STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435009	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MILBANK	1103 SOUTH SECOND STREET MILBANK, SD 57252

(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
F 000	INITIAL COMMENTS A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/7/24 through 10/8/24. Areas included quality of care/treatment. Avantara Milbank was found not in compliance with the following requirements: F609, F610, and F692.	F 000		
F 609 SS=G	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609	1. Resident number 1 discharged on 9/30/2024. Identified concerns were reported to SDDOH on 10/08/2024. All residents have the potential for be affected. All residents were reviewed and any resident able to participate in interviews were interviewed by managerial staff regarding whether they had personally been abused or neglected or if they had witnessed abuse or neglect of any other resident whether by staff or other residents. No further allegations or concerns identified during these interviews. 2. Administrator, DON, and interdisciplinary team in collaboration with the medical director reviewed the current Abuse and Neglect policy on 10/29/2024 No changes were made. All staff were educated on: The Abuse and Neglect Policy; See something, say something; their role and responsibility to ensure residents are free from abuse, neglect, and exploitation; and reporting injuries of unknown origin. Education and training provided by Regional Nurse consultant to all team members responsible for investigating, documenting, and reporting instances of potential abuse, neglect, and exploitation.	11/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
R. Pulse

TITLE
Administrator

(X6) DATE
10/25/2024

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.

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F 609	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on a 10/7/24 complaint intake report review, interview, record review, and policy review. The provider failed to ensure a thorough investigation was completed to rule out if abuse and neglect occurred for one of one sampled resident (1) who had bruising and swelling of unknown origin on the left knee, right wrist, and penis and to report the incidents to the South Dakota Department of Health. Findings include. 1. Review of the 10/7/24 South Dakota Department of Health (SD DOH) complaint intake revealed: * On 8/21/24, staff notified the family that resident 1 had fallen in the bathroom and had a small skin tear. * On 9/22/24, staff notified the family that resident 1's knee is swollen, and it was unknown what had happened. * On 9/29/24, staff was notified by family that resident 1's right wrist was swollen. Nursing was unaware of the swelling, assessed the wrist, and notified the physician. The staff thought the swelling may have been caused by the sling during a transfer. It was also reported that resident 1 had a small bruise on his penis. Review of resident 1's 9/30/24 hospitalization medical records revealed: * Discharge plan had noted "Additionally he [resident 1] fell a few weeks ago and hasn't been using his right hand. Nobody has evaluated his right hand and wrist in the clinic or emergency department [ED]". * Resident one was diagnosed with a right scapholunate ligament tear (tissue that connects	F 609	Additional education to be provided to the Administrator and DON on reporting and investigation of allegations Education will occur no later than November 2, 2024, and those staff not in attendance at education sessions due to vacation, sick leave, or PRN work status will be educated prior to their first shift worked. 3. The Administrator or designee will conduct walking rounds with resident interviews on 10 random residents weekly for 4 weeks and then 10 random residents monthly for 2 months. The Administrator or designee will also complete interviews with 5 random employees weekly for 1 month and then 3 random employees weekly for 2 months to review employee's knowledge of the abuse and neglect policies, reporting injuries of unknown origin and whether employees have witnessed or heard of anything they would consider to be abuse or neglect. The DON or designee will review progress notes each day for the previous day (on Monday for Friday through Sunday notes) to ensure there is not any injury of unknown origin that has not been reported to the DOH and investigated. This audit will be daily (Monday through Friday) for 1 month and then 1 time weekly for two months. Results of these audits will be discussed by the IDT team and the Medical Director at the monthly QAPI meeting to determine if additional audits must be completed or revised.	

