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			07/17/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GLENOAKS SENIOR LIVING CAMPUS is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II (000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II (000) construction. In 1996 and addition was added to the north of the Service Wing that was determined to be of Type II (000) construction. In 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II (000) construction. The building is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 41 at the time of the survey.			K0000			07/17/2026

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K0000 Bldg. 01	Continued from page 2			K0000			07/17/2026
K0353 SS = F Bldg. 01	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 8.5.6.4, 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 06/10/2026 at 10:54 AM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide a 2nd quarter fire sprinkler inspection report. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0353	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does quarterly sprinkler inspections per regulations and maintains documentation. The sprinklers were inspected on the 3rd quarter of 2025 and are currently in compliance All residents and staff have the potential to be affected if the sprinkler system is not inspected quarterly. Maintenance staff were re-educated on the importance of ensuring inspections are conducted per regulations and on maintaining all documentation in a designated binder. Administrator or Designee will audit the documentation binder quarterly to ensure sprinkler inspections are completed per regulations and with the proper documentation present and findings will be brought to the QAA committee for review.		07/17/2026

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K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2026 at 10:57 AM, it was revealed by a review of available documentation that the facility did not conduct a third-shift fire drill in the second quarter of 2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0712	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does perform fire drills every month per regulations and maintains documentation. Fire drills were conducted with documentation for July 2025 and are currently in compliance. All residents and staff have the potential to be affected if fire drills do not occur per regulations. Maintenance staff were re-educated on the importance of ensuring fire drills are conducted per regulations and on maintaining all documentation in a designated binder. Administrator or Designee will audit the fire drill documentation monthly to ensure all fire drills are conducted per regulations with the proper documentation present every month for 6 months and findings will be brought to the QAA committee for review.		07/17/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are			K0761	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does inspect fire doors annually per regulations with documentation. A comprehensive inspection of all fire doors was completed on 6/12/2025 and are in compliance. All residents and staff have the potential to be affected if the fire door inspections do not occur annually per regulations.		07/17/2026

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K0761 SS = F Bldg. 01	Continued from page 4 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2026 at 11:00 AM, it was revealed by a review of available documentation that the fire doors had not been inspected within the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761	Continued from page 4 Maintenance staff were re-educated on the importance of ensuring fire door inspections are conducted per regulations and documented. The annual fire door inspection has been added to the facility's preventive maintenance program on TELS. Administrator or Designee will audit the fire door inspection completion annually to ensure all fire doors are inspected per regulations with the proper documentation present annually and findings will be brought to the QAA committee for review.		07/17/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail			K0222	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does ensure required signage is posted on delayed-egress exit doors in accordance with regulations. Egress door 32 along with a comprehensive audit of the delayed-egress exit doors was completed on 6/12/2026 and are in compliance. Delayed-egress exit door 32 along with any other doors identified during the audit were immediately equipped with the required signage. All residents and staff have the potential to be affected if the delayed-egress exit doors are not equipped with the required signage per regulations. Maintenance staff were re-educated on the importance of ensuring delayed-egress exit doors required signage remains in place and is legible.		07/17/2026

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K0222 SS = E Bldg. 01	Continued from page 5 safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.2.1.6.1.1(4). This deficient finding could have a patterned impact on the residents within the facility. Findings Include: On 06/10/2026 at 11:07 AM, it was revealed by observation and staff interview, that the delayed egress door labeled 32 did not have a readily visible			K0222	Continued from page 5 The Maintenance Director or designee will conduct audits every 3 months of all delayed-egress exit doors for a period of 12 months to verify required signage remains in place, legible, and compliant with regulations and results will be brought forward to the QAA committee for review.		07/17/2026

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K0222 SS = E Bldg. 01	Continued from page 6 sign that read "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS."An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0222			07/17/2026
K0347 SS = E Bldg. 01	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install and inspect corridor smoke detectors per NFPA 101 (2012 edition), Life Safety Code Section 9.6.1.3 or NFPA 99 (2012 edition), Health Care Facilities Code, section 15.7.1.2, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code Section 17.7.4.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/10/2026 at 11:09 AM, it was revealed by observation that the Laundry Room smoke detector was installed next to an air duct where air flow would prevent correct operation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0347	The plan and/or execution of this plan does not constitute admission or agreement by this provider of the truth of the deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. GlenOaks Senior Living Campus does smoke detector audits to ensure they are not located too close to an HVAC supply vent, creating the potential for airflow to interfere with proper smoke detection. The facility's Maintenance Director and Fire Marshal completed a facility wide review of all smoke detector locations during the survey to verify compliance with all smoke detectors. All residents and staff have the potential to be affected if smoke detectors are located too close to an HVAC supply vent. The HVAC vent was relocated to a compliant location on 6/16/2026. The Maintenance Director and designated maintenance staff were educated regarding requirements related to smoke detector placement and the potential impact of HVAC airflow on detector performance. Review of detector locations whenever HVAC modifications, renovations, or construction projects occur. The Maintenance Director or designee will conduct audits of detector locations whenever HVAC modifications, renovations, or construction projects occur, and findings will be brought to the QAA committee for review.		07/17/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 13, 2026

