STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Broadmeadow	500 South Broad Street Middletown, DE 19709

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40264 Based on interview, record review and review of other facility documents, it was determined that for one (R66) out of six residents reviewed for abuse, the facility failed to ensure that that R66 was free from resident to resident physical abuse by R78. Findings include: A review of the facility's abuse policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, revised January 12, 2023, indicated, . It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse . Cross refer F657 A review of R78's clinical record revealed the following: 2/22/23 - R78 was admitted to the facility with diagnoses including but not limited to dementia, depression, and anxiety disorder. 3/6/23 - R78 was care planned for impaired cognition and interventions included to cue, reorient and supervise as needed and to .monitor/document/report when necessary any changes in cognitive function, . changes in: .difficulty expressing self, difficulty understanding others . 4/25/23 - R78 was care planned for potential physically aggressive behaviors as evidenced by yelling, kicking, hitting, slapping, striking out, etc. Interventions included: allowing R78 10 - 15 minutes to calm down and then reapproach, redirecting when visibly irritated and speaking in a calm voice to keep R78 calm and feel non threatened. 1/25/24 - A review of R66's quarterly MDS assessment revealed that R66's cognition was moderately intact and had used a manual wheelchair for mobility during the review period. 2/15/24 - R78's annual MDS assessment revealed that R78's cognition was moderately impaired, had physical and verbal behaviors occurring 1 to 3 days and had used a manual wheelchair for mobility during the review period. 3/25/24 9:37 PM - A facility incident report submitted to the State Agency documented that on 3/25/24 at 6:20 PM, .After dinner resident [R66] reported to the charge nurse that another resident [R78] hit her on the face and found redness on the left eyelid. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/2/24 - A facility 5 day follow up summary submitted to the State Agency documented, Were changes made to Care Plan? Yes . Medication changes; Q 1 hr (hour) safety check. 1/16/25 4:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). The facility failed to ensure that R66 was free from physical abuse by R78 when R66's face was hit by R78 on 3/24/24. 1/22/25 at 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40264 Based on record review and interview, it was determined that for one (R78) out of twenty seven sampled residents, the facility failed to ensure that R78's comprehensive care plan was reviewed and revised based on preferences and needs of the resident and in response to current interventions. Findings include: Cross refer F600 R78's clinical record revealed: 4/25/23 - R78 was care planned for potential physically aggressive behaviors as evidenced by yelling, kicking, hitting, slapping, striking out, etc. Interventions included: - allowing R78 10-15 minutes to calm down then reapproach, - redirecting when visibly irritated and, - speaking in a calm voice to keep R78 calm, and feel non threatened. 3/25/24 9:37 PM - A facility incident report submitted to the State Agency documented that R78 hit R66 on the face. 4/2/24 - A facility 5 day follow up summary documented, Were changes made to Care Plan? Yes . Medication changes; Q 1 hr (hour) safety check. 1/16/23 11:05 AM - A review of R78's potential for physical aggression care plan revealed that it was not revised to include the new safety check interventions. 1/16/2 1:46 PM - In an interview, E2 (DON) confirmed that R78's care plan for physical aggression was not revised and updated after the 3/25/24 resident - to - resident physical altercation between R78 and R66. 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 48409 Based on record review, observation and interview, it was determined that for one (R101) out of three sampled residents, the facility failed to ensure that care was provided to support R101's hearing loss. Findings include: Review of R101's clinical records revealed: 9/17/24 - R101 was admitted to the facility with diagnoses including stroke, cognitive communication deficit and major depressive disorder. 