

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Rest Haven Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1096 North Ohio Street Greenville, OH 45331	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, review of the United States Department of Administration (USDA) website, and facility policy review, the facility failed to maintain a clean and sanitary kitchen and failed to ensure unpasteurized eggs were thoroughly cooked prior to serving. This had the potential to affect all residents in the facility except Resident #9 who does not eat food from the kitchen. The census was 67. Findings include: Observation on 08/04/25 at 9:06 A.M. of the kitchen walk-in refrigerator revealed a box containing unpasteurized eggs. Interview on 08/04/25 at 9:07 A.M. with Dietary Manager (DM) #162 revealed she usually ordered pasteurized eggs. She explained the company was out at the time she was making her order and purchased the unpasteurized instead. DM #162 acknowledged individual eggs were used for residents who requested sunny side up eggs, and they were served to two (#26 and #27) residents that morning for breakfast. DM #162 stated she was not aware pasteurized eggs were required for eggs which were not thoroughly cooked. Further observation of the kitchen on 08/04/25 at 9:12 A.M. revealed three ceiling vents in the serving area of the kitchen. Two of the three vents were approximately three feet in front of the serving tray line. The vents were observed to have dark, round particles scattered approximately eight to 12 inches surrounding the vents. Interview on 08/04/25 at 9:12 A.M. with DM #162 stated the ceiling had what appeared to be dust surrounding the ceiling vents. She acknowledged the area around the serving line should be free of possible contamination. Review of the United States Department of Administration (USDA) website, at https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/eggs/egg-products-and-food-safety, revealed the USDA does not recommend eating raw shell eggs that are not cooked or are undercooked due to the possibility that Salmonella may be present. Review of the facility policy titled, Food Preparation and Service, revised 11/22, revealed identification of potential hazards in food preparation process and adhering to critical control points can reduce the risk of food contamination. Also documented was only pasteurized egg shells are cooked and served when a residents requested undercooked, soft-served or sunny side up eggs.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of water management policies, staff interview, and review of electronic mail documents, the facility failed to ensure the water management plan for Legionella prevention was fully implemented. This had the potential to affect all 67 residents in the facility. The facility census was 67. Findings Include: Review of facility policy titled, The Water Management Plan, dated July 2017, revealed the water management program was based on the Centers for Disease Control and Prevention and the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) documentation. Further review revealed the water management program should include a detailed description and diagram of the water system, a system to monitor the control limits and effectiveness, and documentation of the program. Review of the undated facility Legionella prevention policy revealed water heater water temperatures will be gathered weekly and documented to ensure minimum water temperature of 140 degrees (Fahrenheit) and the ice machines will be cleaned quarterly and documented. Additional review revealed there was no description or diagram of the facility water system. Interview the Director of Maintenance (DOM) #101 on 08/06/25 at 12:10 P.M. revealed the facility was not documenting the water temperature for the water heaters. Further interview revealed the ice machine internals are cleaned by a contracted company twice a year. Review of an electronic mail (email) document from a contracted company dated 08/06/25 confirmed the kitchen ice machine was scheduled to receive maintenance twice a year. Interview with DOM #101 and the Director of Nursing (DON) on 08/07/25 at 2:40 P.M. confirmed there was no written detailed description of the water supply and no diagram was available at the facility. Further interview confirmed the ice machine was cleaned twice a year, but the facility policy indicated it would be cleaned quarterly. Interview with the DOM #101 at 4:10 P.M. on 08/07/25 revealed the facility was able to get a copy of the facility water flow diagram from corporate.