Administrator
GLENOAKS SENIOR LIVING CAMPUS
100 GLEN OAKS DRIVE
NEW LONDON, MN 56273

RE: CCN: 245360
Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245360		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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E0000	Initial Comments On 6/8/26 to 6/10/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			
F0000	INITIAL COMMENTS On 6/8/26 through 6/10/26, a standard recertification survey (S5360044-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53602739C (2594823). NO deficiencies were cited. H53602740C (2586366). NO deficiencies were cited. H53602741C (2573027). NO deficiencies were cited. H53602742C (2565678). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations			F0000			

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 reverse for further 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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F0000	Continued from page 1 has been attained.			F0000			
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the			F0880			

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F0880 SS = F	Continued from page 2 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to maintain an effective infection prevention and control surveillance program to identify, track, and analyze potential infections, including signs and symptoms of infections that did not result in antibiotic treatment, which had the potential to affect all 40 residents who resided in the facility. In addition, the facility failed to ensure appropriate personal protective equipment (PPE) was properly utilized during care for 1 of 1 resident (R2) reviewed for enhanced barrier precautions (EBP). Findings include: The facility's infection surveillance tracking logs from 3/1/26 through 5/31/26, identified the facility had tracked infections when a resident received antibiotic treatment. However, the surveillance logs failed to include monitoring and tracking of resident signs and symptoms of potential infections, including infections or communicable illnesses that had not resulted in antibiotic use. The facility's infection surveillance system failed to ensure all suspected infections were identified, monitored, analyzed, and trended to assist with prevention,			F0880			

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F0880 SS = F	Continued from page 3 investigation, and control of infections within the facility. During an interview on 6/10/26 at 1:01 p.m., Infection Preventionist (IP)-A confirmed the facility had only tracked infections related to antibiotic use. IP-A stated the facility treated resident signs and symptoms of potential infections as they occurred, and symptoms were not documented on the infection surveillance tracking logs unless antibiotic treatment was initiated. IP-A stated concerns such as diarrhea were discussed during morning meetings, including whether other residents had similar symptoms, but the facility did not have a tracking process in place for those symptoms. During an interview on 6/10/26 at 1:37 p.m., Director of Nursing (DON)-A stated the expectation was the facility's infection prevention and control program included monitoring and tracking of all suspected and confirmed infections to identify trends and implement interventions to prevent the spread of infections. R2's quarterly Minimum Data Set (MDS), dated 5/28/26, indicated R2 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), and diagnoses included gastrostomy status (artificial opening created directly into the stomach, typically for a feeding tube), acid reflux, quadriplegia, epilepsy and anemia. R2's care plan, revised 4/9/24, indicated R2 required EPB related to presence of an indwelling medical device, and staff would adhere to the use of EBP during completion of high-contact activities. During observation on 06/09/2026 at 5:20 p.m., a sign posted on R2's room door notified of EBP and directed staff to wear gown and gloves for feeding tube and wound care. During observation on 6/9/26 at 5:25 p.m., LPN-A entered R2's room, obtained water from the bathroom, and applied gloves. LPN-A left the room twice to obtain supplies, applied gloves, and administered R2's medications through the feeding tube. LPN-A then completed hand hygiene, applied new gloves, and completed wound care at feeding tube site. However, LPN-A failed to were a gown while feeding tube activities and wound care was completed. During interview on 6/9/26 at 5:43 p.m., LPN-A stated R2 was on EBP and gown and gloves should			F0880			

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F0880 SS = F	Continued from page 4 have been worn before the medications were administered and wound care was provided to reduce the spread of infection. LPN-A stated she was aware R2 was on EBP and EBP signs were on the door. During interview on 6/10/26 at 1:10 p.m., infection preventionist (IP) stated when a resident was placed on EBP, signs were placed on the door, bins with personal protective equipment (PPE) were placed by the door, and the information was indicated on the resident's care plan. IP stated staff were expected to wear gown and gloves with any high-contact care including dressing, bathing, grooming, feeding tube medication administration and feeding tube cares, to protect the staff and other residents from the spread of infection around the facility. IP stated agency staff received education before their first shift on facility EBP expectations. During interview on 6/10/26 at 2:27 p.m., director of nursing (DON) stated if there was EBP signage and bins outside of the room and the staff were going to touch the resident, staff were expected wear a gown and gloves. DON stated EBP compliance was important to reduce the chance of spreading infection and not putting residents and staff at risk. The facility's Infection Surveillance policy, dated 1/1/26, identified infection surveillance was an ongoing systematic collection, analysis, interpretation, and sharing of infection-related data. The policy identified the purpose of surveillance was to identify infections, monitor infection prevention practices, reduce infections, and prevent the spread of infections. The policy identified nursing staff participated in surveillance by assessing residents and reporting changes in condition, including when residents developed signs and symptoms of infection. The policy further identified the facility would collect data related to possible infections, including infection site, signs and symptoms, trends, patterns, and documentation of resident and staff reported signs and symptoms. The policy indicated all resident infections were to be tracked. The facility's Infection Prevention and Control Program policy, dated 1/1/26, identified the facility maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections. The policy identified a surveillance system was utilized for prevention, identification, reporting, investigation, and control of infections and communicable diseases. The policy			F0880			