9/23/24 - R101's admission MDS documented, Minimum hearing difficulty. 9/30/24 - R101's admission BIMS documented a score of 15, indicating a cognitively intact status. 9/30/24 - R101's communication care plan documented, .[R101] has a communication problem r/t [related to] hearing deficit The interventions included, Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off tv/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed . 11/16/24 - R101 clinical records documented, Seen by audiologist - recommendation for debrox [ear wax softening medication] 5 drops to both ears x 7 days. 12/18/24 - R101's clinical records documented, .Seen by audiologist - [wax] was removed from ears. 12/19/24 - R101's quarterly MDS documented a BIMS score of 14, indicating a cognitively intact status. 12/19/24 - R101's clinical document titled, Cadia Social Services Assessment documented, [E101] declined dentist, hygienist, hearing, sight this quarter R101's clinical records documented eye doctor and audiologist visits in November and December 2024. 12/24/24 - R101's quarterly MDS documented, Moderate hearing difficulty follow up with audiology. 1/14/25 9:00 AM - During an interview the Surveyor attempted to speak with R101, but she pointed to both of her ears and shook her head. The surveyor wrote the questions on paper and asked R101 if she could hear what was being said. R101 wrote, No and pointed to her right ear and, little for her left hear. The surveyor further inquired if R101 had any tools e.g. white board or writing paper to communicate with staff, R101 shook her head from side to side, and wrote No. I asked for hearing aids but did not hear back. I would really like to hear a little better. R101's room lacked evidence of writing paper, white board, or any other type of communication devices. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/15/25 9:10 AM - The Surveyor communicated with R101 using pen and paper. R101 wrote that she was not offered any type of communication tools and denied refusal of hearing aids or medical appointments. R101's room lacked evidence of any type of communication devices. 1/17/25 11:10 AM - During an interview R4 (UM) stated, [R101] was offered hearing aids but she refused. She would say she wants them but refuses when offered. 1/21/25 8:07 AM - R101 was observed in her room, no evidence of communication tools or devices were seen in the room. 1/21/25 9:30 AM - During an interview E18 (CNA) stated, I have to get very close to [R101] and talk loudly to her in her left ear. It's hard because her roommate sometimes think I am talking to her. 1/21/25 10:30 AM - During a telephone interview F3 (Family member) stated, I had brought an amplifier to use during the admission in September. They [the facility] had asked me and my aunt about getting her hearing aids. We said yes but I did not hear anything back about it since then. I would like her to be able to hear better. 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48409 Based on record review, observation and interview, it was determined that for two (R73 and R66) out of three residents reviewed for bowel and bladder, the facility failed to provide appropriate treament and services to achieve or maintain as much nomal bladder function as possible. For R73, the facility failed to ensure that R73's urinary catheter care was monitored in a manner to prevent infection. For R66, the facility failed to maintain or restore continence. Findings include: 1. Review of R73's clinical record revealed: 2/20/22 - R73 was admitted to the facility with diagnoses including obstructive and reflux uropathy (blockage in the tubes that carry urine to the bladder), and retention of urine. 9/24/23 - R73's clinical records documented, .Catheter Care q [every] shift. 10/26/23 - R73's urinary care plan documented, [R73] has an indwelling catheter . The interventions included, .Position catheter bag and tubing below the level of the bladder . R73's Kardex (electronic document for the residents' care) documented, Position catheter bag and tubing below the level of the bladder. 1/9/25 - R73's annual MDS documented a BIMS score of 13, indicating a cognitively intact status. 1/13/25 10:30 AM - R73 was observed sitting in the wheelchair in his room. The urinary collection bag was hanging above the bladder, below the left arm rest of the wheelchair. 