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F 609	Continued From page 2 the scaphoid and lunate bones in the wrist and most common cause is a fall on the wrist). * The assessment and plan on 10/1/24 indicated a right scapholunate ligament tear that required a splint. The resident was not a candidate for surgery. 2. Interview on 10/8/24 at 11:30 a.m. with certified nurse aide (CNA) H revealed: * On or around 9/27/24 she reported to the nursing staff an incident of possible abuse regarding two other CNAs. She reported that the CNA came out of resident 1's room and had stated, "that motherfucker". When CNA H had asked the other CNA what had happened, the CNA stated that resident 1 had started fighting with them during a transfer so instead of using a total body mechanical lift as it was care planned, they decided to use a two-assist (two staff) transfer to get him on the toilet. CNA H reported the incident to an unidentified nurse. She was unsure if it was investigated. * On 9/29/24, she reported to the nursing staff a sore on resident 1's scrotum and a bruise on his penis. CNA H felt that the bruising may have been caused by the two-assist transfer a few days prior. * She was not sure if the bruising was investigated. No one had followed up with her regarding the incident. 3. Record review of nursing progress notes for resident 1 revealed: *A 9/15/24 nursing progress note indicated that the resident was complaining of left knee pain. Evaluation of the knee indicated that the left knee appeared swollen and tender to the touch. The resident had denied any injury that he could remember. A CNA had reported to the nurse that	F 609		

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F 609	Continued From page 3 transferring the resident was difficult that day. It was noted that his left knee was wrapped, elevated, and ice was applied. An appointment would be considered for evaluation the next day. * A 9/29/24 nursing progress note indicated that resident 1's family was visiting during supper and had brought to the attention of the staff that resident 1's right wrist was swollen. It was noted that there were no reports of falls that day and the cause of the swelling was unclear. The physician was notified, and staff were instructed to apply ice to the area and to monitor overnight. If the condition had worsened, an x-ray would have been considered. 4. Interview on 10/8/24 at 12:45 p.m. through 1:00 p.m. with CNA K and director of nursing (DON) B revealed: *If CNA K had witnessed an incident of abuse or neglect, she would report it to the nurse on duty. * DON B stated that all reports to the nurses regarding abuse and neglect would have been taken very seriously and the administrator would have been notified immediately. Interview on 10/8/24 at 1:15 p.m. with administrator A revealed: * She had not been notified of the allegations of abuse regarding resident 1. * She was not able to provide documentation of any investigations to rule out abuse and neglect regarding the injuries of unknown origin related to resident 1's left knee and right wrist. * She stated that it was determined that the localized swelling in resident 1's left knee and right wrist was due to the resident 1's disease process. 5. Review of the SD DOH facility incident	F 609		

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F 609	Continued From page 4 reporting database revealed: * No report was made regarding staff reporting to family that resident 1 had fallen on or around 8/21/24. * No report was made regarding the resident's swollen left knee and the cause was undetermined on 9/22/24. * No report was made regarding the report to staff of resident 1's swollen wrist and the cause was noted to be unclear. * No report was made regarding the bruise on resident 1's penis that was identified on 9/29/24. 6. Review of the provider's 7/31/24 Incident reporting policy revealed: * The provider would report any serious injury sustained by a resident that was not an expected outcome of the disease process would have been reported. * An incident that does not result in serious injury will not be reported. * The policy defined that "physical harm" did not include skin tear or bruise or something that could be covered with a band-aid. But that physical harm included a fracture or blood flow not stopped by a band- aid or hospital treatment that involves more than diagnostic evaluation only with subsequent finding of no injury do not need to be reported. Review of the provider's 7/12/24 abuse and neglect policy revealed: * Injury of unknown origin were injuries that met all three criteria according to the SOM [State Operations Manual]: - The source of injury was not observed by any person. - The source of injury could not be explained by the resident.	F 609		