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F0880 SS = F	Continued from page 5 further identified the IP was responsible for surveillance activities, maintaining documentation of findings and corrective actions, and reporting surveillance findings to the Quality Assessment and Assurance Committee. The policy identified licensed nurses participated in surveillance through assessment of residents and reporting changes in condition. The facility's Enhanced Barrier Precautions policy, dated 2025, indicated PPE for EBP is only necessary when performing high-contact care activities which included wound care and device care or use of feeding tubes.		F0880				
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints		F0605				

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F0605 SS = D	Continued from page 6 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral			F0605			

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F0605 SS = D	Continued from page 7 interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure psychotropic medications were managed appropriately, including failure to complete monitoring for potential adverse effects related to antipsychotic medication use, and failure to ensure a PRN (as needed) psychotropic medication order included a required stop date/duration, for 2 of 5 residents (R6 and R26) reviewed for unnecessary medications. Findings include: R6's annual Minimum Data Set (MDS), dated 5/13/26, identified R6 had moderate cognitive impairment, received antipsychotic medication, and diagnoses included anxiety disorder, bipolar disorder (a mental health condition that caused changes in mood, energy, and activity levels), schizophrenia (a mental health condition that affected a person's thoughts, emotions, and behaviors), and obsessive-compulsive disorder. R6's physician orders, dated 6/10/26, identified an order for risperidone (an antipsychotic) 2 milligrams (mg) by mouth two times a day for schizotypal disorder related to schizophrenia, initiated 3/3/26. R6's physician orders further identified an order for			F0605			

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F0605 SS = D	Continued from page 8 monthly orthostatic blood pressure (to monitor for drop in blood pressure with position changes) while receiving antipsychotic medications, initiated 3/25/26. R6's electronic health record (EHR) from January 2026 through June 2026 identified orthostatic blood pressure monitoring was completed for April 2026. However, the EHR lacked documentation staff completed required monthly orthostatic blood pressure assessments for January, February, March, May and June 2026. R26's significant change MDS, dated 4/29/26, identified R26 had moderate cognitive impairment, and diagnoses included bipolar II disorder (a mental health condition that caused changes in mood and episodes of depression and elevated mood), anxiety disorder, and hallucinations (seeing or hearing things that were not present). R26's physician orders, dated 6/10/26, identified an order for lorazepam (an anti-anxiety psychotropic medication) 0.5 mg by mouth every four hours PRN for anxiety, initiated 5/14/26. However, R26's PRN lorazepam order did not include a stop date, specific duration, or documented prescriber rationale for extending the PRN psychotropic medication beyond 14 days, as required. During an interview on 6/10/26 at 10:05 a.m., registered nurse (RN)-C reviewed R26's order in the EHR and confirmed the lorazepam order did have an ordered end date. During an interview on 6/10/26 at 11:27 a.m., assistant director of nursing (ADON) stated staff attempted other coping mechanisms prior to administering a PRN medication. However, when interventions were ineffective, staff administered the PRN medication. ADON confirmed R26's PRN lorazepam order was initiated on 5/14/26 and did not have a specified stop date. ADON stated PRN psychotropic medications required a 14-day stop date unless the provider documented rationale for continued use beyond 14 days. ADON stated the PRN lorazepam order should have included an end date. During an interview on 6/10/26 at 12:21 p.m., ADON reviewed R6's clinical record and confirmed the orthostatic blood pressure monitoring was only completed in April 2026 and the remaining five monthly assessments from January 2026 through June 2026 were missing. ADON stated the orthostatic blood pressure monitoring was related to			F0605			

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F0605 SS = D	Continued from page 9 the resident's psychotropic medication use and was used to monitor for adverse effects. During an interview on 6/10/26 at 12:40 p.m., director of nursing (DON) stated PRN psychotropic medications required a 14-day end date and, if the medication continued to be needed, the provider should have been contacted for a new order or rationale for continued use. DON stated this was important to ensure the medication continued to be necessary and to discontinue medications residents no longer needed. Additionally, DON stated orthostatic blood pressure monitoring was placed on the medication administration record (MAR) and the shift nurse was responsible for completing the monitoring. DON stated if the monitoring was not completed, it should have been communicated during report. DON stated orthostatic blood pressure monitoring was important because changes in blood pressure could cause the resident to become more unstable on their feet, which increased the risk for falls and other concerns. The facility's Use of Psychotropic Medication(s) policy, dated 2026, indicated psychotropic medications included antipsychotic and anti-anxiety medications. Residents receiving psychotropic medications were to be monitored for effectiveness and adverse effects, and the resident's response to the medication was to be documented in the medical record. Additionally, PRN psychotropic medications, excluding antipsychotics, were limited to 14 days unless the provider documented a rationale for continued use beyond 14 days and included a specific duration.			F0605			
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.			F0628			