1/13/25 12:00 PM - R73 was observed sitting in the wheelchair in the dining room eating lunch. The urinary collection bag was hanging above the bladder, below the left arm rest of the wheelchair. 1/13/25 12:45 PM - R73 was observed sitting the wheelchair in the dining room eating lunch. The urinary collection bag was hanging above the bladder, below the left arm rest of the wheelchair. 1/13/25 1:00 PM - Findings were confirmed with E8 (UM.) 40264 2. A review of R66's clinical records revealed the following: 10/19/23 - R66 was admitted to the facility. 11/1/23 - R66 was care planned for the potential for falls related to .incontinence .with interventions including education on call bell use and calling for help prior to attempting transfer .(12/12/23) and keeping pathway to the bathroom clear and clutter free (12/11/23). 11/1/23 - R66 was care planned for bladder incontinence with interventions including on toileting program as ordered (1/30/24). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/25/24 - R66's quarterly MDS revealed that R66's cognition was moderately impaired and was occasionally incontinent of urine. 4/25/24 - R66's quarterly MDS revealed that R66 had intact cognition and was occasionally incontinent of urine. 7/23/24 - R66's quarterly MDS revealed that R66's cognition was moderately impaired and was occasionally incontinent (loss of control of bladder) of urine. 1/17/25 - A review of R66's fall incident reports from January 2024 through December 2024 revealed the following: - 3/2/24 6:30 AM - Patient found sitting on floor next to her bed .states she was trying to go to the bathroom - just toileted at 5:00 AM - 5/8/24 12:12 AM - Patient found sitting on the floor next to her bed and stated I was going to the bathroom - 7/2/24 11:30 AM - Patient found lying prone on the floor in her room - bed to floor .patient toileted and assisted back to bed . - 8/16/24 1:29 AM - Patient found sitting on the floor next to the toilet in her bathroom - back leaning against the toilet. Last toileted 12:00 AM. toilet after fall. 1/17/25 - A review of Fall Risk Evaluations from January 2023 through January 2025 revealed that R66 needed assistance with toileting. 1/17/25 3:06 PM - During an interview E24 (CNA) stated that, [R66] is a limited assist with toilet, has fallen a lot. She is continent of bladder and she would ask me to take her to the bathroom. She tells me when she wants me to take her to the bathroom. 1/21/25 9:54 AM - In an interview E23 (LPN) stated that [R66] is mostly continent and she transfers herself to the bathroom. We toilet her .sometimes every hour but she also lets us know if she wants to use the bathroom. 1/21/25 2:35 PM - During an interview, E2 (DON) confirmed that R66's person centered toileting program was not revised. E2 presented to the surveyor a copy of R66's incontinence care plan with interventions reviewed and revised on 1/17/25. The facility failed to ensure R66's person centered care plan interventions and a personalized toileting program were reviewed to address R66's falls related to R66's need to use the bathroom. 1/21/25 2:40 PM - Findings were discussed with E1 (NHA) and E2. 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review, observation and interview, it was determined that for two (R97 and R114) out of two residents reviewed for hydration, the facility failed to offer R97 sufficient fluid intake in an accessible manner for her to maintain proper hydration. For R114, the facility failed to ensure that R114 received sufficient fluids to maintain proper hydration or provide additional interventions when R114's oral intake significantly dropped. This failure resulted in harm with R114 being transferred to the hospital on [DATE] with a BUN of 100. Findings include: The BUN (blood urea nitrogen) lab measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney . BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023 1. Review of R114's clinical record revealed: [DATE] - R114 was admitted to the facility with diagnoses including but were not limited to, dementia and stroke with resultant difficulty swallowing and language/speech deficits. [DATE] - R114 was care planned for several problems including: has nutritional problem d/t (due to) . hx (history) need for feeding assistance, advanced age, .poor intake .Interventions for this problem included: . Monitor intake and record q (every) meal .provide assistance cueing meals as needed . [DATE] - R114's care plan was updated with several additional problems including: .