STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casper Mountain Rehabilitation and Care Center	**4305 S Poplar , Casper, Wyoming, 82601**

(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
F0000	INITIAL COMMENTS A complaint investigation was conducted on 4/21/26 through 4/23/26. The survey was prompted by complaint intakes 2706295, 2708872, 2724207, 2704857, 2798630, 2806058, 2806370, and 2965067. The following abbreviations are used throughout this document: ADL: Activity of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant cm: Centimeter DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		05/15/2026
F0573 SS = D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and	F0573	Tag: F0573 – Right to Access/Purchase Copies of Records This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules or civil	05/22/2026

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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F0573 SS = D	Continued from page 1 (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is NOT MET as evidenced by: Based on resident representative and staff interview, medical record review, medical records request log, and policy review, the facility failed to provide a complete copy of medical records after they were requested for 1 of 3 sample residents (#1) reviewed. The census was 82. The findings were: 1. Review of the admission MDS assessment dated 11/1/25 showed resident #1 admitted to the facility on 10/31/25. Further medical record review showed the resident discharged to the hospital on 1/4/26. The resident did not return to the facility following the hospitalization. 2. Review of the medical record request log showed the resident's representative requested the resident's medical records on 2/2/26, which included progress notes, lab results, imaging, results from diagnostic testing, nursing notes, and clinical summaries with the date range of 10/31/25 through 1/4/26. Further review of the records that had been	F0573	Continued from page 1 procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies. Corrective Action for Affected Residents: The Medical Records Director completed a full review of Resident #1's medical record request and ensured that the complete record, including the missing date range (1/1/26–1/4/26), was compiled and provided to the resident representative. The Medical Records Director verified that all requested documentation (including nursing notes, provider notes, labs, diagnostics, and supporting records) were included in the final record. Follow-up communication was completed with the resident representative to confirm receipt and ensure satisfaction with the completed medical record. Identifying other Residents having the Potential to be Affected: The Medical Records Director or designee will conduct a review of all recent medical record requests within the past 90 days to determine if any requests were incomplete, delayed, or missing portions of requested documentation. Any identified concerns will be corrected immediately to ensure full compliance with regulatory requirements. This review will be completed by 5/18/2026. Measures put into place or Systemic Changes: The facility implemented a standardized Medical Records Request Checklist requiring verification of the full requested date range, complete inclusion of all record components, and confirmation of requestor authorization prior to release. A Medical Records Request Tracking Log was implemented to document date of request, authorization status, regulatory due date, and completion date, with escalation procedures for any pending or at-risk requests. Staff will be educated on proper processing of medical record requests, including clarification that once valid authorization is confirmed, records must be processed in full and within	05/22/2026

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F0573 SS = D	Continued from page 2 provided to the resident's representative showed progress notes were provided through 12/27/25. 3. Interview with the resident's representative on 4/22/26 at 10 AM revealed she had requested the resident's medical records, and after 1 month, had been given the resident's hospital records only. She reported it took another week and a half to get the resident's records from the facility, and the records were missing 1/1/26 -1/4/26. She reported she had been unable to get any further response to receive the complete set of records. 4. Interview with the medical records director on 4/22/26 at 12:40 PM revealed the resident's representative had requested the records before she had been the resident's power of attorney (POA). She stated the representative became POA on 2/26/26, and the documents were picked up that day. 5. Interview with the NHA on 4/23/26 at 11:05 AM confirmed there was no reason the resident representative couldn't get all of the records. 6. Review of the facility policy titled "Authorization for Release of Protected Health Information (PHI)" showed "...Staff must confirm: ...Date range is accurate..."	F0573	Continued from page 2 regulatory timeframes without delay by 5/22/26 Plan to Monitor Performance: The Medical Records Director or designee will audit all medical record requests weekly for four (4) weeks, then monthly for two (2) months to ensure completeness, accuracy of date ranges, and timely release of records starting 5/18/2026. The Medical Records Director or designee will also review the Medical Records Request Tracking Log weekly for four (4) weeks, then monthly for two (2) months to ensure timely processing and compliance with regulatory requirements. Any noncompliance will be added to QAPI and addressed monthly by DON or designee Date of Compliance: 5/22/26	05/22/2026
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 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).	F0656	F656 Develop/Implement Comprehensive Care Plan – 483.21(b)(1)(3) Corrective Action for Affected Resident The interdisciplinary team (IDT) completed a full revision of Resident #5's comprehensive care plan to ensure the care plan accurately reflected individualized and person-centered needs, including ADL assistance levels, transfer requirements, mobility status, and resident bathing preferences. This review and revision was completed on 4/23/26. Identifying Other Residents Having the Potential to be Affected The MDS Coordinator or designee conducted a review of resident care plans to identify template-driven language, incomplete fields, or non-individualized interventions. Any identified concerns were corrected immediately to ensure care plans accurately reflected individualized resident needs and measurable interventions. This review was completed by 5/22/26. Measures Put Into Place or Systemic Changes	05/22/2026

