STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING 00 B. WING	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILL POND HEALTH CAMPUS	1014 MILL POND LANE GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 27, 28, and March 3, 4, 5, 6, and 7, 2025 Facility number: 004550 Provider number: 155736 AIM number: 200526450 Census Bed Type: SNF/NF: 31 SNF: 19 Total: 50 Census Payor Type: Medicare: 9 Medicaid: 29 Other: 12 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 11, 2025.	F 0000	The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately coded for 2 of 17 residents reviewed for MDS assessments	F 0641	Assessments audited and modified accordingly. In substantial compliance. No POC needed.	03/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Frye	Executive Director	03/22/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	(Residents 27 and 14). Findings include: 1. Resident 27's record was reviewed on 3/4/25 at 1:34 p.m. The profile indicated the resident's diagnoses included, but were not limited to, cerebral infarction affecting the right dominant side (CVA or stroke, that affects the side of the brain which causes weakness or paralysis on the right side of the body). The admission MDS assessment, dated 2/13/25, indicated the resident had severe cognitive deficit and received both an anticoagulant medication (blood thinner-a medication used to prevent and treat blood clots in blood vessels and the heart) and an antiplatelet medication (a medication used to prevent blood clots from forming by stopping platelets from sticking together). A care plan, dated 2/7/25, indicated the resident was at risk for excessive bleeding and bruising related to her medications. The care plan lacked documentation of the specific type of medication received by the resident. A physician's order, dated 2/11/25, indicated to administer a 75 milligram (mg) tablet of clopidogrel (antiplatelet medication) one time a day. Review of the resident's current and historical physician's orders lacked documentation of an anticoagulant medication ever being prescribed. During an interview, on 3/4/25 at 1:49 p.m., the MDS Support indicated she had reviewed the resident's admission medications, and it lacked documentation of any anticoagulant medications. The MDS assessment had been coded incorrectly.			

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	The "CMS (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2024, indicated, "...N0415 High Risk Drug Classes: Use and Indication (continued)...Steps for Assessment: 1. Review the resident's medical record for documenting that any...medications were received by the resident and indications for their use during the 7-day look-back period...Coding Instructions: Code all High Risk medications...Column 1: Check if resident is taking any of the medications...during the 7-day look-back period...Column 2: If column 1 is checked, check if there is an indication noted for all medications in the drug class...." 2. On 3/5/25 at 1:30 p.m., the medical record of Resident 14 was reviewed. The resident was admitted to the facility on 6/20/24. Admitting diagnosis included, but were not limited to, congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs) and cellulitis of right lower limb (a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin). A physician order, dated 6/7/24, indicated cleanse bilateral lower extremities, allow to dry, apply 2 layer wraps: 1st layer Zinc Una boot (a compression bandage made of gauze or cotton that contains zinc oxide paste), then 2nd layer Coban (a non-sterile self-adherent elastic compression wrap that functions like a tape but sticks only to itself), change twice weekly and as needed once a day on Monday, Thursday. A nutrition care plan, dated 6/26/24, indicated resident was malnourished/at risk for malnutrition related to diagnoses, inadequate nutrient/energy			

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	intakes, and/or metabolic demands. Intervention included but not limited to. Skin: incontinence care, wraps bilateral legs, have Roho cushion (a gel cushion for the chair) for long term use due to wounds. An annual Minimum Data Set (MDS) assessment, dated 12/29/24, indicated the resident was cognitively intact and required extensive assistance with daily care needs. Section M-G of the MDS indicated application of non-surgical dressings (with or without topical medications) other than to feet. It was not coded on the MDS. The medical record indicated the resident was receiving non-surgical wraps to both lower legs twice weekly. Section M - H of the MDS, indicated application of ointments/medications other than to feet was coded on the MDS. The medical record lacked documentation of a physician order for application of ointments to bilateral legs. On 3/5/25 at 2:00 p.m., during an interview with the MDS clinical support consultant. She indicated the MDS coordinator coded the MDS as ointment to legs rather than non-surgical dressings, thinking that was the correct coding. On 3/5/2025 at 2:15 p.m., the MDS clinical consultant provided a document titled, "CMS's RAI version 3.0 manual," dated October 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet. Do not code application of non-surgical dressings for pressure ulcers/injuries other than to feet in this item; use M1200E, Pressure ulcer/injury			

