STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495302	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Health & Rehab Center	2406 Atherholt Road Lynchburg, VA 24501

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 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** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to have medication available for administration in accordance with physician orders for two residents (Resident #3-R3 and Resident #4-R4) in a survey sample of four residents. The findings included: 1. For R3, who missed three doses of IV antibiotic, the facility staff failed to notify the physician to afford the opportunity for alternate treatment orders to be administered. On 3/12/25, a closed record review was conducted of R3's chart. This review revealed that R3 was admitted to the facility on [DATE], from the hospitalization where he was diagnosed with severe sepsis. According to the hospital discharge summary, R3 was to continue Cefazolin 2 g, IV piggyback, every 8 hours Infectious disease was consulted during R3's hospitalization . The hospital discharge documentation also noted, . MSSA bacteremia. Initial blood cultures revealed MSSA bacteremia . The patient has been seen by infectious disease; the patient is to continue on cefazolin 2 g IV every 8 hours to complete 14 days with the last day being 1/8/2025 . According to the hospital medication administration record (MAR), R3's last dose of Cefazolin was administered on 1/7/25 at 10:37 a.m. According to the facility's MAR, R3 received the first dose of Cefazolin on 1/8/25 at 12 noon, resulting in the administration of only one dose on 1/7/25 and one dose on 1/8/25. According to the MAR, the nurse noted on 1/8/25 for the 4 a.m. dose, Med not available Provider and pharm [pharmacy] were made aware. According to the nursing note dated 1/8/25 at 4:39 a.m., it read, Patient's cefazolin, 2-gram, recon soln, intravenous order was not administered due to not unavailability [sic]. Provider and Pharm [pharmacy] aware and Pharm stated it will be delivered on the next run. There was no documentation regarding the doses missed on 1/7/25, or that the antibiotic was available in 1-gram dosing, to see if the physician wanted to give an alternate order. On 3/13/25 at 10:20 a.m., the director of nursing and regional director of clinical services met with the surveyor and presented a timeline of R3's antibiotic. According to the facility presented timeline, they noted R3 admitted on [DATE] at 1:52 p.m., per MD [medical doctor] discharge orders medication is to be completed on 1/8, Medication scheduled for 1/8/25 x 3 doses, 2 additional doses added to 1/9/25 to constitute the previous dose on 1/7/25 and 1/8/25. The facility provided a copy of the MAR for R3 which noted he received two doses of the antibiotic on 1/9/25. (continued on next page)

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	495302	A. Building B. Wing	03/13/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For R4, who missed several consecutive doses of IV Cefazolin, the facility staff failed to notify the doctor. On 3/12/25, a clinical record review was conducted of R4's chart. This review revealed that R4 was admitted to the facility on [DATE]. According to the hospital discharge summary, R4 was hospitalized and treated for acute metabolic encephalopathy, Staphylococcus aureus bacteremia, and was noted with severe sepsis. The orders included, Cefazolin 2 g, IV piggyback every 8 hours. According to the medication administration record, R4 received the first dose of Cefazolin on 3/9/25 at 9 a.m. , which was the second scheduled administration for that day. The notes indicated R4's two doses scheduled for 3/8/25, were not given with the notation, Not administered: drug/item unavailable comment: has not arrived from pharmacy. The first dose scheduled for 3/10/25 at 2 a.m., had the notation, rewritten. There was no indication that the doctor was made aware of the medication not being available, the missed doses, or given the opportunity to give alternate orders. On 3/12/25, in the afternoon, interviews were conducted with licensed practical nurses (LPN #1, LPN #2, and LPN #3). LPN #3 was the unit manager. Each of the three nurses explained that the pharmacy delivers twice daily. When asked what action is needed if a medication is not available for administration when it is due/scheduled, each of the nurses explained that the process is to call the doctor to make them aware and call the pharmacy to see where the medication is. On 3/12/25, in the afternoon, licensed practical nurse (LPN #1), explained that the pharmacy stocks an e-kit [emergency supply of medications] that is maintained at the facility. LPN #1 took the surveyor into the medication room and showed her a listing of items contained within the E-kit, which included Cefazolin, in a 1 gram vial, and that a quantity of 4 vials was maintained at the facility. Since the provider was not made aware of the doses that were not administered for R3 and R4, the physician was not given the opportunity to determine if he wanted the 1-gram doses to be administered nor was the physician given the opportunity to provide new orders with consideration of the 1-gram dose availability. On 3/12/25 at 3:24 p.m., during an interview with the director of nursing (DON), the DON stated that if orders are received by 10 a.m., they will not arrive at the facility until the next morning between 1 a.m. and 4 a.m. When asked, what the facility can do to ensure new admissions receive their medications, the DON went on to indicate that the facility can ask the hospital to administer medications due prior to the resident discharging, they can check the emergency supply of medications maintained at the facility and if it is not available there, they can notify the doctor and pharmacy, and have the medication STAT 'ed [urgently sent], but she added that is still a 4 hour window. The DON went on to say, The doctor can change it to something we have until the medication arrives. A facility policy titled, 7.0 Medication Shortages/Unavailable Medications was provided. According to the policy, which read in part, . 