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F0656 SS = D	Continued from page 3 (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 medical record review, and staff interview, the facility failed to ensure the comprehensive care plan was implemented for 1 of 3 sample residents (#5) reviewed for care plans. The findings were: 1. Review of the admission MDS assessment dated 2/9/26 showed resident #5 had a BIMS score of 15 out of 15, which indicated intact cognition, and diagnoses which included septicemia, diabetes mellitus, and cellulitis of the left lower limb. Further review showed the resident was dependent for all transfers. Review of the resident's care plan initiated on 2/9/26 and revised on 3/8/26 showed "ADL: [name] has an ADL self-care performance deficit and is dependent with self care tasks to include: bathing, transfers, personal hygiene tasks, bed mobility, dressing, eating, toilet use, ambulation and locomotion r/t [related to] obesity, infection, and wounds. The following concerns were identified: a. Review of the care plan initiated on 2/10/26 and last revised on 3/23/26 showed "BATHING PREFERENCE: Resident prefers (specify: showers/bed baths on (specify: days of week/shift?)	F0656	Continued from page 3 A Care Plan Completion Checklist was implemented requiring verification that comprehensive care plans include: Defined ADL assistance levels Number of staff required for care and transfers Resident preferences Measurable interventions Elimination of incomplete template fields The interdisciplinary care planning process was reinforced requiring participation from Nursing, MDS, Social Services, and Therapy, as applicable, during admission, significant change, and routine care plan review processes. Education was provided to licensed nurses, MDS staff, and interdisciplinary team members regarding requirements for individualized, person-centered care planning and consistent implementation of care plan interventions. Plan to Monitor Performance The MDS Coordinator or designee will audit five (5) resident care plans weekly for four (4) weeks, then monthly for two (2) months beginning 5/18/26. Audits will evaluate: Completeness of care plans Elimination of template language Inclusion of measurable interventions Consistency between assessments and care plans Staff implementation of care planned interventions	05/22/2026

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F0656 SS = D	Continued from page 4 and (has no preference of care giver type) prefers assistance with bathing to be provided by a (Specify: male/female)" b. Review of the care plan initiated on 2/9/26 and last revised on 3/23/26 showed "BATHING/SHOWERING: The resident requires (specify: supervision, limited, extensive, dependent) with __ person assist with bathing" c. Review of the care plan initiated on 2/10/26 and last revised on 3/23/26 showed "BED MOBILITY: The resident requires (SPECIFY: supervision, limited extensive, dependent) with __ person assist to turn and reposition in bed" d. Review of the care plan initiated on 3/23/26 showed "DRESSING: The resident requires (SPECIFY what assistance) with __ person assist for dressing" e. Review of the care plan initiated on 3/23/26 showed "TRANSFER: The resident requires (SPECIFY what assistance) by (X) staff to move between surfaces (SPECIFY FREQ) and as necessary." 2. Interview with the MDS nurse on 4/23/26 at 11:44 AM confirmed the care plan was incomplete and it was not patient-centered.	F0656	Continued from page 4 Immediate corrective action will be provided for any identified noncompliance. Results of audits will be reviewed through the QAPI process monthly. Additional monitoring will be implemented as determined necessary by the QAPI committee. Date of Compliance 5/22/26	05/22/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure a safe environment during mechanical lift transfers for 1 of 3 sample residents (#5) reviewed. The findings were: 1. Review of the admission MDS assessment dated 2/9/26 showed resident #5 had a BIMS score of 15	F0689	F689 Free of Accident Hazards/Supervision/Devices – 483.25(d)(1)(2) Corrective Action for Affected Resident Resident #5 was immediately assessed to ensure transfer status accurately reflected the need for a mechanical lift with a two-person assist. The resident's comprehensive care plan was reviewed and updated to reflect current transfer requirements and safety interventions. Direct observation of resident transfers was completed to validate safe transfer practices. Staff involved in the resident's care received re-education regarding facility policy prohibiting single-person mechanical lift transfers, mechanical lift safety expectations, and the requirement for two staff members during all mechanical lift transfers. Identifying Other Residents Having the Potential to be Affected The Director of Nursing (DON) or designee conducted a review of all residents requiring mechanical lift transfers to identify residents who	05/22/2026