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	care...M1200H Application of Ointments/Medications Other than to Feet. Do not code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure ulcer/injury care. This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents). Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions. This category does not include ointments used to treat non-skin conditions (e.g., nitro paste for chest pain, testosterone cream)...." 3.1-31(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to ensure a physician order was obtained for a Tubigrip (a tubular bandage that provides support for sprains, strains, swelling, and more) for 1 of 1 resident reviewed for limited range of motion (Resident 32). Findings include: During the initial pool observation, on 2/28/25 at 10:46 a.m., Resident 32 was sitting up in bed eating breakfast and a dressing was noted on the resident's left arm from her hand to up past her elbow. The resident indicated the wrap had been on her left arm for a while because she banged it on the side rail of her bed, and she was unable to use her left arm normally. Resident 32's record was reviewed on 3/3/25 at 10:18 a.m. The profile indicated the resident's	F 0684	1 What corrective action was taken for the resident affected by the alleged deficient practice. Resident 32 suffered no ill effects from the alleged deficient practice. Hospice residents with preventative skin measures have been reviewed to ensure MD orders are in place as appropriate. 2 What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice? Like residents have the potential to be affected by the alleged deficient practice. Nurses have been educated on obtaining MD orders as appropriate and put in orders as appropriate. 3 What systemic measures or	03/24/2025

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	diagnosis included, but were not limited to, brain mass (a cancerous or noncancerous mass or growth of abnormal cells in the brain), Alzheimer's disease with early onset (when Alzheimer's is diagnosed before the age of 65 years old), and edema, unspecified (swelling caused by excess fluid in tissues or body cavities). A quarterly Minimum Data Set (MDS) assessment, dated 1/12/25, indicated the resident had moderate cognitive impairment and had functional impairment on one side. A care plan, dated 7/8/24, indicated the resident was at risk for skin breakdown; requires assistance with bed mobility, transfers, and toileting. Interventions included, but were not limited to, left arm geri sleeve (long sleeve to help prevent skin shear) and avoid shearing skin during positioning, transferring, and turning. The care plan lacked an intervention indicating the resident had a Tubigrip on left arm. During an interview with a family member, on 3/3/25 at 1:30 p.m., the family member indicated the dressing had been on the resident's left arm for awhile and she thought it was because of the swelling in her left arm and skin tears. A late entry progress note, dated 12/26/24, indicated Resident 32 had a new skin tear to her left arm and had increased swelling in her arm. Steri strips (thin adhesive bandages that help close wounds) applied to the skin tear. A progress note, dated 1/26/35, indicated Resident 32 had received another skin tear to left forearm during care while turning in bed. Left arm was very edematous and the resident had little movement in the arm.		changes are put in place to ensure the alleged deficient practice does not recur. Hospice residents with preventative skin treatments will be reviewed during clinical meetings to ensure MD orders have been obtained as appropriate. As a measure of ongoing compliance, DHS or designee will audit to ensure residents have orders in place as appropriate, audits will consist of 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months 4 How will corrective actions be monitored to ensure alleged deficient practice does not recur: As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	A progress note, dated 2/1/25, indicated Resident 32 had a skin tear to her left upper posterior arm. Resident's arm noted to be very edematous, skin was very frail, and thin due to swelling. Hospice notified and would assess the resident tomorrow. A hospice progress note, dated 2/2/25, indicated Resident 32 had a skin tear to the back of left arm. The resident's record lacked documentation of a physician order for any kind of wrap or dressing/sleeve to resident's left arm. During an interview, on 3/3/25 at 2:21 p.m., the Certified Resident Medication Aide (CRMA) 5 indicated the resident had on a dressing/sleeve due to the skin tears on her left arm. During an interview, on 3/3/25 at 2:22 p.m., Registered Nurse (RN) 6 indicated Resident 32 had skin tears to her left arm and it was swollen, so the dressing/sleeve was used as a preventive measure. During an interview, on 3/4/25 at 9:04 a.m., the Clinical Support Nurse indicated Resident 32 had a Tubigrip on her left arm but was unable to find a physician order for its use. On 3/4/25 at 1:55 p.m., the Clinical Support Nurse provided a document with a revised date of 9/21/17, titled, "Physician - Provider Notification Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...To ensure the resident's physician or practitioner is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provisions of appropriate interventions for care ...1. Resident			

