STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide quarterly trust fund statements for two of three residents (R12, R13) reviewed for resident funds in the sample of 16. Findings include: The facility's Accounting and Records of Resident Funds policy dated April 2021 documents each individual accounting records are available to the resident/representative through quarterly statements which include the beginning balance, total deposits/withdrawals, interest earned, funds available through petty cash, and the total amount of petty cash on hand. 1.) R12's Minimum Data Set (MDS) dated [DATE] documents R12 has severe cognitive impairment. R12's Resident Statement Landscape includes withdrawals and deposits for date range 5/22/26-6/1/26 and current balance as of 6/17/26. R12's Resident Trust Statement with date range 4/1/26-5/19/26 documents an accounting of withdrawals and deposits. On 6/17/26 at 11:28 AM V23 Business Office Manager stated the prior accounting system wasn't great and V23 has only been providing quarterly trust fund statements to residents. V23 knows who wants the statements or if a resident asks. V23 stated R12 opened R12's trust fund account in November 2024. R12's trust fund statements would go to V41 (R12's Family) but V23 has not provided any quarterly trust fund statements to V41. 2.) R13's MDS dated [DATE] documents R13 has moderate cognitive impairment. R13's Resident Statement Landscape includes withdrawals and deposits for date range 5/22/26-6/15/26 and current balance as of 6/17/26. R13's Resident Trust Statements dated 3/1/26-5/19/26 document an accounting of withdrawals and deposits. On 6/17/26 at 10:30 AM R13 stated has money in an account managed by the facility but R13 was unaware of any statements provided for this account. On 6/17/26 at 12:02 PM V40, R13's Family, stated V40 is only R13's healthcare power of attorney as V40 signed off for the facility to manage R13's funds and receive R13's Supplemental Security Income. V40 stated V40 does not receive statements for R13's trust fund account. On 6/17/26 at 11:28 AM V23 stated R13 opened a trust fund account in April or May 2024 and R13's quarterly trust fund statements would go to V40. V23 confirmed V23 has not provided quarterly statements for R13's trust fund account to V40.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report a trust fund account met the Supplemental Security Income (SSI) limit which could affect eligibility for Medicaid or SSI for one of three residents (R15) reviewed for resident funds in the sample list of 16. Findings include: The facility's Accounting and Records of Resident Funds policy dated April 2021 documents the business office representative will notify the resident if the balance in his/her personal funds account reaches $200 less than the resident's SSI resource limit and when the amount in that account (along with the value of the resident's other non-exempt resources) reaches the SSI resource limit for one person and the resident may lose eligibility for Medicaid or SSI. On 6/17/26 at 12:30PM, R15 stated that R15 never received any letters about R15's trust account balance, or any spend down money that the facility would be taking for services. R15 stated no one has talked to R15 regarding this and stated there is no other person the facility would send notices to on R15's behalf. R15's Minimum Data Set, dated [DATE] documents R15 as cognitively intact. R15's profile documents R15 as R15's own responsible party. R15's Resident Trust Accounting Ledger dated 4/1/26-5/19/26 documents a deposit of $14,753.78 on 4/3/26, a deposit of $16,061.09 on 4/15/26 and includes a total balance of $31,878.46. R15's Resident Statement Landscape dated 6/17/26 documents a total balance of $30,753.72. The State of Illinois Department of Human Services (DHS) Notice of Decision dated 5/20/26, provided by V23 Business Office Manager, documents as of 7/1/26 R15's medical benefits will change and R15 must meet a spenddown deductible due to R15's resources being over the limit. This notice documents that R15 will not get assistance to pay the nursing facility until R15 has used R15's excess resources to pay the facility for R15's cost of care, which is identified as $8,525.0. This notice documents the right to appeal this decision, how to file an appeal and the appeal must be submitted within 60 days of the notice. On 6/17/26 at 10:26 AM V23 stated R15 recently got a large back pay from disability income and DHS sent a notice that required a spend down of $8,500 due to exceeding the SSI resource limit. At 11:28 AM V23 stated R15 will be required to pay the spend down of $8,525.00 to the facility for room/board charges. V23 stated R15 received the disability deposits approximately 60 days ago and V23 spoke with R15 regarding this spend down within the last 30 days but V23 does not have documentation of this.