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F0689 SS = D	Continued from page 5 out of 15, which indicated intact cognition, and diagnoses which included septicemia, diabetes mellitus, and cellulitis of the left lower limb. Further review showed the resident was dependent for all transfers. Review of the resident's care plan last revised on 3/8/26 showed "ADL: [name] has an ADL self-care performance deficit and is dependent with self care tasks to include: bathing, transfers, personal hygiene tasks, bed mobility, dressing, eating, toilet use, ambulation and locomotion r/t obesity, infection, and wounds." The following concerns were identified: a. Observation on 4/22/26 at 4:08 PM showed CNA #1 was in the room of resident #5, and transferred the resident from his/her wheelchair to the bed using a full body mechanical lift. Further observation showed the CNA performed the transfer without the assistance of another staff member. b. Interview with the resident on 4/23/26 at 9:26 AM revealed that s/he does not get into his/her wheelchair every day because “Some days there isn’t enough staff." c. Interview with the DON on 4/22/26 at 4:19 PM revealed there should be two staff members to perform transfers when using the full body mechanical lift. d. Interview with the administrator on 4/23/26 at 11:06 AM revealed he “had not heard that there were residents staying in bed due to lack of staff to use 2 people with the Hoyer lift. It is a teamwork issue. Even the nurses are available to help.” e. Review of the facility policy titled "Safe Resident Handling/Transfers dated 1/1/26 showed, “...#8 Compliance guideline: Two staff members must be utilized when transferring residents with mechanical lift...”	F0689	Continued from page 5 had the potential to be affected by the deficient practice. The review included verification that transfer status, Kardex information, and comprehensive care plans accurately reflected the requirement for a two-person assist during mechanical lift transfers. Any identified concerns were corrected immediately. This review was completed by 5/15/26. Measures Put Into Place or Systemic Changes All licensed nurses, CNAs, and agency staff were re-educated regarding mechanical lift safety standards and facility policy requiring two staff members for all mechanical lift transfers without exception. Education included reinforcement that staff are required to obtain assistance and wait for a second staff member prior to initiating any mechanical lift transfer. Education was completed by 5/22/26. All CNAs and nurses completed hands-on competency validation for mechanical lift transfers, including return demonstration of proper two-person transfer technique. Staff unable to demonstrate competency will not perform mechanical lift transfers until competency validation is successfully completed. The DON, Unit Managers, or designee implemented random daily observations of resident transfers beginning 5/18/26 on all shifts, including weekends, to provide real-time supervision, ensure compliance with safe transfer practices, and immediately correct any unsafe practices identified. Plan to Monitor Performance The DON, Unit Managers, or designee will conduct audits of mechanical lift transfers weekly x5 observations for two (2) weeks, then x3 observations for two (2) weeks, followed by two (2) monthly audits for two (2) months beginning 5/18/26. Audits will include verification that: Two staff members are present during mechanical lift transfers Proper equipment use and transfer technique are followed Care plans accurately reflect transfer requirements	05/22/2026

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F0689 SS = D		F0689	Continued from page 6 Staff consistently implement transfer interventions as care planned Immediate corrective action will be provided for any identified noncompliance. Audit results will be reviewed through the Quality Assurance and Performance Improvement (QAPI) process monthly. Additional monitoring will be implemented as determined necessary by the QAPI committee. Date of Compliance 5/22/26	05/22/2026
F0880 SS = D	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	F0880	F880 Infection Prevention & Control Program – 483.80(a)(1)(2)(4)(e)(f) Corrective Action for Affected Residents The facility reviewed Residents #2 and #26 for Enhanced Barrier Precautions (EBP) criteria and confirmed both residents require EBP per CDC guidelines. Wound care practices for applicable residents were immediately corrected to ensure consistent use of gowns and gloves during all high-contact care activities. The wound nurse responsible for care received re-education and completed competency validation regarding appropriate PPE use and EBP requirements per CDC guidelines. The Infection Prevention Nurse completed direct observation of wound care and high-contact resident care activities to validate compliance with PPE expectations and infection prevention practices. Identifying Other Residents Having the Potential to be Affected The Director of Nursing (DON) or designee conducted an audit of all residents receiving wound care, indwelling device care, ostomy care, or other high-contact care activities to determine whether Enhanced Barrier Precautions were appropriately identified, ordered, and implemented. Residents identified as meeting EBP criteria were immediately placed on appropriate precautions with updated care plans, physician orders, and signage. This review was completed on 5/15/26. Measures Put Into Place or Systemic Changes	05/18/2026