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F0628 SS = D	Continued from page 10 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;			F0628			

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F0628 SS = D	Continued from page 11 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.			F0628			

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F0628 SS = D	Continued from page 12 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is			F0628			

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F0628 SS = D	Continued from page 13 not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide written information regarding bed hold and return rights when a resident was transferred to the hospital for 1 of 1 resident (R6) reviewed for hospitalization. Findings include: R6's annual Minimum Data Set (MDS), dated 5/13/26, identified R6 had moderate cognitive impairment and diagnoses included mild cognitive impairment, schizophrenia (a chronic mental health disorder affecting thoughts, perceptions, and behavior), bipolar disorder (a mood disorder characterized by episodes of depression and mania), and seizure disorder/epilepsy. R6's progress note, dated 12/5/25 at 5:55 a.m., indicated R6 was transferred to the hospital on 12/5/25 after being found on the floor experiencing active seizure activity with convulsions and unresponsiveness. However, R6's EHR lacked evidence the facility provided R6 and/or R6's resident representative with a written bed hold notice at the time of transfer to the hospital. During an interview on 6/09/26 at 2:50 p.m., Social Service Designee (SSD) stated nursing staff completed bed hold paperwork when residents were transferred to the hospital. During an interview on 6/10/26 at 10:05 a.m., registered nurse (RN)-C stated when a resident was sent to the hospital, the nurse obtained a verbal bed hold from the resident if they were able to provide one. If the resident was unable, the nurse contacted the resident's representative by telephone and			F0628			

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F0628 SS = D	Continued from page 14 obtained the information. RN-C stated the bed hold information was documented in the progress notes. During an interview on 6/10/26 at 11:27 a.m., Assistant Director of Nursing (ADON) stated the nurse on duty was responsible for asking about the bed hold. ADON stated a paper form was completed and, if needed, uploaded into the resident's electronic record. During an interview on 6/10/26 at 12:21 p.m., ADON confirmed R6's clinical record lacked bed hold documentation for R6's 12/5/25 hospitalization. During an interview on 6/10/26 at 12:40 p.m., Director of Nursing (DON) stated when a resident was transferred to the emergency room, nurses were expected to complete paperwork regarding the bed hold. DON stated if the resident was unable to complete the information, the resident representative should have been contacted to obtain verbal confirmation. DON stated the form included the date the resident was transferred and the hospital location. DON further stated completion of the bed hold process was important for billing, insurance, held the resident's placement, and ensured the correct disposition was documented. The facility's Bed Hold Notice policy, dated/revised 2025, identified the facility would provide written information to the resident and/or resident representative regarding bed hold practices both in advance and at the time of transfer for hospitalization or therapeutic leave. The policy identified the written information would include the duration of the state bed hold policy, reserve bed payment information, facility bed hold policies, and conditions related to the resident's return to the facility. The policy further identified that during an emergency transfer, the facility would provide written notice of bed hold policies to the resident and/or resident representative within 24 hours and would maintain a signed and dated copy of the bed hold notice in the resident's file and/or medical record.			F0628			
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a			F0656			

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F0656 SS = D	Continued from page 15 resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included individualized interventions for the use of a seat belt while seated in a wheelchair for 1 of 1 resident (R4) reviewed for comprehensive care plans. Findings include:			F0656			

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F0656 SS = D	Continued from page 16 R4's quarterly Minimum Data Set (MDS) dated 3/31/25, identified R4 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R4's diagnoses included dementia, paraplegia (loss of movement and function in the lower body), and dysarthria and anarthria (difficulty or inability to speak clearly due to problems with muscle control). The MDS further identified R4 received antipsychotic and antidepressant medications, used a trunk restraint daily, and had no impairment of the upper extremities. During an observation on 6/8/26 at 1:15 p.m., R4 was observed seated in his wheelchair with a seat belt (trunk restraint) secured over R4's lap. R4's comprehensive care plan, dated 4/9/26, failed to identify the use of a wheelchair seat belt and individualized interventions related to the seat belt use, including the purpose of the device, level of required staff assistance, monitoring, safety considerations, and resident-specific needs related to the interventions. During an interview on 6/10/26 at 9:27 a.m., nursing assistant (NA)-A stated R4's seat belt was not indicated on the NA care sheet that direct R4's cares. NA-A stated staff attempted to apply R4's seat belt in the morning and R4 frequently refused use of the seat belt. NA-A further stated the seat belt should have been included on R4's care plan. During an interview on 6/10/26 at 9:54 a.m., NA-B stated R4 utilized a seat belt when seated in his wheelchair. NA-B stated staff attempted to apply the seat belt, and R4 frequently refused and yelled at staff. During an interview on 6/10/26 at 12:21 p.m., assistant director of nursing (ADON)-A stated the seat belt was assessed with a change in condition. ADON-A confirmed the seat belt was not identified in R4's care plan. ADON-A stated the seat belt should have been included on R4's care plan. During an interview on 6/10/26 at 12:40 p.m., director of nursing (DON)-A stated the seat belt should have been included in R4's care plan because the care plan directed staff on how to provide care for the resident. The facility's Comprehensive Care Plans policy, dated/revised 2025, identified the facility developed and implemented a comprehensive person-centered care plan for each resident that included measurable			F0656			

