STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145927	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Oasis	16000 South Wabash South Holland, IL 60473

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to follow their policies for care planning and fall prevention by not ensuring care plans were developed based on assessments and individual needs; by not reviewing and updating care plans for appropriateness; and by not ensuring adequate personalized interventions were identified. This failure applied to two of four residents (R3 and R5) reviewed for care planning. Findings include: 1. R3 is a [AGE] year-old male with a diagnoses history of COPD, Heart Failure, Unspecified Convulsions, and Alcohol Abuse who was admitted to the facility 08/14/2024. R3's Fall Risk assessment dated [DATE] documents he is at high risk for falls. R3's Fall Risk Assessments dated 08/20/2024, 11/12/2024, and 12/29/2024 document his fall risk factors include diuretic medication, antiseizure medication, antihypertensive medication, psychotropic medication; occasional - frequent incontinence, inability to independently stand, requires hands on assistance to move from place to place; predisposing conditions including heart, pain, and fatigue/weakness. R3's Physician Order History includes an order effective from 12/26/2024 - 02/18/2025 for one 25mg Seroquel (Antipsychotic) tablet to be given by mouth twice daily related to restlessness and agitation. R3's progress note dated 12/30/2024 at 3:45 PM documents he was seen pushing on exit door setting alarm off. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Physical Therapy Evaluation and Plan of Treatment report dated 01/01/2025 he was recently admitted to the hospital due to a mini stroke and other medical complexities and was referred for physical therapy due to decreased functional mobility, decrease in strength, decreased coordination, decreased neuromotor control, decreased postural alignment, increased need for assistance from others, functional limitation with ambulation and falls/fall risk; his prior medical history includes congestive heart failure, stroke, coronary artery disease, seizures, and alcohol abuse; R3's behavior include being impulsive; he feels unsteady when walking and worries about falling; he requires partial/moderate assistance with walking 10 - 50 feet, chair to bed transfer, and toilet transfer; barriers likely to impact discharge to the next level include multiple medications/management required; patient characteristics that may impact treatment includes lacks insight into condition and risk factors, multiple medical conditions/history, and multiple medications; precautions include fall risk, confusion, and heart/cardiovascular conditions; and assistive devices include two wheeled walker. R3's Current Care Plan documents he is at risk for falls related to requiring assistance with activities of daily living and for transfers and mobility related tasks with interventions implemented 08/15/2024 including be sure call light is within reach and encourage the resident to use it for assistance as needed, staff to respond promptly to all requests for assistance, and complete the Fall Risk Review per the facility protocol. R3's Current fall care plan does not include high risk interventions of bed positioning and locking, keeping items he frequently uses near him, maintaining a clutter free environment, and keeping an assistive device within reach if ambulatory. R3's Current Care Plan does not include interventions for behaviors or use of psychotropic medications. 2. R5 is a [AGE] year-old male with a diagnoses history of Quadriplegia, Heart Failure, End Stage Renal Disease, Chronic Kidney Disease, Dependence on Renal Dialysis, Urinary Tract Infection, Metabolic Encephalopathy, Partial Paralysis following Stroke, and Dehydration (02/15/2025) who was admitted to the facility 01/31/2025. R5's admission Dehydration Risk Review dated 02/01/2025 documents he is at risk for dehydration. R5's nursing progress note dated 2/1/2025 documents he is a new admission on an oral antibiotic for UTI (Urinary Tract Infection) and sepsis. R5's Physician Progress Note dated 2/4/2025 at 12:15 PM documents his BUN (Blood Urea Nitrogen) levels were 26 and creatine levels were 3.14. R5's blood labs dated 02/04/2025 document abnormalities including high BUN (Blood Urea Nitrogen) at 26, and high creatinine at 5.05. R5's progress note created by V5 (Licensed Practical Nurse) dated 2/14/2025 at 2:54 PM documents writer received order for resident to go to the hospital emergency room for medical evaluation and treatment related to EKG results. R5's hospital record dated 02/14/2025 documents he is a [AGE] year-old male sent from the nursing home for abnormal labs and EKG; patient tachycardic; Patient is symptomatic, found to have dry oral mucosa and tachycardia; Labs with AKI (Acute Kidney Injury) consistent with dehydration; treated with IV (Intravenous) fluid. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Current Care Plan initiated 02/17/2025 documents he is at possible risk for dehydration with signs and symptoms related to a history of dehydration with interventions including: Encourage resident to drink all fluids offered at all meals and during activities attended and follow up with RD for proper hydration. On 02/25/2025 at 3:48 PM V3 (Assistant Director of Nursing) stated risk factors that would indicate if a resident is at high risk for falls include use of assistive devices such as walkers, attempting to move, transfer, or stand without assistance; use of psychotropic medications, hypertensive medications, seizure medications; certain conditions such as seizures, hypertension, stroke, coronary vascular disease; and substance use. V3 stated the facility does have different levels of fall risks. V2 (Director of Nursing) confirmed that the facility determines level of risk based on resident's risk factors. V2 stated fall interventions are implemented when falls occur or if there is a significant change of condition. On 02/26/2025 at 12:00 PM V2 (Director of Nursing) stated on R3 08/14/2024 fall risk assessment she had marked him as at risk. On 02/26/2025 at 3:44 PM V2 (Director of Nursing) stated she agrees with R3's most current fall care plan because it included care plans for other diagnoses and the only time we will update care plans for falls is if the resident has a fall. V2 stated the majority, or all the residents are at risk for falls. V2 stated not all residents are at the same risks for falls. V2 and V3 (Assistant Director of Nursing) stated they are not aware of R3 being impulsive that they know of. V2 stated she believes R3's fall interventions were personalized and adequate as of the time he was hospitalized because she updates the fall interventions as falls occur. V2 agreed the purpose of fall interventions is to prevent a fall if at all possible. V2 stated interventions for restlessness and agitation would include approaching R3 in a calm manner and redirection. V2 stated residents with behaviors can become agitated and lose balance and fall. V1 (Administrator) stated being restless could lead to tiredness which could contribute to accidents. V2 stated all care plans are individualized for residents. V3 stated restlessness and agitation would trigger a behavioral care plan. On 02/27/2025 at 12:34 PM V1 (Administrator) stated per nursing a just a baseline care plan is initiated upon admission and needs to be completed within 48 hours and R5's baseline care plan did not need to include a care plan for dehydration however when he went out to the hospital and returned a dehydration care plan was completed on 2/17/24. The facility's Care Plan Policy received 02/26/2025 states: All residents will have an individualized plan of care developed to assist them in achieving and maintaining their optimal status. The residents comprehensive care plan initiated upon admission within 24 hours. The Interdisciplinary Team develops a comprehensive, individualized care plan based on interdisciplinary team assessments and comprehensive assessment of the resident prior to the care conference. Concerns, problems, and needs are listed based on resident's individual needs. The facility's Care Plan Policy received 02/26/2025 states: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All residents who scored (High Risk or At Risk) for falls please make sure that there is a (Fall Risk) care plan in place with individualized appropriate intervention. No (Cookie Cutter) care plans permitted. The following interventions should be implemented for every resident who scored high risk for falls; keep bed at the position that promotes resident safety; keep items that residents frequently use near them; maintain a clutter free environment; if a resident is ambulatory keep assistive device within reach; make sure bed remains in the lock position. All care plans for those residents who have interventions for falls should be reviewed and updated for appropriateness. Other fall prevention interventions that may be considered based on Because Factor may include, but not limited to behavior modifications. The facility's Hydration Policy received 02/26/2025 states: The purpose of the policy is To establish guidelines to ensure each resident receives sufficient fluid intake to maintain proper hydration in accordance with calculated need. It