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F 609	Continued From page 5 - The injury was suspicious because of the extent of the injury or the location of the injury (the injury was in an area not generally vulnerable to trauma) or the number of injuries at one particular point in time or the incident of injuries over time. * Examples of possible reportable injuries that may fall under the definition of injuries of unknown origin included: - Unobserved/unexplained fractures, sprains, or dislocations. - Unobserved/unexplained scratches or bruises found in suspicious locations such as the head, neck, upper chest, and back. - Unobserved/unexplained swelling that was not linked to a medical condition. - Unobserved/unexplained bruising or other injuries in the genital area, inner thighs, or breasts. - Unobserved/unexplained injury requiring transfer to the hospital for examination and/or treatment. - Any injury that was explained and appeared to be a result of abuse must be reported. * If abuse was suspected the provider would have: - Took immediate steps to assure the protection of the residents. - Notified the appropriate/designated authorities or organization. - Conducted a careful and deliberate investigation centering on facts, observations, and statements from the alleged victim and witnesses. - Notified authorities if the abuse was also a case of a crime. - Report investigation findings to the state health department.	F 609		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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F 610	Continued From page 6 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on a 10/7/24 complaint intake report review, interview, record review, and policy review. The provider failed to ensure a thorough investigation was completed to rule out if abuse and neglect occurred for one of one sampled resident (1) who had bruising and swelling of unknown origin on the left knee, right wrist, and penis and to report the incidents to the South Dakota Department of Health. Findings include. 1. Review of the 10/7/24 South Dakota Department of Health (SD DOH) complaint intake revealed: * On 8/21/24, staff notified the family that resident 1 had fallen in the bathroom and had a small skin tear. * On 9/22/24, staff notified the family that resident 1's knee is swollen, and it was unknown what had	F 610	1. Resident #1 no longer resides at facility. Identified concerns were reported to the DOH on 10/8/24 with subsequent investigation. All Residents have the potential to be affected. All residents were reviewed and any resident able to participate in interviews were interviewed by managerial staff regarding whether they had personally been abused or neglected or if they had witnessed abuse or neglect of any other resident whether by staff or other residents. No further allegations or concerns identified during these interviews. 2. Administrator, DON, and interdisciplinary team in collaboration with the medical director reviewed the current Abuse and Neglect policy on 10/29/2024 No changes were made. All staff were educated on: The Abuse and Neglect Policy; See something, say something; their role and responsibility to ensure residents are free from abuse, neglect and exploitation; and reporting injuries of unknown origin. Education and training provided by Regional Nurse consultant to all team members responsible for investigating, documenting, and reporting instances of potential abuse, neglect and exploitation. Additional education to be provided to the Administrator and DON on reporting and investigation of allegations. Education will occur no later than November 2, 2024, and those staff not in attendance at education sessions due to vacation, sick leave, or PRN work status will be educated prior to their first shift worked.	11/02/2024

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F 610	Continued From page 7 happened. * On 9/29/24, staff was notified by family that resident 1's right wrist was swollen. Nursing was unaware of the swelling, assessed the wrist, and notified the physician. The staff thought the swelling may have been caused by the sling during a transfer. It was also reported that resident 1 had a small bruise on his penis. Review of resident 1's 9/30/24 hospitalization medical records revealed: * Discharge plan had noted "Additionally he [resident 1] fell a few weeks ago and hasn't been using his right hand. Nobody has evaluated his right hand and wrist in the clinic or emergency department [ED]". * Resident one was diagnosed with a right scapholunate ligament tear (tissue that connects the scaphoid and lunate bones in the wrist and most common cause is a fall on the wrist). * The assessment and plan on 10/1/24 indicated a right scapholunate ligament tear that required a splint. The resident was not a candidate for surgery. 2. Interview on 10/8/24 at 11:30 a.m. with certified nurse aide (CNA) H revealed: * On or around 9/27/24 she reported to the nursing staff an incident of possible abuse regarding two other CNAs. She reported that the CNA came out of resident 1's room and had stated, "that motherfucker". When CNA H had asked the other CNA what had happened, the CNA stated that resident 1 had started fighting with them during a transfer so instead of using a total body mechanical lift as it was care planned, they decided to use a two-assist (two staff) transfer to get him on the toilet. CNA H reported the incident to an unidentified nurse. She was	F 610	3. The Administrator or designee will conduct walking rounds with resident interviews on 10 random residents weekly for 4 weeks and then 10 random residents monthly for 2 months. The Administrator or designee will also complete interviews with 5 random employees weekly for 1 month and then 3 random employees weekly for 2 months to review employee's knowledge of the abuse and neglect policies, reporting injuries of unknown origin and whether employees have witnessed or heard of anything they would consider to be abuse or neglect. The DON or designee will review progress notes each day for the previous day (on Monday for Friday through Sunday notes) to ensure there is not any injury of unknown origin that has not been reported to the DOH and investigated. This audit will be daily (Monday through Friday) for 1 month and then 1 time weekly for two months. Results of these audits will be discussed by the IDT team and the Medical Director at the monthly QAPI meeting to determine if additional audits must be completed or revised.	