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F0656 SS = D	Continued from page 17 objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs. The policy indicated the comprehensive care plan included all services identified in the resident's comprehensive assessment and services met professional standards of quality, and the care plan included resident-specific interventions that reflected the resident's needs and preferences.			F0656			
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident care plans were revised for 1 of 1 resident (R28) reviewed for elopement. Findings include: R28's Admission Record, dated 6/10/26, indicated diagnoses of Alzheimer's			F0657			

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F0657 SS = D	Continued from page 18 disease, major depression, anxiety disorder, hallucinations and muscle weakness. R28's quarterly Minimum Data Set (MDS), dated 4/10/26, indicated R28 was severely cognitively impaired, received substantial/maximal assistance assist with eating, and was dependent with all other activities of daily living (ADLs). R28 resided on the secured memory care unit and a keypad code was required to enter and exit the secured unit. During multiple observations on 6/8/26 through 6/10/26, when R28 was not in her room recliner watching TV or sleeping, R28 was propelled by staff to and from her room to dining room and to activities off the secured memory unit in the main dayroom of the facility. R28's last Elopement Risk Assessment, dated 11/10/25, R28 scored a "3", indicating a low risk for elopement. The assessment indicated "a score of 5 or more is considered to be at risk for elopement". R28's care plan, revised 8/23/23, indicated R28 was at high risk for elopement with a score of "10" and wandered with "no rational purpose and attempting to open doors". However, R28 was observed dependent with all transfers, mobility, cares, meals and activities. During an interview on 6/09/26 at 2:15 p.m., trained medication assistant (TMA)-A stated R28 was totally dependent on staff for all her cares but does feed self when food cut into finger foods. TMA-A stated she had not seen resident attempting to exit the unit, nor would be able to reach the keypads from her wheelchair. During an interview on 6/10/26 at 11:24 a.m., registered nurse (RN-A) and social service designee (SSD) stated resident was no longer "actively exit seeking". SSD stated she had observed resident "fiddling with doorknob going out to the enclosed courtyard but had not been able to open it. RN-A stated it had been a "long time" since R28 had been an elopement risk. During an interview on 6/10/26 at 11:33 a.m., the director of nursing (DON) stated the facility's expectation for care plan revision would be any changes noted during an assessment (quarterly/annual/significant change) or in review at a resident's care conference. The corporate nurse agreed R28 was no longer an elopement risk. The facility's Comprehensive Care Plan policy, dated 2025, indicated the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.			F0657			

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F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure a restorative device was implemented and monitored to maintain a resident's highest practicable level of function when staff failed to ensure a right hand splint used for contracture management had a current order, and failed to document application attempts or refusals of the splint for 1 of 3 residents (R4) reviewed for range of motion. Findings include: R4's quarterly Minimum Data Set (MDS), dated 3/31/26, identified R4 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R4's diagnoses included arthritis, paraplegia (loss of movement and/or sensation in the lower part of the body), and dysarthria and anarthria (conditions that affected a person's ability to speak clearly). On 6/8/26 at 11:28 a.m., R4 was observed with his right hand completely contracted with his thumb positioned inside his curled hand. R4 stated he thought he had a splint or something to put in his hand but was unsure. R4's care plan, dated 4/9/26, identified R4 had a self-care deficit related to requiring assistance with			F0688			

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F0688 SS = D	Continued from page 20 ADLs and impaired mobility. The care plan directed staff to apply R4's right hand splint as ordered and as R4 allowed, use a rolled washcloth if the splint was unavailable, check skin integrity with application and removal, and notify the primary care provider (PCP) of any abnormalities. Nursing assistant care sheet, undated, identified R4 required a hand splint to the right hand. R4's electronic health record (EHR) identified a splint order had been discontinued in February 2026. However, R4's EHR lacked a current physician order for the right hand splint. Additionally, the EHR lacked instructions identifying when the splint was to be applied, the length of time the splint was to be worn, removal instructions, and monitoring requirements. The EHR further lacked documentation to determine if staff attempted to apply the splint, used the care-planned alternative intervention of a rolled washcloth, monitored skin integrity, or if R4 refused the intervention. During an interview on 6/10/26 at 9:27 a.m., nursing assistant (NA)-A confirmed R4's right hand splint was listed on the nursing assistant care sheet. NA-A stated staff attempted to apply the splint in the mornings and R4 would frequently refuse. During an interview on 6/10/26 at 9:54 a.m., NA-B stated staff attempted to apply R4's splint, and R4 would frequently yell at staff and refuse application. During an interview on 6/10/26 at 11:27 a.m., the assistant director of nursing (ADON) stated R4 had a splint in his room and frequently refused the splint when staff attempted application. The ADON reviewed R4's medical record and confirmed there was no current order for the splint and no documentation to show staff attempted to apply the splint or that R4 refused the splint. The ADON stated the splint order had been discontinued in error in February 2026 and should have remained active. During an interview on 6/10/26 at 12:40 p.m., the Director of Nursing (DON) stated when a resident was evaluated by therapy and a splint was recommended, the recommendation should have been processed as an order. The DON stated the splint order should have been placed on the medication administration record (MAR) for staff to document application of the splint or resident refusal. The DON further stated residents were screened quarterly and with a change in condition to determine continued need for the splint and to identify any decline in function.			F0688			