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to monitor vital signs and laboratory results and assess/monitor/document/report changes in condition for one of three residents (R1) reviewed for falls in the sample list of 16. This resulted in R1 being sent to the hospital 4 days after a fall, being diagnosed with a brain breed and later dying. Findings include: R1's Care Plan (undated) documents V16 as R1's legal appointed Guardian and includes interventions to advocate and discuss the best interest of R1; encourage appointed responsible party to discuss options, advanced directives and wishes with R1; and inform V16 of changes in R1's condition. R1's diagnoses include Hypertension and Atrial Fibrillation. Interventions include administering medications as ordered and monitoring for effectiveness, daily skin inspection for bruising/bleeding, increased risk of bleeding post fall, laboratory results as ordered, monitor/document/report adverse reactions of anticoagulant including sudden severe headaches, nausea/vomiting, diarrhea, lethargy, bruising, loss of appetite, sudden changes in mental status, and significant changes in vital signs. R1's April and May 2026 Medication Administration Records document R1 received Coumadin (anticoagulant) 2 milligrams (mg) by mouth daily, monitor Prothrombin Time/International Normalized Ratio (PT/INR (clotting times) monthly, and R1 received Ciprofloxacin (antibiotic) 500 mg by mouth daily 4/7/26-4/11/26. R1's Ciprofloxacin order documents a moderate drug interaction as this medication may increase the anticoagulant effects of Coumadin. There is no documentation in R1's electronic medical record (EMR) that PT/INR was obtained after 4/1/26. R1's Progress Note dated 4/16/26, recorded by V14 Nurse Practitioner, documents R1's blood pressure was elevated 145/91 millimeters of mercury (mmHg) and instructions to monitor R1's blood pressure closely and if high blood pressure persists will consider adjusting dose of Losartan. There is no documentation in R1's EMR that R1's blood pressure was routinely monitored until after R1 sustained a fall on 5/4/26. R1's Nursing Notes document R1 had diarrhea on 5/1/26 and nausea/vomiting on 5/2/26. There is no documentation R1's EMR that a provider was notified of R1's diarrhea or nausea/vomiting. R1's Nursing Note dated 5/4/2026 at 10:55 AM documents R1 sustained a fall during staff assist. R1 denied pain and R1 refused to go to the emergency room for evaluation. R1's Nursing Note dated 5/5/26 at 7:52 PM documents V15 Physician was given update report and R1's complaints of generalized not feeling well for the last week and R1 believes R1 has a Urinary Tract Infection. Orders received for urinalysis with culture and sensitivity. R1's nursing notes document R1 received Tylenol 650 mg (ordered as needed) once on 5/6/26 and once on 5/7/26 for complaints of pain/headache. R1's neurological assessment form dated 5/4/26-5/7/26 document no headache, no altered behavior, no loss of consciousness, and hand grasps equal. There is no documentation in R1's EMR of R1's bruising to right shoulder, right rib, or right side of head. There is no documentation in R1's EMR that a provider was notified of R1's complaints of headache, bruising, changes in speech or level of alertness prior to 5/9/26. R1's EMR does not document any follow up communication with V16 regarding R1's changes in condition and refusal to go to the hospital after 5/4/26. V23's (Business Office Manager (BOM)) undated Written Statement documents: On 5/6/26 R1 came to V23's office to request a cash withdrawal from R1's trust fund account. At that time R1 reported R1 had a headache and felt weak. On 5/7/26 V23 went to R1's room and R1 appeared to still have headaches. R1 had reported the same as on 5/6/26, and R1 seemed slower to answer questions. V23 reported this to an unidentified nurse. On 5/8/26 V23 went to R1's room, R1 could barely sit up and had trouble answering V23 due to R1's headaches. R1 was continuously rubbing R1's head. V23 was concerned how much R1 had declined from the day prior and V23's concerns were reported to V2 Director of Nursing (DON). R1's Nursing Note dated 5/9/2026 at 4:41 AM documents the following: Three days ago, R1 started complaining that R1 didn't feel good. At 9:00 PM last evening R1 became weaker and had difficulty holding cups and required two assist from staff for transfers. R1 was encouraged to go to the hospital but refused several times. V15 Physician was notified earlier by day shift nurse and V15 gave orders to send to emergency room if R1 agreed and/or symptoms changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	R1 complained of nausea throughout the night. R1 became weaker and R1's voice became soft and barely heard. R1's hand grasps and mobility became less and more difficult and R1 began to fall asleep during conversations. At this time R1 agreed to go to the hospital. R1's emergency room Notes dated 5/9/26 document upon arrival R1 complained of headache and R1's blood pressure was 173/114 mmHg. R1's PT/INR was 92.7/12.6, critically high. R1's Computed Tomography (CT) scan showed a large left sided intraparenchymal with mass effect and midline shift (brain bleed), and medications/treatments were given to reverse blood-thinning effects. R1 was transferred to another hospital for higher level care. R1's Intensive Care Unit History & Physical dated 5/9/26 documents R1 had bruising to right side of head and significant weakness to right arm/hand. R1's Death Certificate dated 5/9/26 documents R1's cause of death as Intraparenchymal Hemorrhage as a consequence of fall. Significant conditions contributing to death: Compression of Brain, Intracranial Bleed, Chronic Kidney Disease, and Dementia. On 6/15/26 at 2:47 PM V16 (R1's Guardian) stated: V16 did not find out about R1's condition until V16 received a call from the hospital. V16 