(1) has the potential for pressure ulcers, decreeased functional mobility .Interventions for this problem included : .encourage adequate nutrition/hydration . (2) has an ADL (activities of daily living) self- care performance deficit r/t (related to) weakness . Interventions for this problem included: . Eating- [R114] is supervision of one person with feeding . [DATE] - E33 (dietician) documented in R114's EMR, . [Facility] Nutrition Risk Assessment . Estimated fluids - ml (milliliter) -1200 - 1440 . Feeding status - Needs some assistance with meal set up or eating . Assessment - .[R114] is able to feed herself after set up with some cueing . [R114] meets criteria for malnutrition d/t (due to) dementia and variable intake . [DATE] - E27 (MD) ordered in R114's EMR, .Med Pass (medication pass) three times a day 120 ml (additional water) . This order added 360 mls of additional water that R114 consumed each day. [DATE] - E34 (NP) documented in R114's EMR a follow up progress note, .History of present illness: Pt (patient) appears clinically stable . Labs [DATE] . Na (sodium) 141 mmol (millimole)/L (liter) (normal range , d+[DATE]) . BUN 20.0 mg (milligram) /dL (deciLiter) (normal range 7XXX,d+[DATE].0), creatinine 0.70 mg/dL (normal range 0.52 - 1.04) . Plan: weight stable: appetite variable but mostly acceptable . Continue Remeron . and encourage fluids . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R114's BUN at the time of this encounter was elevated at 20.0, which was reflective of R114 being intravascularly dry or dehydrated. Of note, this note was not signed by the provider until [DATE], which was five and a half months after the encounter. The notes are only available to be read in the resident's EMR after they are signed off by the provider so this note was not available to be read until [DATE]. [DATE] - E22 (NP) reviewed R114's labs, which documented a sodium level of 141, a BUN of 18 and a creatinine level of 0.90. The BUN was slightly elevated at 18, where the normal range was 7.0 to 17.0. The daily totals of R114's oral intake was: [DATE] - 1560 mls, ,d+[DATE]% consumption of meals for 2 out of 3 meals, dinner was 0 - 25% consumed, [DATE] - 1440 mls, ,d+[DATE]% consumption of meals for 2 out of 3 meals, dinner was 0 - 25% consumed, [DATE] - 1320 mls, ,d+[DATE]% consumption of meals for 2 out of 3 meals, dinner was 76 -100% consumed, [DATE] - 1320 mls, 26- 50% consumption of 2 out of 3 meals, dinner was 76 - 100% consumed. [DATE] - E35 (RN supervisor) documented in R114's EMR, [R114] is asymptomatic. Roommate with positive results [COVID]. Resident with room change to [room number] and contact/droplet isolation precautions initiated per protocol . [DATE] - 1380 mls, 26 - 50% consumption of breakfast, lunch and dinner were ,d+[DATE]% consumed, [DATE] - 1080 mls, 0 - 25% consumption of breakfast and lunch, dinner was ,d+[DATE]% consumed. CNA documented under ADL - Eating Self performance task that the Activity (eating) did not occur for lunch. [DATE] - 960 mls, 0 - 25 % consumption of all 3 meals, [DATE] - 880 mls, 0 - 25 % consumption of breakfast and lunch, dinner was ,d+[DATE]% consumed. CNA documented under ADL - Eating Self performance task that the Activity (eating) did not occur for lunch. [DATE] - 1080 mls, 0 - 25 % consumption for all 3 meals. CNA documented under ADL - Eating Self performance task that the Activity (eating) did not occur for breakfast. [DATE] - 780 mls, 0 - 25 % consumption for breakfast, lunch and dinner were ,d+[DATE]% consumed. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Of note, R114's oral intake dramatically dropped after she was placed on isolation precautions for a COVID exposure on [DATE]. R114's oral intake for the four days prior to the isolation precautions all fell within R114's normal oral intake range. For the seven days that R114 was on isolation precautions prior to her transfer tot he hospital, on six of those days R114's oral intake was documented to be significantly lower then normal. Additionally from [DATE] to [DATE], out of the twenty meals offered during these seven days, R114 was documented as not eating an entire meal five times. R114 failed to eat twenty-five percent of her meals during this period. The facility failed to ensure R114 met her stated hydration goals by supervising, cueing and monitoring R114's intake at meals. R114's EMR lacked evidence that the facility notified the providers of R114's decrease in oral intake. [DATE] 6:17 AM- E22 gave a verbal telephone order entered into R114's EMR, CBC (complete blood count) CMP (complete metabolic panel) one time only for increase in lethargy for 1 day. [DATE] 6:23 AM - E36 (LPN) documented in R114's EMR progress note, Noted with increase lethargy. Hydration unsuccessful. New order for CBC, CMP . Until this [DATE] note, despite five days (,d+[DATE] to [DATE]) of R114 poor oral intake, the facility lacked evidence that this decrease in R114's oral intake was acknowledged by the staff and/or reported to the providers. [DATE]- 300 mls, 0 - 25 % consumption of breakfast and lunch prior to transfer to the hospital. CNA documented under ADL - Eating Self performance task that the Activity (eating) did not occur for both breakfast and lunch. [DATE] 12:58 PM - Per the [county paramedic's] Prehospital Care Report, R114 was transferred to the hospital for an altered mental status . patient is noted to be in Atrial fibrillation at a rate of 170 bpm (beats per minute). Patient is also tachypnic (sic) (rapid breathing) at a rate of about 40. Patient is an obligate mouth breather and her oral cavity is noted to be dry . [DATE] 2:27 PM - R114's facility lab results documented a sodium of 158 mmol/dL (normal range , d+[DATE]), creatinine 1.80 mg/dL (normal range 0.52- 1.04). There was no reported BUN value on this lab report. [DATE] 2:01 PM - [Hospital] laboratory report documented R97's admission/emergency room labwork with a BUN result of 101mg/dL, with this lab's normal range as 8- 22 mg/dL. From [DATE] to [DATE], R114's BUN elevated from 18 ([DATE] lab work) to 100 ([DATE] hospital lab work). [DATE] 00:25 AM - C2's [hospital] history and physical documented in R114's hospital EMR, . [R114]'s lab work was significant for sodium of 157 and a creatinine of 2.21 from a baseline of 0.9, and a BUN of 101 . Assessment/Plan: Sepsis, unspecified organism- unclear source but patient has mulit-organ failure including her kidneys, her liver as well as evidence of new onset A-fib . [DATE] - R114 expired at [hospital] on hospice service. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	[DATE] 11:45 AM - Review of R114's EMR progress notes lacked evidence of any notation regarding R114's decreased oral fluid intake or any notification of R114's providers regarding her decreased oral intake until [DATE] 6:23 AM progress note in which E36 (LPN) documented, .Hydration unsuccessful . [DATE] 2:33 PM - During an interview, E4 (RN/unit manager) stated, It was not unusual for [R114] to ignore you if she did not want to deal with you. She played possum. She often refused her meds. Her vital signs were normal but as the day [[DATE]] progressed she became tachycardic and her breathing changed so we sent her out. She had had labs drawn that morning but they were not back when we sent her out. [DATE] 8:16 AM - During an interview, E36 (LPN) stated, . [R114] was her normal self. (neurologically) I was trying to give her water to drink because I was worried about dehydration. Cross refer F656 and F810. 2. Review of R97's clinical record revealed: [DATE] - R97 was admitted to the facility with diagnoses including but were not limited to, dementia and difficulty swallowing. [DATE] 9:56 AM - E13 (dietician) documented on the [facility] Nutrition Risk Assessment in R97's EMR, . Estimated fluids- ml (milliliter) - 1500 - 1800 ml (,d+[DATE] ml/kg) (kilogram) . Feeding status - Needs some assistance with meal set up or eating . Assessment - .Daughter reports good oral intake but has had to assist with meals . [DATE] 10:05 AM - E13 (dietician) ordered in R97S EMR, Regular diet .Adaptove equipment: please issue divided plate, built up utensils ands [NAME] cup with straw at all meals. [DATE] 1:00 PM - E27 (MD) ordered in R97's EMR, Med Pass one time a day 120 mls and Juven two times a day for 4 weeks. Mix with 240 mls water. These two orders accounted for 600 mls of R97's documented oral intake during this time period. [DATE] - R97 was care planned for several problems including: .