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the emergency medication supply. Facility staff should notify pharmacy and arrange for a STAT deliver, if medically necessary . 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain new orders or directions for alternate administration . No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to have medication available for administration in accordance with physician orders for two residents (Resident #3-R3 and Resident #4-R4) in a survey sample of four residents. The findings included: 1. For R3, the facility staff failed to have intravenous (IV) Cefazolin (an antibiotic) available to administer as ordered by the physician. On 3/12/25, a closed record review was conducted of R3's chart. This review revealed that R3 was admitted to the facility on [DATE], from the hospitalization where he was diagnosed with severe sepsis. According to the hospital discharge summary, R3 was to continue Cefazolin 2 g, IV piggyback, every 8 hours . Infectious disease was consulted during R3's hospitalization . The hospital discharge documentation also noted, . MSSA bacteremia. Initial blood cultures revealed MSSA bacteremia . The patient has been seen by infectious disease; the patient is to continue on cefazolin 2 g IV every 8 hours to complete 14 days with the last day being 1/8/2025 . According to the hospital medication administration record (MAR), R3's last dose of Cefazolin was administered on 1/7/25 at 10:37 a.m. According to the facility's MAR, R3 received the first dose of Cefazolin on 1/8/25 at 12 noon. R3 missed two doses on 1/7/25 and one dose on 1/8/25. According to the MAR, the nurse noted on 1/8/25 for the 4 a.m. dose, Med not available Provider and pharm [pharmacy] were made aware. According to the nursing note dated 1/8/25 at 4:39 a.m., it read, Patient's cefazolin, 2-gram, recon soln, intravenous order was not administered due to not unavailability [sic]. Provider and pharm [pharmacy], aware and Pharm stated it will be delivered on the next run. There was no documentation that reflected the missed doses of IV antibiotic on 1/7/25. On 3/12/25, in the afternoon, interviews were conducted with licensed practical nurses (LPN #1, LPN #2, and LPN #3). LPN #3 was the unit manager. Each of the three nurses explained that the pharmacy delivers twice daily, and they have a process for STAT [emergent] medications to be delivered as well. They explained when an admission is coming in, they enter the orders into the electronic health record as early as they can, which also transmits to the pharmacy, so that the pharmacy can send the medications to the facility. When asked if a medication is not available for administration when it is due/scheduled, each of the nurses explained that the process is to call the doctor to make them aware and call the pharmacy to see where the medication is. On 3/12/25 at 2:18 p.m., a phone call was placed to the facility's contracted pharmacy. According to the pharmacy representative, R3's Cefazolin order was received in the pharmacy on 1/7/25 and filled for 6 bags/doses. It was delivered to the facility on [DATE] at 2:41 a.m. The pharmacy representative also confirmed that the pharmacy delivers to the facility twice daily. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 3:24 p.m., during an end of day meeting, the facility administrator, director of nursing, and regional director of clinical services, were made aware of the above findings and the concern that R3 missed multiple doses of IV antibiotic due to the medication being unavailable. On 3/13/25 at 10:20 a.m., the director of nursing and regional director of clinical services met with the surveyor and presented a timeline of R3's antibiotic. According to the facility presented timeline, they noted R3 admitted on [DATE] at 1:52 p.m., per MD [medical doctor] discharge orders medication is to be completed on 1/8, Medication scheduled for 1/8/25 x 3 doses, 2 additional doses added to 1/9/25 to constitute the previous dose on 1/7/25 and 1/8/25. 2. For R4, the facility failed to have IV Cefazolin available for administration as per physician orders. On 3/12/25, a clinical record review was conducted of R4's chart. This review revealed that R4 was admitted to the facility on [DATE]. According to the hospital discharge summary, R4 was hospitalized and treated for acute metabolic encephalopathy, Staphylococcus aureus bacteremia, and was noted with severe sepsis. The orders included, Cefazolin 2 g, IV piggyback every 8 hours. According to the medication administration record, R4 received the first dose of Cefazolin on 3/9/25 at 9 a.m. , which was the second scheduled administration for that day. the notes indicated R4's two doses scheduled for 3/8/25, were not given with the notation, Not administered: drug/item unavailable comment: has not arrived from pharmacy. The first dose scheduled for 3/10/25 