has been R1's Guardian since 2018 due to an adult protective services case and the condition R1 was found in R1's home at that time. At that time R1 had poor cognition but that improved with proper medication/care. R1 has a history of negating R1's health and R1 never wanted to go to the hospital. R1 tried to contest the guardianship a few years ago but that did not go through, and the guardianship remained in place. All R1's medical decision making is supposed to go through V16. V16 stated the facility should have notified V16 of R1's changes in condition and refusal to be hospitalized so that V16 could have come to the facility to speak with R1 to discuss the risks and try to convince R1 to go to the hospital. On 6/15/26 at 11:53 AM V10 Licensed Practical Nurse (LPN) stated the following: R1 seemed R1's normal self the week prior to R1's fall. On 5/4/26 V7 Certified Nursing Assistant (CNA) transferred R1 from the toile to the chair, V7 reported R1 got dizzy, mis-stepped and fell. V7 and R1 denied R1 hit R1's head during the fall and R1 initially had no complaints or signs of injury/bruising. Emergency Medical Services came to the facility but R1 refused to go to the hospital. Vital signs and neurological assessments were completed. R1 complained of headache with Tylenol given as noted on the MAR. Physician and Guardian notification is documented in the nursing notes. On 6/15/26 at 2:02 PM V23 BOM stated: On 5/6/26 R1 came to get cash around 2-3:00 PM. V23 brought R1's money to R1's room on 5/7/26 around 2-3:00 PM. R1 was slow to respond and had a headache on both days. V23 reported this to V10 LPN and R1 refused to go to the hospital. The next day V23 decided to check on R1, R1 kept rubbing R1's head complaining of headache, R1 was slower to respond to questions and was unable to sit up. These things had progressively gotten worse over these three days. By the third day R1 struggled to find answers but was still alert and oriented to person, place, time and situation but R1 again refused to go to the hospital. V23 reported R1's condition to a nurse and V2 DON and R1's condition was also discussed in the management's morning meetings. On 6/15/26 at 2:50 PM V24 LPN confirmed V24 was R1's nurse on dayshift on 5/8/26. V24 stated V24 does not work that hall very often and was not as familiar with R1. V24 stated R1 was not feeling well, generalized fatigue, urine test results were pending and V24 thought a urinary tract infection (UTI) was the cause of R1's symptoms. V24 was not aware R1 had complained of headaches or was slow to respond. V24 stated V24 would have assessed R1 and reported this to V15 which would be documented in a nursing note. On 6/15/26 at 3:11 PM V20 LPN stated: Following R1's fall on 5/4/26 R1 generalized not feeling well and could not pinpoint any specifics other than being tired and sleeping more, and V20 thought this was related to a UTI. V20 had heard that R1 had complained of headache but R1 has had them before, and R1 was slow to answer questions which gradually got worse after the fall. Physician and guardian notification would be documented in the nursing notes. R1 had changes in hand grasps during R1's assessments which was difficult to assess because R1 kept falling asleep during the assessment. On 5/8/26 R1 was slumped over and unable to hold his head up. R1 had stopped eating and fluid intake had decreased. R1 had bruising to R1's right side ribs, right ear and right side of R1's head. R1's symptoms gradually got worse over the course of days. R1 refused to go to the hospital all (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	night but finally agreed on the morning of 5/9/26. On 6/16/26 at 10:56 AM V7 CNA stated: R1 seemed perfectly fine the week prior to R1's fall. R1 was standing at the sink with R1's walker and R1 started to go down. V7 used the gait belt and tried to break R1's fall the best V7 could but R1's right side took the brunt of the fall. R1's fall was sudden as if R1 passed out and when R1 came to R1 was unaware R1 had fallen. On 6/16/26 at 11:07 AM V2 DON stated post fall monitoring should be done every shit and documented in the nursing notes. V2 stated vital signs are documented in the resident's EMR monthly unless there is an acute change and ordered more frequently. V2 confirmed nurses should document any signs or symptoms of changes in condition and neurological status and provider/guardian notification in the nursing notes. V2 stated V2 was off from work when R1 fell and did not return until 5/7/26, staff thought R1's symptoms were related to a UTI. V2 confirmed V2 was aware of R1's symptoms on 5/8/26. V2 stated V2 did not attempt to contact V16. At 11:58 AM V2 confirmed all documentation regarding provider/guardian notification and blood pressure monitoring for R1 was provided. V2 confirmed R1's blood pressure was not routinely monitored after 4/16/26 prior to R1's fall, no PT/INR results after 4/1/26, and no documented communication with a provider regarding interaction between Ciprofloxacin and Coumadin. On 6/16/26 at 12:40 PM V47 Pharmacist stated Ciprofloxacin has potential for moderate interaction with Coumadin and increases the bleeding effects, and PT/INR should be monitored closely during coadministration. On 6/15/26 at 12:17 PM V14 Nurse Practitioner stated V14 assessed R1 post fall on 5/4/26 and again on 5/7/26 when R1 complained of