(1) a potential nutritional problem r/t (related to) advanced age, . self-feeding difficulty requiring adaptive equipment . Interventions for this problem included: provide adaptive equipment for feeding as needed .Monitor intake and record .[R97] has an ADL (activities of daily living) self-care performance deficit r/t limited mobility . (2) has impaired cognitive function/dementia . Interventions for this problem included: Cue, reorient and supervise as needed . (3) has an ADL (activities of daily living) self-care performance deficit r/t (related to) limited mobility .Interventions for this problem included: Assist with eating as needed . The daily totals of R97's fluid intake were: [DATE] - 1440 mls [DATE] - 1200 mls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Broadmeadow	500 South Broad Street Middletown, DE 19709

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	[DATE] - 1680 mls. [DATE] - 1080 mls. [DATE] - 1800 mls. [DATE] - 1410 mls. [DATE] - 1800 mls. [DATE] - 1760 mls. [DATE] - 1560 mls. [DATE] 1:31 PM - R97's lab revealed a BUN (blood urea nitrogen) level of 61.0 mg(milligrams)/ dL (deciliter). The BUN normal reference level for this lab was 7.0 to 17.0 mg/dL so R97's BUN result of 61.0 was elevated and reflective of a state of dehydration. [DATE] 2:32 PM - E29 (NP) documented in R97's EMR reviewing these lab results. R97's EMR lacked evidence of E29 addressing R97's elevated BUN in either a progress note or with any new orders. [DATE] - 1920 mls. [DATE] - 1680 mls. [DATE] - 1320 mls. [DATE] 4:06 PM- The surveyor observed R97's bedside table with a full, white styrofoam cup with a straw and ice water in it. [DATE] 10:30 AM - The surveyor observed R97's bedside table with a full, white styrofoam cup with a straw and ice water in it [DATE] - 1310 mls. [DATE] - 1430 mls R97's stated hydration goals were 1500 - 1800 mls per day. From [DATE] to [DATE], there were seven out of fourteen days, where it was documented that R97's oral fluid intake was less than her documented minimum fluid goal. The facility failed to ensure R97 met her stated hydration goal by failing to provide bedside water in a Kennedyadaptive cup that R97 could independently consume, failing to assist and cue R97 to drink her bedside water, and failing to address R97's decreased oral fluid intake with R97's provider. From [DATE] to [DATE], the CNA staff documented in R97's CNA tasks list report under Eating Self-performance- How resident eats and drinks, regardless of skill? that for twenty-nine times of the thirty-nine recorded entries, R97 was Total dependence - full staff performance with regards to this task. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	[DATE] 10:30 AM - Review of R97's EMR progress notes lacked evidence of any notation regarding R97's decreased oral fluid intake or any notification of R97's providers regarding her decreased oral intake. [DATE] 1:01 PM - During an interview, E30 (LPN) stated, [R97] gets an adaptive cup on her meal trays. But I have never seen one on her bedside tray during non-mealtimes. She usually gets her bedside water in a white styrofoam cup . [DATE] 1:07 PM - During an Interview, E32 (OT) stated, [R97] is ordered specialized dining utensils. it is part of the diet order . She [R97] is ordered a Kennedy cup because the handle allows her to pick the cup up independently. [DATE] 1:35 PM - Review of R97's orders and CNA tasks list report lacked evidence of an order related to R97 utilizing a [NAME] adaptive cup outside of her meal tray. [DATE] 2:45 PM - During an interview, E24 (CNA) stated, When we pass the [bedside] water, we use the white styrofoam cups for [R97]. There is no any documentation in the tasks regarding specialty cups. There is not an order. If there3 is a specialty cup on her bedside table, I would pour the water from the styrofoam cup to the specialty cup. Most times, the specil cups come on the food trays. [DATE] 3:28 PM - E15 (CNO) presented the surveyor with a copy of a new order for R97 stating offer water in Kennedy cup q (every) shift. E15 also provided a copy of R97's CNA tasks list report with a new task Provide Q (every) shift water in Kennedy cup. [DATE] 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).