at 2 a.m., had the notation, rewritten. On 3/12/25 at 2:18 p.m., a telephone call was placed to the facility's contracted pharmacy. When asked about R4's Cefazolin, the pharmacy reported they received the order and keyed it on 3/8/25 and said, it manifested at 7:07 p.m., and was set-up to go on the 11 o'clock p.m. run that evening. The pharmacy indicated they didn't have any details regarding when it was actually delivered to the facility but knew the delivery driver picked it up from the pharmacy at 3:30 a.m., on 3/9/25. On 3/12/25, in the afternoon, interviews were conducted with licensed practical nurses (LPN #1, LPN #2, and LPN #3). LPN #3 was the unit manager. Each of the three nurses explained that the pharmacy delivers twice daily, and that they have a process for STAT [emergent] medications to be delivered as well. They explained when an admission is coming in, they enter the orders into the electronic health record as early as they can, which also transmits to the pharmacy, so that the pharmacy can send the medications to the facility. When asked about needed action if a medication is not available for administration when it is due/scheduled, each of the nurses explained that the process is to call the doctor to make them aware and call the pharmacy to see where the medication is. On 3/12/25 at 3:24 p.m., during an end of day meeting with the facility administrator, director of nursing (DON), regional director of clinical services (RDCS), the above findings were discussed. The DON stated that if orders are received by 10 a.m., they will not arrive at the facility until the next morning between 1 a.m. and 4 a.m. When asked, what the facility can do to ensure new admissions receive their medications, the DON stated that the facility can ask the hospital to administer medications due prior to the resident discharging, they can check the emergency supply of medications maintained at the facility and if it is not available there, they can notify the doctor and pharmacy and have the medication STAT 'ed [urgently sent], but that is still a 4 hour window. She went on to say, The doctor can change it to something we have until the medication arrives. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 9:50 a.m., R4 was visited in his room. A family member, who identified themselves as the resident's daughter was at the bedside. R4 was asked about medications and if he had any delay in receiving medications or missed any doses, the resident stated that they were not aware, but the family member reported that R4 had confusion and was not reliable in recall of events. On 3/13/25 at 10:20 a.m., the DON and RDCS presented the surveyor with a timeline they had prepared regarding R4's IV antibiotic. The timeline read, Missed 2 doses on 3/8/ and 3/9, stated pharmacy delivered medication at 330a.m on 3/9/25 . admitted on [DATE] at 1234 p.m., Ordered for Cefazolin 2gm IV q8hrs [every 8 hours]. 3/8/25 at 1800 [6pm] nursing charted against order, Medication not here from pharmacy. 3/9 at 2 a.m., nursing charting against the rewritten order documented .the medications changed to be administered at 9am, 5 pm, and 1 am. (nurse states she was unaware she didn't unpack mediation right when they were delivered.) Medication arrived from the pharmacy at 330 am, Next dose at 9am moving forward administered. Additional doses added to residents abx [antibiotic] regimen when noticed. [sic] The facility policy titled, 4.0 Authorization and Communication of Orders was provided and reviewed. According to the policy, it read in part, .10. Facility should verify transfer/transition and admission orders with the resident's physician/prescriber before they are communicated to the pharmacy. 10.1 Once admission orders are verified, staff should promptly transmit medication orders to the pharmacy. A delay in transmission of new orders to the pharmacy may impact the time of delivery and resident access to medically necessary medications . A facility policy titled, 7.0 Medication Shortages/Unavailable Medications was provided. According to the policy, which read in part, . 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the emergency medication supply. Facility staff should notify pharmacy and arrange for a STAT deliver, if medically necessary . 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain new orders or directions for alternate administration . No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents were free from significant medication errors, resulting in multiple missed doses of intravenous (IV) antibiotics for two residents (Resident #3- R3 and Resident #4-R4) in a survey sample of four residents. The findings included: 1. For R3, who was ordered IV Cefazolin by an infectious disease doctor for treatment of MSSA [methicillin-susceptible Staphylococcus aureus] bacteremia, the resident missed three consecutive doses. On 3/12/25, a closed record review was conducted of R3's chart. This review revealed that R3 was admitted to the facility on [DATE], from the hospitalization where he was diagnosed with severe sepsis. According to the hospital discharge summary, R3 was to continue Cefazolin 2 g, IV piggyback, every 8 hours . Infectious disease was consulted during R3's hospitalization . The hospital discharge documentation also noted, . MSSA bacteremia. Initial blood cultures revealed MSSA bacteremia . The patient has been seen by infectious disease; the patient is to continue on cefazolin 2 g IV every 8 hours to complete 14 days with the last day being 1/8/2025 . According to the hospital medication administration record (MAR), R3's last dose of Cefazolin was administered on 1/7/25 at 10:37 a.m. According to the facility's MAR, R3 received the first dose of Cefazolin on 1/8/25 at 12 noon. R3 missed two doses on 1/7/25 and one dose on 1/8/25. According to the MAR, the nurse noted on 1/8/25 for the 4 a.m. dose, Med not available Provider and pharm [pharmacy] were made aware. According to the nursing note dated 1/8/25 at 4:39 a.m., it read, Patient's cefazolin, 2-gram, recon soln, intravenous order was not administered due to not unavailability [sic]. Provider and pharm [pharmacy], aware and Pharm stated it will be delivered on the next run. On 3/12/25 at 2:18 p.m., a phone call was placed to the facility's contracted pharmacy. According to the pharmacy representative R3's Cefazolin order was received in the pharmacy on 1/7/25 and filled for 6 bags/doses. It was delivered to the facility on [DATE] at 2:41 a.m. The pharmacy confirmed they deliver to the facility twice daily and have a process for STAT [emergent] medications. On 3/12/25 at 2:40 p.m., an interview was conducted with a registered nurse (RN #1). When asked about antibiotics, RN #1 said, You cannot miss a dose and have to take all of the antibiotics. RN#1 replied, Usually when a dose is missed you take it as soon as you realize it. When asked why you can't miss doses, RN #1 said, Because it [the infection] can try to work against the antibiotic and build up resistance. When asked what the risk is of someone missing a few doses in the middle of a course of antibiotics is, RN #1 said, It's a big risk. You have to talk to the doctor and may have to extend the treatment. You can't miss a dose of antibiotics at all. (continued on next page)

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	495302	A. Building B. Wing	03/13/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 2:47 p.m., an interview was conducted with a licensed practical nurse (LPN #3), who identified as the unit manager. When asked about antibiotic use and missed doses, LPN #3 said, When someone has an infection, they have to finish the course of antibiotics unless the doctor says otherwise. When asked what the risk is, if someone misses doses of antibiotics, LPN #3 said, You risk the infection growing and long-term can become resistant to antibiotics all together. When asked what action is needed if an antibiotic is not available for administration, LPN #3 said, We call the pharmacy to see if we can get it STAT 'ed to us and notify the doctor to see if they want to change the orders. On 3/13/25 at 10:20 a.m., during an interview with the director of nursing (DON) and regional director of clinical services (RDCS), the DON reported, It is an understanding by doctor [name redacted] if missed doses, we add to the end. When asked if this is an acceptable course of treatment for infections, the DON said, I have identified some opportunities. When asked if this is in accordance with the facility's antibiotic stewardship program and if adding doses to the end of the course of treatment is the acceptable thing to do, the DON said, No. On 3/13/25 at 11:06 a.m., an interview was conducted with a registered nurse, who was the facility's infection preventionist (IP). During the interview with the IP she mentioned, It is an understanding with the provider that antibiotic doses are added to the end of the course of treatment for missed doses. When asked why someone would miss doses, the IP explained, Our pharmacy is in Richmond. We have a backup box, but if it is not available in the back-up box we communicate to the doctor. When asked why it is important for someone to receive all the doses of an antibiotic, the IP said, Because it is treating an infection, and it is ordered by the doctor. When asked to explain any risks related to missing doses during treatment with antibiotics, the IP explained that It [the infection] could create a resistance to the antibiotic, it may not treat the infection appropriately [because therapeutic levels are not maintained]. When asked how often this happens, the IP said, Here lately it has been more, since we switched pharmacies. We had [pharmacy name redacted] here in [local city name redacted] but that closed and our cut off times have changed. We have had a good amount of IV antibiotics, but I feel like it has happened more than it did in the past. When asked if she had talked to the medical director and/or pharmacy about reviewing the contents and quantity of the emergency supply of medications maintained in house, the IP said, When the unit manager notified me. We have 1 gram of Ceftin versus the 2 grams. We had discussed talking to the pharmacy about the amount of antibiotics we have in the back-up box. When asked if that conversation had been held, the IP stated, No. When asked if a meeting had been scheduled, the IP said, No. According to the facility policy titled, Antimicrobial Stewardship Program Policy, which read in part, As a component of the monthly infection prevention and control committee (IPCC) meeting the facility's use of antibiotics will be reviewed to include: monitoring/tracking of antibiotic prescribing, use, and resistance in order to promote a culture of optimal antibioitic use within the facility . The policy did not address missed doses of antibiotic treatment. On 3/13/25, the facility administrator, director of nursing and regional director of clinical services were made aware of the above findings. No additional information was provided.