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	assessments for change in condition suspected injury, event of unknown origin or ordered lab and or other diagnostic tests should be completed in a timely manner ...." 3.1-37			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure that a nebulizer (a small machine that turns liquid medicine into a mist that can be inhaled into the lungs) mask was bagged when not in use for 1 of 2 residents reviewed for respiratory care (Resident 19). Findings include: During the initial observation of Resident 19, on 2/28/25 at 9:41 a.m., the resident's nebulizer mask was observed un-bagged and sitting on her bed side table. During a random observation, on 3/4/25 at 9:41 a.m., the resident's nebulizer mask was observed un-bagged and sitting on her bed side table. During a random observation, on 3/5/25 at 9:18 a.m., the resident's nebulizer mask was observed un-bagged and sitting on her bed side table. At the same time the Clinical Support observed the un-bagged mask. Resident 19's record was reviewed on 3/4/25 at 9:47 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atherosclerotic heart disease of native coronary	F 0695	1.What corrective action was taken for the resident affected by the alleged deficient practice? Residents 19 was not affected by alleged deficient practice. Residents with nebulizers were audited to ensure nebulizer masks were placed in a storage bag when not in use. Resident's nebulizer mask was used 1 time and hadn't been used since. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice? Like residents have the potential to be affected by the alleged deficiency. The campus nursing staff have been educated on placing nebulizer masks in storage bags when not in use. 3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur. Resident's with nebulizer masks in use will be observed for a plastic storage bag when not in use during rounds. As a measure of ongoing compliance, IP Nurse	03/24/2025

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	artery (a buildup of fats, cholesterol and other substances in and on the walls of the heart arteries that reduces blood flow) and stage 4 chronic kidney disease (a condition where the kidneys are severely damaged and are not filtering waste well). A quarterly Minimum Data Set (MDS) assessment, dated 12/6/24, indicated the resident had no cognitive deficit. The assessment lacked documentation of any shortness of breath (SOB). Review of the resident's care plans lacked documentation of any respiratory concerns, or the use of medications related to respiratory concerns. A physician's order, dated 2/19/25, indicated to administer one 0.5 milligram (mg)-3 mg (2.5 mg base)/3 milliliter (ml) vial of ipratropium-albuterol solution (a medication which works by opening the airways and reducing inflammation in the lungs to help the patient breathe) for nebulization every 4 hours as needed. Review of the February 2025 medication administration record (MAR) indicated the resident had been administered one nebulizer treatment on, 2/20/25 at 2:36 p.m., for congestion. A Nurse Practitioner (a registered nurse with advanced training to diagnose and treat patients) note, dated 2/19/25 at 10:15 a.m., indicated the resident had been seen for increased weakness and fatigue. She had the flu the other week. No SOB was documented, but she had a productive cough (a cough that brings up mucous or phlegm [thick substance secreted by the mucous membranes of the respiratory passages]). Interventions included, but were not limited to,		or designee will audit 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. ="" p="">	

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	Duonebs (medication that combines ipratropium and albuterol to treat chronic obstructive pulmonary disease) every 4 hours as needed. During an interview, on 3/5/25 at 9:18 a.m., the Clinical Support indicated the resident's nebulizer mask should have been bagged and dated for storage when not in use. On 3/5/25 at 9:40 a.m., the Clinical Support provided a document, with a review date of 12/16/24, titled, "Respiratory Equipment," and indicated it was the policy currently being used by the facility. The policy indicated, "...SOP Details...3. Medication Nebulizers...f. Store...in plastic bag, marked with date and resident's name, between uses...." 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure a recommendation made by the Pharmacists was addressed in a timely manner for 1 of 5 residents reviewed for unnecessary medications (Resident 22). Findings include: Resident 22's record was reviewed on 2/28/25 at 2:10 p.m. The profile indicated the resident's diagnoses included, but were not limited to, hypertensive heart and chronic kidney disease with heart failure (conditions that can lead to heart failure that linked to high blood pressure) and stage 5 chronic kidney disease (a condition when the kidneys are severely damaged and have	F 0757	1. What corrective action was taken for the resident affected by the alleged deficient practice. Residents 22 suffered no ill effects from the alleged deficient practice. Pharmacy recommendations are reviewed by MD timely. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the deficient practice and through clinical leader education to ensure pharmacy recommendations are addressed in a timely manner the	03/24/2025

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	stopped doing their job of filtering waste from the blood). The profile lacked documentation of a diagnosis of hypotension (low blood pressure). A quarterly Minimum Data Set (MDS) assessment, dated 1/26/25, indicated the resident had no cognitive deficit and received dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are not functioning properly). A care plan, dated 4/17/24, indicated the resident was non-compliant with physician orders, which included, but were not limited to, not taking medications. The care plan lacked documentation of the resident having hypotension. A pharmacy recommendation, dated 4/29/24, indicated to consider adjusting the dose times and hold parameters for the resident's Midodrine (anti-hypotensive medication) 5 milligrams (mg) three times a day (TID). The statement, "Leave alone," had been written on the bottom of the document with the date of 5/2/24. The recommendation lacked any physician documentation to justify the statement. During an interview, on 3/3/25 at 1:58 p.m., the Clinical Support indicated she could not find documentation for a rationale for the statement "leave alone." A pharmacy recommendation, dated 6/24/24, indicated to avoid giving the evening dose of Midodrine 5 mg TID after evening meal or within 4 hours of bedtime to prevent supine hypertension (HTN-high blood pressure when lying down). The document indicated the task had been completed. Review of the June 24 medication administration record (MAR) indicated the medication had been		campus will ensure MD includes documentation of review with rationale given for declinations and addressed timely. 3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. Clinical leaders will review pharmacy recommendations during CCM for timely follow up by MD. As a measure of ongoing compliance, director of health services (DHS) or designee will audit pharmacy recommendations with timely follow up weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. ="" p="">	