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to complete a Minimum Data Set (MDS) assessment accurately for one (#70) of one residents reviewed for MDS assessment accuracy. The facility census was 67. Findings include: Review of the medical record for Resident #70 revealed an admission date of 04/09/25 with diagnoses of cerebral infarction, cognitive communication deficit, aphasia following cerebral infarction, type II diabetes mellitus without complications, and urinary tract infection. Review of the MDS assessment dated [DATE] revealed Resident #70 was cognitively able to make daily decisions with modified independent, and the resident did not have a urinary tract infection in the last 30 days. Review of the hospital Discharge summary dated [DATE] revealed Resident #70 was started on intravenous antibiotic medication for a urinary tract infection. Review of the progress note dated 04/15/25 at 6:16 P.M. revealed Resident #70 was readmitted to the facility with a diagnosis of urinary tract infection with an order for an antibiotic medication. Review of the Discharge Return Anticipated MDS assessment dated [DATE] revealed Resident #70 was cognitively able to make daily decisions with modified independent, and the resident did not have a urinary tract infection in the last 30 days. Review of the hospital Discharge summary dated [DATE] revealed Resident #70 was started on oral antibiotics for a urinary tract infection. Review of the progress note dated 05/01/25 at 4:52 P.M. revealed Resident #70 continued on the antibiotic for a urinary tract infection. Review of the Discharge Return Not Anticipated MDS assessment dated [DATE] revealed Resident #70 was cognitively able to make daily decisions with modified independent, and the resident did not have a urinary tract infection in the last 30 days. Interview on 08/07/25 at 8:31 A.M. with MDS Coordinator #147 confirmed Resident #70 did have a urinary tract infection on admission on [DATE], and had a diagnosis of a urinary tract infection on her hospital readmission dates of 04/15/25 and 04/26/25. MDS Coordinator #147 confirmed the MDS assessments dated 04/13/25, 04/24/25, and 05/06/25 did not list Resident #70 as having a urinary tract infection in the last 30 days. Review of the Resident Assessment policy, dated October 2023, revealed information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations and interviews.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of facility policy, the facility failed to ensure interventions and continued assessments were implemented for a skin condition. This affected one (#14) of three residents reviewed for skin conditions. The facility census was 67. Findings include: Review of medical record for Resident #14 revealed an admission date of 06/26/23. The resident was admitted with diagnoses including Alzheimer's disease, anxiety, depression, and chronic obstructive pulmonary disease (COPD). Review of the quarterly MDS assessment dated [DATE] revealed Resident #14 had impaired cognition, required set up assistance for eating, and supervision for bed mobility, transfers, and toileting hygiene. Review of Resident #14's care plan included a potential risk for impairment of skin integrity with interventions to provide treatments per physician orders. Review of Resident #14's physician orders revealed an order for weekly skin assessments with a start date of 04/20/25. Observation of Resident #14 on 08/04/25 at 10:34 A.M. revealed a reddened area on the resident's chin approximately 0.6 centimeters (cm) long by (x) 0.3 cm wide x 0.0 cm deep. Review Resident #14's progress note dated 07/27/25 revealed redness was observed on the resident's chin, and the resident stated the area felt bumpy with no complaints of pain or itchiness. The physician was updated. Review of Resident #14's 07/27/25 skin assessment documented redness to the chin with no measurements documented. The intervention was cream. Interview on 08/06/25 at 4:02 P.M. with Licensed Practical Nurse (LPN) #134 revealed she had noticed the red area on Resident #14's chin; however, there were no orders for a treatment. LPN #134 proceeded to show a secured text message Physician #1 was send, to confirm the physician was notified, but there was no return text documented. LPN #134 acknowledged there were no other skin assessments of Resident #14's chin since the original assessment on 07/27/25. Interview on 08/07/25 at 3:33 P.M. with the Director of Nursing (DON) acknowledged there was no additional documentation of the redness of Resident #14's chin after 07/27/25 and no treatment was in place for the skin condition. Review of Resident #14's physician orders revealed an order for house lotion to the face due to dryness as the resident tolerates and to monitor the red area on her chin for signs and symptoms of infection until healed with a start date of 08/08/25. Review of the facility's undated policy titled, Pressure Prevention and Managing Skin Integrity, revealed findings would be documented and skin interventions would be implemented and documented on the appropriate form.