is the policy of the Nursing Department to monitor the resident's fluid balance in accordance with assessed needs or problems. The Dietary Manager or R.D. (Registered Dietitian) will calculate fluid requirement for each resident admitted to the facility and will record fluid needs on the Nutritional Assessment tool. Fluid Needs will be calculated. At the time of admission and periodically a licensed nurse will assess the residents need for hydration monitoring. Fluid needs will initially be calculated by the Dietary Manager or Dietitian on the nutrition assessment. A care plan will be developed to address hydration needs by Dietary department. Identify fluid needs. Reassessing, modifying and documenting the care plan and assignments will be made in accordance with changes in the resident's response to the plan and changes in condition.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews, the facility failed to complete a post fall assessment of a resident immediately following a fall; failed to ensure a resident's physician was notified after a fall; failed to ensure residents received medications as ordered by the physician; and failed to ensure the physician was notified of abnormal lab results. These failures applied to three of four residents (R3, R4, R5) reviewed for quality of care and resulted in R3 having a delay in care of approximately two days after a fall in which R3 was found to have a hip fracture that required surgical intervention. Findings include: 1. R3 is a [AGE] year-old male with a diagnoses history of COPD, Heart Failure, Unspecified Convulsions, and Alcohol Abuse who was admitted to the facility 08/14/2024. R3's Current Care Plan documents he is at risk for falls related to requiring assistance with activities of daily living and for transfers and mobility related tasks with interventions implemented 08/15/2024 including be sure call light is within reach and encourage the resident to use it for assistance as needed, staff to respond promptly to all requests for assistance, and complete the Fall Risk Review per the facility protocol. R3's progress note created by V18 (Licensed Practical Nurse) dated 2/15/2025 at 2:17 PM documents resident appears to be more confused in a.m. and not verbally understood by writer, refused to eat breakfast/lunch even with encouragement/setup, resident is also losing control of bowel/bladder, refuses to get out of bed to toilet self as he normally does or sit up to eat; Orders received to send resident out for altered mental status and failure to thrive; at 4:52 PM writer received call from the hospital charge nurse stated that resident is being admitted for left hip fracture, that left leg is inverted, rotated and shorten, she also stated that fracture appears to be 48 hours old. Resident is scheduled for surgery in a.m. R3's Fall Incident report dated 02/15/2025 documents he was sent to the hospital for evaluation and treatment due to change in condition and was informed by the hospital via phone on 02/15/2025 at approximately 4:52 PM that he had a left hip fracture. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Unusual Occurrence Final Investigative Report dated 02/19/2025 documents on 02/15/2025 at approximately 2:17 PM, R3 was sent to the hospital for evaluation due to refusal of meals, incontinence of bowel and bladder, and refusal to get out of the bed which were acute change of condition per nursing assessment. The nurse was informed by the hospital nurse at 4:30 PM that R3 had a left hip fracture and will be admitted to the hospital. Undated witness statement from V7 (Licensed Practical Nurse) documents on 02/14/2025 at 3:45 PM she was off duty and returned to the facility because she forgot her phone and observed aides running to a room to assist R3 off the floor, she assisted the aides at this time to remove R3 off the floor, observed him, and no pain was observed. Witness statement from R12 dated 02/15/2025 documents he reported R3 had a fall trying to pick up a resident that fell in their room and aides assisted R3 from the floor; Witness statements from R13 dated 02/15/2025 documents he reported R3 fell . It was daylight at the time and aides assisted him from off the floor; Witness statement from V18 (Licensed Practical Nurse) dated 02/15/2025 documents she reported his roommates informed that he fell two days ago in their room and aides picked him up off the floor; Witness statement from V9 (Certified Nursing Assistant) dated 02/17/2025 documents she reported she worked from 3-11 PM on Friday and approximately between 3:30 - 4PM she observed R3 on the floor, the nurse checked him and helped place R3 on his bed. R3's roommates reported R3 was trying to