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F0688 SS = D	Continued from page 21 The facility's Use of Assistive Devices policy, undated, indicated assistive devices were provided to residents requiring equipment to maintain or improve function and quality of life. The policy indicated assistive devices would be based on the resident's assessment and plan of care. The policy further indicated staff would monitor for consistent use of the device, and refusals or problems with the device would be documented in the medical record. The facility's Prevention of Decline in Range of Motion policy, undated, indicated the facility would provide interventions and/or therapy to maintain or improve range of motion, including appropriate equipment such as braces or splints. The policy indicated care plan interventions would include the type of treatment, frequency and duration of treatments, and resident goals. The policy further indicated the nurse responsible for the resident would monitor for consistent implementation of interventions, and refusals or problems associated with range of motion interventions would be documented in the medical record.			F0688			
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to ensure dialysis-related care needs were coordinated and implemented, including failure to clarify and implement fluid restriction interventions, for a resident at risk for fluid overload for 1 of 1 resident (R11) reviewed for dialysis services. Findings included: R11's quarterly Minimum Data Set (MDS), dated 4/23/26, identified R11 had intact cognition, required assistance with activities of daily living (ADLs), and received dialysis services. R11's diagnoses included hypertension (high blood pressure), peripheral vascular disease (PVD; a condition causing decreased blood flow through the blood vessels),			F0698			

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F0698 SS = D	Continued from page 22 renal insufficiency (reduced kidney function), diabetes mellitus, schizophrenia (a mental health disorder affecting thoughts, emotions, and behaviors), and polyneuropathy (damage to multiple nerves causing weakness, numbness, or pain). R11's care plan, initiated 1/29/26, identified R11 had a diagnosis of end stage renal disease (permanent kidney failure requiring dialysis or transplant), received dialysis, and was at risk for fluid overload, and interventions directed staff to monitor for signs and symptoms of hypovolemia (low fluid volume) and hypervolemia (excess fluid volume). The care plan further directed staff to monitor, document, and report edema, unexplained weight gain, neck vein distention, difficulty breathing, increased heart rate, elevated blood pressure, changes in level of consciousness, and abnormal breath sounds. Additional interventions included obtaining lab reports, completing before and after dialysis assessments per dialysis protocol, and obtaining weights per facility protocol. However, the care plan failed to identify the amount of fluid R11 was allowed to receive daily and to direct staff to monitor fluid intake. R11's electronic health record (EHR) identified R11 received dialysis services. However, the EHR failed to identify a physician order or dialysis recommendation specifying the amount of fluid R11 was allowed to receive daily. Additionally, the EHR failed to identify documentation the facility communicated with the dialysis provider to clarify R11's fluid restriction recommendations, obtain necessary orders, and implement interventions to guide staff in monitoring fluid intake. On 6/9/26 at 11:50 a.m., R11 entered the dining room in his wheelchair. R11 was provided a cup of coffee and a glass of ice water. R11 then requested a large pitcher of water from the dining aide. On 6/9/26 at 12:09 p.m., R11 was observed in his room with three water pitchers on his bedside table, along with a bottle of water and a plastic cup that was half full of water. On 6/10/26 at 9:08 a.m., R11 was observed with one water pitcher, two plastic cups, and a bottle of water on his bedside table. R11 stated he was supposed to limit his water intake but did not know how much fluid he was allowed. During an interview on 6/9/26 at 5:45 p.m., nursing assistant (NA)-C stated R11 was on a renal diet but did not have any restrictions regarding fluids. NA-C			F0698			