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure an investigation was completed following a resident fall. This affected one (#10) of three reviewed for falls. The facility census was 67. Findings include: Review of the medical record for Resident #10 revealed an admission date of 06/17/22 with diagnoses including age related osteoporosis without current pathological fracture, type II diabetes mellitus without complications, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the discharge return anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively impaired and had one fall with major injury since admission. Review of the care plan dated 06/20/22 revealed Resident #10 had a potential for or was at risk for injuries/falls related to diagnoses and history of falls with interventions of anticipate needs as able, encourage non-skid footwear at all times, monitor safety/preventative devices for application, and instruct on use of adaptive equipment as needed. Review of the progress note dated 01/18/24 at 10:36 P.M. revealed staff was assisting Resident #10 putting on a new brief when the resident lost her balance and fell. Review of the Fall During Staff Assist report, dated 01/18/24 revealed Resident #10 was being assisted with putting on a new brief when the resident lost her balance and fell over. The resident was standing up in front of the toilet with the walker in front of her when the fall occurred. Interview on 08/07/25 at 2:52 P.M. with the Director of Nursing (DON) confirmed Resident #10 did fall on 01/18/24 when a staff member was providing assistance with applying a brief to the resident. The DON also revealed a fall investigation was not fully completed with witness statements and documentation of who was present during the fall and how it happened. The DON confirmed the facility did not have a policy on completing investigations.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview, and review of facility policies, the facility failed to ensure residents received meals prior to scheduled appointments and failed to receive nutritional supplements as ordered. This affected two (#8 and #40) of eight residents reviewed for nutritional services. The census was 67. Findings include: 1. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE] with a re-admission on [DATE]. Diagnoses for Resident #8 include end stage renal disease and chronic obstructive pulmonary disease. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had mildly impaired cognition and was receiving dialysis treatments. Review of Resident #8's care plans dated 05/19/25 revealed a focus for altered nutrition relating to dialysis and other co-morbidities. A goal for the focus include the facility will provide nourishing meals daily to meet the needs of the resident. An intervention included to provide meals per diet order. Observation on 08/05/25 at 8:50 A.M. of Resident #8's room revealed the resident was not in the room and the breakfast tray containing a fried egg, breakfast sandwich, glass of orange juice, and a cup of coffee was sitting on the resident's night stand. The food appeared to be untouched and the silverware was still wrapped in a napkin. Interview on 08/05/25 at 9:08 A.M. with Licensed Practical Nurse (LPN) #107 revealed Resident #8 goes out of the facility for dialysis on Tuesday, Thursdays, and Saturdays. Per LPN #107, the resident leaves around 6:30 A.M. before breakfast was served at 8:00 A.M. LPN #107 stated she was unaware of any breakfast provided to Resident #8 before she goes to dialysis and stated she was unaware if the resident had refused her breakfast meal in the mornings before dialysis. Interview on 08/05/25 at 10:11 A.M. with Certified Nurse Aide (CNA) #117 revealed the aide arrives at the facility around 6:30 A.M. CNA #117 stated usually on the days Resident #8 goes to dialysis she was not in her room when CNA #117 arrives for her shift. CNA #117 stated the breakfast trays are served between 7:30 A.M. and 8:00 A.M. after Resident #8 leaves for her appointments. CNA #117 stated if the resident requests any breakfast the staff can provide her a snack upon request. CNA #117 stated she was unaware of any time Resident #8 has refused her meals. CNA #117 stated when the resident returns if lunch meal has been served the resident's lunch tray was placed in the refrigerator on the unit and given to her when she requests her meal. Interview on 08/05/25 at 2:12 P.M. with Resident #8 revealed the resident stated she had not been offered any food for breakfast on days she has to leave at 6:30 A.M. for dialysis. Resident #8 stated she had not refused her meals but stated she will wait until she returns to the facility to eat her lunch. Resident #8 stated no staff have offered her a supplement for her trips to dialysis. Resident #8 stated she was unaware she could request supplements or snacks for her appointments. 