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F 610	Continued From page 8 unsure if it was investigated. * On 9/29/24, she reported to the nursing staff a sore on resident 1's scrotum and a bruise on his penis. CNA H felt that the bruising may have been caused by the two-assist transfer a few days prior. * She was not sure if the bruising was investigated. No one had followed up with her regarding the incident. 3. Record review of nursing progress notes for resident 1 revealed: *A 9/15/24 nursing progress note indicated that the resident was complaining of left knee pain. Evaluation of the knee indicated that the left knee appeared swollen and tender to the touch. The resident had denied any injury that he could remember. A CNA had reported to the nurse that transferring the resident was difficult that day. It was noted that his left knee was wrapped, elevated, and ice was applied. An appointment would be considered for evaluation the next day. * A 9/29/24 nursing progress note indicated that resident 1's family was visiting during supper and had brought to the attention of the staff that resident 1's right wrist was swollen. It was noted that there were no reports of falls that day and the cause of the swelling was unclear. The physician was notified, and staff were instructed to apply ice to the area and to monitor overnight. If the condition had worsened, an x-ray would have been considered. 4. Interview on 10/8/24 at 12:45 p.m. through 1:00 p.m. with CNA K and director of nursing (DON) B revealed: *If CNA K had witnessed an incident of abuse or neglect, she would report it to the nurse on duty. * DON B stated that all reports to the nurses	F 610		

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F 610	Continued From page 9	F 610		

regarding abuse and neglect would have been taken very seriously and the administrator would have been notified immediately.

Interview on 10/8/24 at 1:15 p.m. with administrator A revealed:
* She had not been notified of the allegations of abuse regarding resident 1.
* She was not able to provide documentation of any investigations to rule out abuse and neglect regarding the injuries of unknown origin related to resident 1's left knee and right wrist.
* She stated that it was determined that the localized swelling in resident 1's left knee and right wrist was due to the resident 1's disease process.

5. Review of the SD DOH facility incident reporting database revealed:
* No report was made regarding staff reporting to family that resident 1 had fallen on or around 8/21/24.
* No report was made regarding the resident's swollen left knee and the cause was undetermined on 9/22/24.
* No report was made regarding the report to staff of resident 1's swollen wrist and the cause was noted to be unclear.
* No report was made regarding the bruise on resident 1's penis that was identified on 9/29/24.

6. Review of the provider's 7/31/24 Incident reporting policy revealed:
* The provider would report any serious injury sustained by a resident that was not an expected outcome of the disease process would have been reported.
* An incident that does not result in serious injury will not be reported.

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F 610	Continued From page 10 * The policy defined that "physical harm" did not include skin tear or bruise or something that could be covered with a band-aid. But that physical harm included a fracture or blood flow not stopped by a band- aid or hospital treatment that involves more than diagnostic evaluation only with subsequent finding of no injury do not need to be reported. Review of the provider's 7/12/24 abuse and neglect policy revealed: * Injury of unknown origin were injuries that met all three criteria according to the SOM [State Operations Manual]: - The source of injury was not observed by any person. - The source of injury could not be explained by the resident. - The injury was suspicious because of the extent of the injury or the location of the injury (the injury was in an area not generally vulnerable to trauma) or the number of injuries at one particular point in time or the incident of injuries over time. * Examples of possible reportable injuries that may fall under the definition of injuries of unknown origin included: - Unobserved/unexplained fractures, sprains, or dislocations. - Unobserved/unexplained scratches or bruises found in suspicious locations such as the head, neck, upper chest, and back. - Unobserved/unexplained swelling that was not linked to a medical condition. - Unobserved/unexplained bruising or other injuries in the genital area, inner thighs, or breasts. - Unobserved/unexplained injury requiring transfer to the hospital for examination and/or treatment.	F 610		