sleeping more and being weak. V14 stated R1 never reported a headache to V14 or V14 would have ordered a CT scan and hospital transfer. V14 stated R1 was on a low dose of Coumadin and V15 Physician ordered monthly PT/INR. V14 stated R1 was given Ciprofloxacin in April 2026, this medication can increase the bleeding effects of Coumadin, and the facility should have been monitoring R1's PT/INR at that time. V14 stated an aneurysm was the cause of R1's brain bleed and Coumadin can increase PT/INR contributing to bleeding. At 1:36 PM V14 stated the facility should have assessed R1's vision, pupil response, vital signs and hand grasps on 5/8/26 and notified V15 Physician of R1's symptoms. On 6/17/26 at 12:08 PM V14 stated V14 gives orders verbally to the nursing staff when V14 rounds at the facility. V14 stated R1's MAR should have reflected an order to check R1's blood pressure daily. V14 stated increased blood pressures could have contributed to R1's brain bleed but usually associated with systolic blood pressure of 190s, and R1 had been 140s. The facility's Change in a Resident's Condition or Status policy dated December 2025 documents the nurse will notify the resident's provider and resident's representative when there is a change in physical or cognitive status, a need to alter the resident's medical treatment significantly, and when the resident refuses treatments two or more consecutive times. The facility's Anticoagulation-Clinical Protocol dated November 2018 documents the following: Assess residents for bleeding and possible complications related to anticoagulant use. The physician should collaborate with pharmacy and nursing staff to identify potentially serious drug interactions with anticoagulants, including antibiotics. The physician should adjust the anticoagulant dose or change the medications that interact with the anticoagulant to ensure stabilized PT/INR within therapeutic range, and the physician will order PT/INR periodically to monitor the effects of anticoagulant therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure consistent access to fluids to maintain adequate hydration for one (R9) of three residents reviewed for hydration on a sample of three.On 6/15/26 at 10:20 AM, R9 was observed sitting in a wheelchair in front of the television, calling out and asking for a drink of water. Due to R9's total visual impairment, R9 was unaware that the water cup on the over-bed table was half full. The over-bed table was pushed against the wall next to the bedside table, placing it completely out of R9's reach. Although the call light was resting in R9's lap, it was not used to summon assistance.R9's Minimum Data Set (MDS) documents the resident is cognitively intact with little to no cognitive impairment. The care plan, dated 5/19/26, identifies R9 as visually impaired and includes the following interventions: Tell the resident where you are placing their items. Be consistent. The care plan further documents that R9 has impaired functional abilities related to vision impairment, including glaucoma and blindness in the left eye.On 6/15/26 at 10:22 AM, V2, Director of Nursing (DON), was informed of R9's request and the placement of the over-bed table. V2 approached R9, verbally identified themselves, and responded to the request. The over-bed table was repositioned directly in front of R9's wheelchair, and the water cup was placed within reach. V2 verbally oriented R9 to the cup's location using the clock-face method by stating the water cup was at 12 o'clock. R9 independently grasped the cup and drank approximately 150 milliliters (mL) of water. V2 reminded R9 that the call light was in the resident's lap and encouraged its use when assistance was needed. The room was left with both the water cup and call light within reach.On 6/15/26 at 10:45 AM, V2 DON stated staff would continue to monitor R9's fluid intake, ensure hydration was accessible, and perform two-hour rounding to support hydration and overall health.On 6/16/26 at 10:00 AM, R9 stated, I can't always find my water. Staff do get it for me when I ask.On 6/16/26 at 10:10 AM, V25, Traditions Hospice Registered Nurse (RN), arrived to provide care. V25 was asked to place the over-bed table in front of R9 upon completion of care. V25 stated fresh ice water had been provided, the over-bed table had been positioned in front of R9, R9 had been informed of the location of the water cup, and both the large red assistance button and the call light in R9's lap had been identified. V25 encouraged R9 to use the call light when assistance was needed.On 6/17/26 at 1:15 PM, R9 was again observed seated in front of the television with the over-bed table pushed against the wall next to the bedside table, placing it completely out of reach. While in the room speaking with a family member using a portable phone, V2 DON repositioned the over-bed table in front of R9 and informed the resident of the location of the drinking cup.The facility's Resident Hydration and Prevention of Dehydration policy states the facility will strive to provide adequate hydration and prevent and treat dehydration. The policy further states that nurse aides will provide and encourage intake of bedside, snack, and meal fluids daily and routinely as part of resident care.R9's care plan directs staff to tell the resident where personal items are placed and to do so consistently.