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	given between 6:00 p.m., and 10:00 p.m. The MAR lacked documentation of the specific time the medication had been administered. A pharmacy recommendation, dated 7/22/24, indicated to avoid giving evening dose of Midodrine 5 mg TID after evening meal or within 4 hours of bedtime to prevent supine HTN. The document indicated the task had been completed. Review of the July 2024 MAR indicated the evening dosage times had been changed to 4:00 p.m., to 6:00 p.m. During an interview, on 3/3/25 at 2:26 p.m., the Executive Director (ED) indicated the expectation was that pharmacy recommendations would be addressed within the time prior to the next pharmacy medication regimen review date. During an interview, on 3/3/25 at 2:28 p.m., the Clinical Support indicated she was not able to locate a specific policy related to the physician addressing the pharmacy recommendations. The facility would follow the State and Federal regulations. It was expected that all pharmacy recommendations would be addressed timely by the physician and the facility. 3.1-48(a)(4) 3.1-48(a)(6)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure proper labeling of prepared food, and the facility failed to dispose of expired food for 1 of 2 kitchen observations. This had the potential to affect 50 of 50 residents who received food from the kitchen.	F 0812	1. What corrective action was taken for the resident affected by the alleged deficient practice. No residents suffered ill effects from the alleged deficient practice. Kitchen staff were educated at	03/24/2025

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	155736	A. BUILDING 00 B. WING	03/07/2025

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	Findings include: 1. During an initial kitchen tour with the Business Office Manager (the Dietary Manager was unavailable), on 2/27/25 at 10:27 a.m., a plastic container of prepared chicken salad was observed on a shelf in the walk-in refrigerator. There was no label or use by date on the container of chicken salad. The business office manager was not aware of when the chicken salad was prepared and how long it had been in the walk-in refrigerator. She indicated the chicken salad would have to be discarded since it did not contain a label with a use by date on it. During an interview, on 2/27/25 at 10:30 a.m., Dietary Services Assistant 8 indicated prepared food was good for 4 days and then should be discarded. 2. In the refrigerator, on 2/27/25 at 10:32 a.m., there was a plastic container of prepared poppy seed dressing with a use by date of 2/24/25, container of prepared lemonade with a use by date of 2/24/25, container of prepared apple raspberry juice with a use by date of 2/24/25, container of prepared blue Gatorade with a use by date of 2/24/25, and an opened container of thickened liquid with a use by date of 2/24/25. The business office manager indicated the juices and salad dressing should have been discarded. During an interview, on 3/4/25 at 9:26 a.m., the Dietary Manager indicated prepared food items were good for 3 days and then should be discarded. The food items should contain a label with a use by date and then should be discarded after that date.		time of observation to ensure prepared foods have the appropriate label and expired foods were disposed of. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice? All residents have the potential to be affected. Kitchen staff have been educated on labeling prepared foods per policy and to dispose of expired foods per policy. 3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur. As a measure of ongoing compliance, executive director (ED) or director of food services (DFS) or designee will complete 5 kitchen observations to ensure prepared foods have appropriate label and expired foods are disposed of appropriately weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur. For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at	

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	On 2/27/25 at 12:30 p.m., the Clinical Support Nurse, provided a document with a review date of January 2025, titled, "Leftover Food Storage", and indicated it was the policy currently being used by the facility. The policy indicated, " ...To enforce proper storage and usage of leftover food and ultimately avoid microbial foodborne illness ...2. Date all food and use or discard within three days ...." 3.1-21(i)(3)		least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is achieved. ="" p=""> ="" p=""> ="" p="">	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: February 27, 28, and March 3, 4, 5, 6, and 7, 2025 Facility number: 004550 Residential Census: 32 Mill Pond Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on March 11, 2025.	R 0000	The submission of this plan of correction does not indicate an admission by Mill Pond Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Mill Pond Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility	

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			respectfully requests from the department a desk review for substantial compliance.	