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F 610	Continued From page 11 - Any injury that was explained and appeared to be a result of abuse must be reported. * If abuse was suspected the provider would have: - Took immediate steps to assure the protection of the residents. - Notified the appropriate/designated authorities or organization. - Conducted a careful and deliberate investigation centering on facts, observations, and statements from the alleged victim and witnesses. - Notified authorities if the abuse was also a case of a crime. - Report investigation findings to the state health department.	F 610		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692	1. Resident number 1 was discharged on 9/30/2024 and no corrective action could occur. Resident numbers 2, 4, 5, and 6 have water pitchers in room. Resident 3 has thickened liquids available in room and accessible on the unit for staff to provide fluids. All residents are at risk for reduced hydration. 2. Administrator, DON, dietary manager, RD, and interdisciplinary team in collaboration with the medical director reviewed the current Hydration policy on 10/24/2024 and no changes were made. The DON or designee will provide education to all staff who are responsible for hydration assistance on the following: Documentation expectations, responsibilities of their role, and hydration pass duties. Education will occur no later than November 2, 2024, and those staff not in attendance at education sessions due to vacation, sick leave, or PRN work status will be educated prior to their first shift worked.	11/02/2024

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	435009	A. BUILDING _____ B. WING _____	C 10/08/2024

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F 692	Continued From page 12 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on complaint intake report review, record review, observation, interview, and policy review. The provider failed to ensure adequate fluid intake, monitoring, and interventions for 6 of 6 sampled residents [1, 2, 3, 4, 5, & 6] resulting in dehydration and hospitalization for one of six sampled residents [1]. Findings include: 1. Review of the 10/7/24 South Dakota Department of Health (SD DOH) complaint intake report revealed: *On 7/29/24, it was observed by resident 1's family member that he was having difficulty eating and was asking for more water. He had already had his liquid limitation for supper. Resident 1's family member asked for additional fluids for resident 1 and was denied additional fluids due to resident's fluid restriction. *On 8/29/24, it was observed by a family member that resident 1's water pitcher was out of reach for the resident, it was unmarked and sitting next to his roommate's urinal. The straw wrapper was still on the straw that was placed in the water pitcher. *On 9/30/24, Resident 1's family requested reports on resident 1's vital signs, weights, and intake and output records. The provider was unable to locate the intake and output in the records. Review of resident 1's 9/30/24 hospitalization medical records revealed: * Resident was hospitalized on 9/30/24 * History and physical on 9/30/24 reported weakness that was multifactorial due to acute dehydration and malnutrition.	F 692	3. The DON or designee will conduct audits of 10 random resident rooms 3 days per week at various times to ensure the resident has water and water pitcher is within resident's reach. Audits will be weekly for 4 weeks and then monthly for 2 months. Additionally, the DON or designee will audit 5 resident charts to ensure fluid intake is documented. Audits will be weekly for 4 weeks and then monthly for 2 months. Results of these audits will be discussed by the IDT team and the Medical Director at the monthly QAPI meeting to determine if additional audits must be completed or revised.	

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F 692	Continued From page 13 * Resident had drank three liters of fluid on the day of admission to the hospital. * Discharge plan on 9/30/24 reported dehydration and weakness. * Laboratory findings included: - Potassium was low at 3.4. - BUN (blood urea nitrogen) was high at 27. - Albumin was low at 3.2 and is an indicator of poor nutrition. 2. Observation on 10/7/24 at 11:21 a.m. revealed: * Resident 2's water pitcher was out of reach. * Resident 3 did not have a water pitcher. * Residents 4 and 5 both had a full water pitcher sitting on their nightstands. The pitchers were not cold and there was no visible ice in the water. 3. Interview on 10/7/24 at 1:15 p.m. with dietary aide I revealed: * She would document the resident's fluid intake on the daily nutrition intake form and enter it into the residents Electronic Medical Record (EMR). * The daily fluid intake forms would have been filed at the nurse's station. Interview on 10/7/24 at 1:30 p.m. with certified nurse aide (CNA) H revealed: *Resident 3 should have had a water pitcher and should have been offered water between meals and during care. *Residents who were to have their liquids thickened would not normally have fluids offered to them between meals. Interview and observation on 10/7/24 at 2:00 p.m. with CNA E revealed: * She had been employed with the provider for 45 years. * Resident 3 required thickened liquids and	F 692		