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F0698 SS = D	Continued from page 23 reviewed R11's care sheet and stated it did not identify a fluid restriction. During an interview on 6/10/26 at 8:10 a.m., Fresenius Kidney Care registered nurse (RN)-D stated R11 should have been on fluid restrictions, as most residents receiving dialysis required fluid restrictions. RN-D stated R11's fluid restriction was 1800 milliliters (mL) daily. During an interview on 6/10/26 at 9:27 a.m., NA-A stated R11 was not on a fluid restriction. NA-A reviewed R11's care sheet and stated it identified a dialysis diet but did not include a fluid restriction. NA-A stated if a resident had a fluid restriction, it would have been listed on the care sheet and provided an example of another resident whose fluid restriction was listed. During an interview on 6/10/26 at 9:54 a.m., NA-B stated fluid restrictions were listed on the care sheet. NA-B reviewed R11's care sheet and stated R11 was not identified as having a fluid restriction. During an interview on 6/10/26 at 9:57 a.m., trained medication aide (TMA)-B stated fluid restrictions were listed on the resident medication administration record (MAR) orders. TMA-B reviewed R11's MAR and stated it did not indicate R11 was on a fluid restriction. During an interview on 6/10/26 at 11:27 a.m., assistant director of nursing (ADON) stated dialysis residents were monitored using a dialysis communication sheet completed prior to appointments. The ADON stated R11 was on a fluid restriction. After reviewing R11's record, the ADON stated fluid restrictions were usually listed under the diet order but stated, "I am not seeing it typed in for him. I don't see an active fluid restriction in place for him." The ADON stated fluid restrictions were important because excess fluids could be disruptive to the dialysis process and impact the resident's blood and medications. During an interview on 6/10/26 at 12:37 p.m., the director of nursing (DON) stated not all dialysis residents were on fluid restrictions and restrictions depended on provider orders. The DON stated staff were expected to educate residents regarding risks and benefits, update dialysis and the physician as needed, and communicate with dialysis regarding fluid restriction orders. The DON stated communication and formal conversations regarding dialysis-related needs should have been documented.			F0698			

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F0698 SS = D	Continued from page 24 The facility's Fluid Restriction policy, undated, identified fluid restrictions would be followed according to physician orders. The policy identified fluid restrictions may be needed for residents with medical conditions including end stage renal disease (ESRD). The policy directed nurses to obtain and verify physician orders for fluid restrictions, including the amount of fluid allowed in a 24-hour period. The policy further directed staff to communicate fluid restrictions to appropriate departments, document the restriction according to facility protocol, and ensure bedside water was included in the resident's daily fluid allowance.			F0698			
F0825 SS = D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure specialized rehabilitative services were provided as ordered when the facility failed to ensure a physician's order for occupational therapy (OT) evaluation and treatment was completed timely for 1 of 1 resident (R4) reviewed for specialized rehabilitative services. Findings include: R4's quarterly Minimum Data Set (MDS), dated			F0825			

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F0825 SS = D	Continued from page 25 3/31/25, identified R4 had moderate cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included arthritis, paraplegia (loss of movement and/or sensation in the lower part of the body), dorsalgia (back pain), aphasia (difficulty understanding or expressing speech), and dysarthria and anarthria (difficulty speaking due to impaired muscle control). The MDS further identified R4 had impairment on both sides of the lower extremities, and a trunk restraint was used daily. R4's progress note, dated 5/29/26 at 3:00 p.m., identified R4 was seen during provider rounds, and the provider was informed of R4's concerns related to decreased range of motion (ROM) in the right hand. The provider wrote an order for occupational therapy (OT) to evaluate and treat R4's right hand contracture (shortening or tightening of muscles, tendons, or other tissue that limits movement) and decreased ROM as indicated. The progress note identified therapy was informed and the order was entered into the electronic health record (EHR). R4's EHR identified the OT order was entered on 5/29/26. However, the EHR lacked evidence an OT evaluation was completed, services were initiated, or R4's right hand contracture and decreased ROM were assessed and addressed per the provider order. During an interview on 6/10/26 at 11:58 a.m., director of therapy (DTR) stated therapy completed quarterly screens for residents. DTR stated R4 was last seen by OT for positioning needs, which ended on 4/29/25, and R4 received a custom wheelchair. DTR stated R4 received physical therapy (PT) services beginning on 11/5/25 and was later discharged. DTR stated R4's most recent quarterly screen was completed on 5/26/26, and therapy did not identify significant changes at that time. DTR stated he was not aware of any new therapy orders after the last quarterly screen. DTR stated if therapy identified a change in condition, therapy would request orders for PT/OT services. DTR stated R4's quarterly screen, dated 5/26/26, had been considered R4's baseline. During an interview on 6/10/26 at 1:30 p.m., DTR stated he had not received the 5/29/26 OT order. DTR reviewed emails dated 5/29/26 and identified three unopened emails. DTR opened the emails and the OT order summary dated 5/29/26 was contained in one of the three previously unopened emails. During an interview on 6/10/26 at 11:27 a.m.,			F0825			