2. Review of the medical record for Resident #40 revealed an admission date of 03/24/22 with diagnoses of major depressive disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed Resident #40 was cognitively impaired and had not lost five (5) percent (%) or more in the last month or had a loss of 10% or more in last six (6) months. Review of Resident #40's weight logs revealed a weight of 211.0 pounds on 05/14/25 and a weight of 200.8 pounds on 05/28/25. Review of the Doctor Notification of Weight Change form dated 06/18/25 revealed the physician was notified of Resident #40's 27 pound weight loss over a 6 month period. Review of the progress note dated 06/19/25 at 9:52 A.M. revealed a new order was received for Resident #40 to received Med Pass 120 milliliters (mL) two times daily due to a 11.8% weight loss. Review of Resident #40's physician orders revealed and order dated 07/08/25 for 60 mL of Med Pass daily. Interview on 08/06/25 at 10:18 A.M. with Registered Dietician #221 confirmed on 06/20/25 she had already recommended Resident #40 to start on Med Pass 120 mL twice daily due to weight loss and that order was not initiated. Interview on 08/06/25 at 10:27 A.M. with LPN #196 confirmed she received a verbal order for Resident #40 on 06/19/25 for Med Pass 120 mL twice daily due to an 11.8% weight loss. Interview also confirmed the order was not written and not implemented. Review of the principles and standards of nutritional care policy, dated September 2018, revealed residents' nutritional care will be consistent with current standards of clinical practice for the elderly or facility population and comply with regulatory standards as applicable. Review of the medication and treatment orders policy, dated July 2016, revealed orders for medications and treatments will be consistent with principles of safe and effective order writing. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the facility's policy, the facility failed to ensure residents were not unnecessarily prescribed antibiotic medications. This affected one (#19) resident of five residents reviewed for unnecessary medications. The census was 67. Findings include: Record review for Resident #19 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #19 include hemiplegia, weakness, dysphagia, chronic obstructive pulmonary disease, and heart disease. Further review of the resident's diagnoses records revealed no active diagnosis for bronchiectasis (a chronic lung condition where the airways (bronchial tubes) become widened and damaged, making it difficult to clear mucus). Review of Resident #19's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and received antibiotic medications. Review of Resident #19's physician orders dated 04/01/24, and revised on 07/16/24, revealed the resident was to receive Levaquin (antibiotic) 750 milligrams (mg) orally daily on the first of the month for five (5) days each month for bronchiectasis. Per the order the medication had no stop date. Review of Resident #19's care plans dated 12/06/23 to 10/24/25 revealed no focus for any type of infection risk in the care plans. Review of Resident #19's complete blood count (CBC) laboratory test dated 04/01/25 revealed no evidence in the test results indicating any infection process. [NAME] blood cells were within normal range and no abnormal results were noted. Review of the pharmacist's monthly medication reviews dating from July 2024 to July 2025 revealed each month the pharmacist reviewed Resident #19's medications and made no recommendations regarding the antibiotic. Interview on 08/07/25 at 11:30 A.M. with the Director of Nursing, (DON) revealed Resident #19 was receiving the Levaquin oral antibiotic for prophylactic reasons to prevent bronchiectasis. Per the DON, the staff have consulted with the prescribing physician and explained the resident had no signs of infection; however, the physician continued to prescribe the antibiotic to the resident. The DON verified the Levaquin was an unnecessary medication in terms of the resident having no signs or symptoms of a respiratory infection and stated the resident continued to receive the oral antibiotic for 5 days a month per the physician's order. Review of the facility policy titled, Medication Therapy, dated 04/2007, revealed the facility will ensure all residents' medication regimen shall only include medications necessary to treat existing conditions.		