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F 692	Continued From page 14 residents with thickened liquids would sometimes not have water available at their bedside. * There would have been thickened liquids in the fridge to offer resident 3. * There was no thickened liquid in the fridge where CNA E stated it would be. * She thought resident 3 should have had water or liquids offered to her during resident checks and when providing her care. * Resident 3 would need assistance to drink and could not communicate her needs to staff. Interview on 10/7/24 at 2:10 p.m. with CNA F revealed: * The resident's water pitchers were filled with water and ice twice during the day shift. * It was not in her normal procedure to encourage residents to drink water between meals. Interview on 10/7/24 at 3:30 p.m. with Administrator A revealed: * Resident 1 was on a 2000 milliliter (mL) a day fluid restriction related to heart failure. * Dietary staff were to provide Resident 1 with 960 mL per day. * Nursing staff were to provide Resident 1 with 1040 mL per day. * Resident 1's fluid intake should have been documented in two places in the resident's EMR. * Administrator A stated that Resident 1's EMR fluid intake report was not an accurate account of the resident's actual fluid intake. * There was no process in place to accurately document resident's fluid intakes. Interview on 10/7/24 at 4:00 p.m. with registered nurse (RN) G revealed: * If a resident was on a fluid restriction, the CNAs would have given him the fluid intake report at the	F 692		

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F 692	Continued From page 15 end of the shift. He would have noted the amount left in the resident's water pitcher and then documented in the treatment administration record (TAR). Interview on 10/8/24 at 9:00 a.m. with dietary aide J revealed: * She would document the resident's fluid intake on the daily nutrition intake form and enter it into the resident's EMR. * If she noticed a resident had not drunk any fluids all day, she would only record this in the EMR but not report it to the nursing staff because she is not part of the medical staff. Interview 10/8/24 at 9:44 a.m. with director of nursing (DON) B and (DON) D revealed: * On 10/7/24 Resident 5 had not consumed any fluids for breakfast, lunch, or supper. * On 10/7/24 Resident 6 had not consumed any fluids for breakfast, lunch, or supper. * The resident's recorded fluid intakes from the daily nutrition intake form that would have been entered into the EMR would have not alerted nursing staff if a resident was not drinking fluids. 4. Review of residents 1's 7/17/24 care plan revealed: * He had impaired skin integrity. * Interventions included: - Staff were to encourage good nutrition and hydration. Review of Resident 2's 8/28/24 care plan revealed: * Resident 2 was "at risk for alteration in nutritional status related to: recent admission, poor PO [oral] intake and a skin wound." * She required assistance with [ADLs] activities of	F 692		

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F 692	Continued From page 16 daily living. This included eating. * She had impaired skin integrity. * Interventions included: - Staff were to encourage good nutrition and hydration in order to promote healthier skin. - Staff were to monitor for signs and symptoms of dehydration and weight loss. - She would sit at the assisted table for meals for eating assistance. Review of Resident 3's 5/1/24 care plan revealed: * She was at risk for impaired skin integrity. * She was at risk for alteration in nutritional status. * Interventions included: - Staff were to offer extra fluids. - Staff were to encourage good nutrition and hydration in order to promote healthier skin. - Staff were to encourage fluid intake to help liquefy secretions. - She was dependent on staff for all care needs. - She was dependent on staff for assistance with meals. Review of resident 4's 7/18/24 care plan revealed: * He had required assistance with ADLs including eating. * He was at risk for altered skin integrity. * Interventions included: - He was dependent on staff for eating and drinking. - Staff were to encourage good nutrition and hydration. Review of resident 6's 7/18/24 care plan revealed: * He had the potential for impaired skin integrity. * He was at risk for dehydration due to use of a	F 692		

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F 692	Continued From page 17 diuretic. * Resident took Lasix related to edema (fluid retention). * Interventions included: -Staff were to assess for signs of dehydration. -Staff were to encourage good nutrition and hydration in order to promote healthier skin. -Staff were to monitor for any sign and symptoms of fluid deficit. Review of the provider's 7/30/24 Hydration policy revealed: * The purpose of the policy was to ensure that residents are adequately hydrated. * Staff were to encourage fluid intake unless contraindicated. * Staff were to ensure that during meals, residents have fluids with their food. * Staff were to ensure that during meals, there is an available source of hydration when a resident asks for it. * Staff were to ensure that residents who are able to drink and pour themselves water have water pitchers *Those residents with physician orders for strict intake and output (I & O) will have their intake and output strictly measured and recorded in their I & O record.	F 692		