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F0880 SS = D	Continued from page 7 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 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 observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure infection prevention practices, including personal protective equipment (PPE), was used during wound care for 2 of 3 sample residents (#2, #26) reviewed for enhanced barrier protection (EBP). The findings were: 1. Review of the admission MDS assessment dated	F0880	Continued from page 7 The Infection Prevention and Control Program policy was revised to reflect current CMS and CDC guidance regarding Enhanced Barrier Precautions, including definitions of high-contact care activities and required PPE use. A standardized EBP workflow was implemented requiring: Identification of qualifying residents Initiation of EBP orders Care plan updates Appropriate signage placement Availability of PPE outside resident rooms Ongoing compliance monitoring All licensed nurses, CNAs, and agency staff received education regarding Infection Prevention Program requirements, Enhanced Barrier Precautions, hand hygiene, environmental disinfection, and appropriate PPE use during wound care and other applicable high-contact care activities. Education included differentiation between Standard Precautions, Contact Precautions, and Enhanced Barrier Precautions. Plan to Monitor Performance The Infection Prevention Nurse or designee will conduct direct observation audits of wound care and high-contact care activities beginning 5/18/26 with: Weekly x5 observations for two (2) weeks Then x3 observations for two (2) weeks Then two (2) monthly audits for two (2) months Audits will evaluate:	05/18/2026

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Casper Mountain Rehabilitation and Care Center	**4305 S Poplar , Casper, Wyoming, 82601**

(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
F0880 SS = D	Continued from page 8 2/24/26 showed resident #2 had a BIMS score of 15 out of 15, which indicated intact cognition, and diagnoses which included chronic venous hypertension with ulcer and inflammation of bilateral lower extremities. Further review showed the resident had 4 venous/arterial ulcers present. Review of the resident's care plan last revised on 4/6/26 showed “Wound management [name] has a left anterior lower leg wound x [times] 2 and a left lateral malleolus wound and left medial calf wound.” The following concerns were identified: b. Observation on 4/21/26 at 3:43 PM showed wound nurse applied an unna boot dressing to the resident's left lower leg. The Nurse wore gloves but did not wear a gown. a. Review of the medical record showed a photograph of the resident’s left lower leg wound which had dimensions of “length 4.12 cm, width 2.56 cm, depth 00.2 cm, area 6.29 cm [squared]” and “wound moderate exudate [drainage], serous clear watery fluid which is separated from solid elements.” 2. Review of the admission MDS assessment dated 3/3/26 showed resident #26 had a BIMS score of 15 out of 15, which indicated intact cognition, and diagnoses which included unspecified abdominal hernia with obstruction, without gangrene. Review of the resident’s care plan last revised on 2/27/26 showed “Wound management post-surgical, midline surgical incision to abdomen.” The following concerns were identified: a. Observation on 4/22/26 at 10:30 AM showed the wound nurse changed a dressing located on the resident’s upper quadrant of his/her abdomen. Further observation showed the nurse did not wear a gown. 3. Interview with the wound nurse on 4/22/26 at 11 AM confirmed she “had not been using a gown when doing wound care.” When asked what her expectations for enhanced barrier precautions was, she stated, "gloves and hand hygiene." 4. Interview with the infection control nurse on 4/22/26 at 11:05 AM revealed she expected enhanced barrier precautions to be used when changing ostomy bags, G-tubes [gastronomy tubes], and foley catheters. Further interview revealed she was in the process of writing a new policy. 5. Review of the policy titled “Infection Prevention and Control Program” last updated 2018 showed no guidance on Enhanced Barrier precautions.	F0880	Continued from page 8 PPE compliance Appropriate implementation of EBP Hand hygiene compliance Environmental disinfection practices Appropriate identification of residents requiring EBP Immediate corrective action will be provided for any identified noncompliance. Audit results will be reviewed through the QAPI process monthly. Additional monitoring will be implemented as determined necessary by the QAPI committee. Date of Compliance 5/18/26	05/18/2026