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F0825 SS = D	Continued from page 26 assistant director of nursing (ADON) stated R4's right hand contracture had remained the same, R4's grip was tighter than normal, and the provider wrote orders for OT and PT assessments. ADON stated when a provider wrote an order, the nurse on duty was responsible for entering the order and placing it in a designated location at the nurses' station for a second check. ADON stated staff were expected to document a progress note to update the interdisciplinary team and discuss new orders during morning meetings. ADON provided facility morning meeting minutes dated 6/1/26 which identified therapy staff were present and aware of R4's new OT/PT orders. During an interview on 6/10/26 at 12:40 p.m., director of nursing (DON) stated orders were processed by the nurse on duty and scanned. DON stated some orders, including orders processed by agency nurses, were provided to nursing leadership for follow up. DON stated therapy orders were either scanned directly to therapy staff or provided as a hard copy. The facility's Consulting Physician/Practitioner Orders policy, undated, identified physician/practitioner orders were to be followed according to facility procedures. The policy directed nursing staff to process orders timely, including documenting the order, entering the order, and following facility procedures to ensure the order was carried out. The facility's Therapy Screen policy, undated, identified the Rehabilitation Department would perform therapy screens to identify needed services for residents. The policy directed therapists to complete screens for clinical referrals timely as determined by the facility and document the screen in the resident's medical record.			F0825			
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.			F0881			

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F0881 SS = D	Continued from page 27 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement an effective antibiotic stewardship program when the facility failed to complete antibiotic time-outs to evaluate the effectiveness and continued need for antibiotic therapy for 2 of 2 residents (R5 and R23) reviewed for antibiotic use. Findings include: R5's quarterly Minimum Data Set (MDS),dated 5/13/26, identified R5 had severe cognitive impairment and diagnoses included Alzheimer's disease. R5's physician orders, 5/14/26, identified an order for Macrobid (an antibiotic) Oral Capsule 100 milligrams (mg) by mouth two times a day for urinary tract infection (UTI) suspicion related to increased agitation for five days. The order was initiated on 5/15/26, and discontinued on 5/20/26. R5's electronic health record (EHR) lacked evidence the facility had completed an antibiotic time-out (reviewed R5's response to the antibiotic, monitored for improvement or worsening symptoms, reviewed available laboratory results, evaluated if the antibiotic remained appropriate, or determined if any changes to the treatment plan were needed). R23's comprehensive MDS, dated 4/6/26, identified R23 had severe cognitive impairment and diagnoses included renal (kidney) failure and diabetes mellitus. R23's physician orders, dated 5/29/26, identified the following antibiotic orders: Bactrim 400-80 mg by mouth twice daily, initiated on 3/28/26 and discontinued on 4/9/26. Amoxicillin 875 mg by mouth twice daily, initiated on 3/31/26 and discontinued on 4/5/26. Ciprofloxacin HCl 250 mg by mouth twice daily, initiated on 4/4/26 and discontinued on 4/13/26. Cephalexin 500 mg by mouth three times daily, initiated on 4/19/26 and discontinued on 4/27/26. Cipro 500 mg by mouth twice daily, initiated on 6/8/26 and discontinued on 6/13/26. R23's EHR lacked evidence the facility had completed antibiotic time-outs for the five separate			F0881			

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F0881 SS = D	Continued from page 28 antibiotic courses prescribed between 3/28/26 and 6/13/26, to ensure the antibiotics remained appropriate and effective. During an interview on 6/10/26 at 1:01 p.m., Infection Preventionist (IP) stated the facility utilized Loeb or McGeer criteria to determine if residents met criteria for antibiotic treatment. IP-A stated if a resident met criteria, information was sent to the provider for review. IP-A stated when a resident was started on an antibiotic, a 72-hour antibiotic time-out was expected to be completed and documented in the EHR. IP-A stated the antibiotic time-out included reviewing the resident's symptoms, response to treatment, and determining if the antibiotic remained appropriate. IP-A antibiotic time-outs had not been consistently completed as expected. IP-A stated she reviewed residents receiving antibiotics, entered their symptoms into the EHR, and faxed providers to request laboratory orders when indicated. IP-A stated antibiotic time-outs were important to ensure residents receive the correct antibiotic and to determine if a different antibiotic was more appropriate. IP-A reviewed R5 and R23's medical records and confirmed antibiotic time-outs were not completed. During an interview on 6/10/26 at 1:37 p.m., Director of Nursing (DON) stated the expectation was for resident signs and symptoms to be monitored and trended to identify concerns, patterns, or potential outbreaks. DON-A stated she expected antibiotic use be monitored, and appropriate antibiotic time-outs completed, tracked, and trended. DON-A stated antibiotic time-outs were important to protect residents from antibiotic overuse, unnecessary antibiotic treatment, and to ensure appropriate antibiotic stewardship. The facility's Antibiotic Stewardship Program policy, dated 1/1/26, identified the purpose of the program was to optimize the treatment of infections while reducing adverse events associated with antibiotic use. The policy identified nursing staff were to assess residents suspected to have infections, notify the physician, and utilize antibiotic protocols including McGeer criteria and Loeb Minimum Criteria. The policy identified the facility would monitor antibiotic use by monitoring residents' response to antibiotics and laboratory results when available to determine if the antibiotic continued to be indicated or if adjustments were needed. The policy further identified nursing staff were to monitor the initiation of antibiotics, monitor the resident's response to the antibiotic, review laboratory results, and consult with the practitioner to determine if the antibiotic should			F0881			

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F0881 SS = D	Continued from page 29 continue or if adjustments were needed based on findings.			F0881			