help R9 up and fell . R3's hospital report dated 02/15/2025 documents he was admitted from the nursing home for lethargy but noted at baseline while at the emergency department and instead found to have a left thigh fracture and is unable to explain how he fell . R3 was assessed to have an acute fracture of the left hip and the circumstances of the fall are unclear; patient with a high level of risk based on: acute or chronic illnesses or injury which poses a threat to life or bodily function; he is a [AGE] year old male presenting with a fall at the nursing home and left thigh fracture and underwent surgical treatment for fracture on 02/16/2025; the etiology of the fall is unclear, suspect mechanical. On 02/25/2025 at 12:27 PM V2 (Director of Nursing) stated she completed the investigation on 02/19/2025 for R3's fall that occurred 02/15/2025. V2 stated there was confusion about his fall and they were trying to determine when R3 had a fall. V2 stated she concluded after the investigation that R3 had a fracture. V2 stated she wanted to go back to 02/14/2025 because someone said he fell two days ago but he was up and walking on 02/15/2025 so she said that couldn't be correct. On 02/25/2025 at 2:07 PM V2 (Director of Nursing) stated V7 (Licensed Practical Nurse) was suspended for three days because she did not complete an incident report for R3's fall because she said she was off the clock when R3 fell . V2 stated V7 assisted the aides with getting R3 up after he fell on [DATE] and then left the facility immediately after. V2 stated V7 should have let someone know R3 had a fall. V2 stated V7 will be terminated because she failed to inform anyone about a fall that resulted in an injury. V2 stated an injury could occur due to failure to report a fall or failure to properly assess a resident after a fall. V2 stated if you continue to put pressure on an injury after a fall that could result in harm. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 02/25/2025 at 2:52 PM V8 (Certified Nursing Assistant) stated at approximately 3:15 PM on 02/14/2025 as she was entering the unit where R3 's room was located V9 (Certified Nursing Assistant) observed R9 crawling on the floor. V8 stated V9 informed her of this as well as V7 (Licensed Practical Nurse). The nurse walked with her (V8) and V9 towards R9. V8 stated she found R9 crawling on all fours directly outside of R3 's room. V8 stated once they made it to the doorway of R3's room on the other side of the threshold, R3 was laid out parallel to the wall. V8 stated V7 stated R3's was on the floor too. V8 stated V7 then asked R3 if he was ok, what was he doing, asked him if he hit his head then answered for him no you didn't hit your head then instructed her (V7) and V9 to get him up. V8 stated V9 and V7 then assisted R3 off the floor, then she (V8) and V9 helped R9 up into her wheelchair and placed R9 at the nurses station. V8 stated V7 said she's not reporting it, she was ready to go, they didn't hit their head and they're alright. V8 stated V7 then sat at the nurses station until approximately 3:30 then left the facility. V8 stated V7 did not perform an assessment of R3 when he fell . V8 stated neither she nor V9 reported this to anyone else. V8 stated she was trained to report falls to the nurse and the nurse was present and aware of R3 's fall. On 02/25/2025 3:21 PM V9 (Certified Nurse Assistant) stated on 02/14/2025 at approximately 3:15 PM she was coming in from getting a linen bag then approached the nurses station and could see R9 sitting on the floor. V9 stated she informed V7 (Licensed Practical Nurse) that R9 was on the floor. V9 stated then she, V7 and V8 (Certified Nursing Assistant) approached the threshold of R3 's room and observed R3 was on the floor. V9 stated V7 said R3 is on the floor too and then immediately went to assess R3. V9 stated V7 assessed R3's body by patting him on his head, arms, legs, and back and then asked her (V9) and V8 to help R3 into bed. V9 stated she's unsure of R3's response while V7 was assessing him. V9 stated during this time she was observing R9 who was just sitting on the floor. V9 stated she remained standing in R3's doorway in between R9 and R3 while V7 assessed R3. V9 stated V7 asked R3 if he was ok and if anything hurt but she doesn't recall his response. V9 stated R3 looked like he was in pain and grunted when she, V7, and V8 picked him up and placed him in his bed. V9 stated after they placed R9 in the wheelchair, V7 stated she was getting ready to leave then went and got her bags and things and left. V9 stated R9 didn't have any injuries and didn't show any signs of pain other than grunting while being picked up. V9 stated she believes R3 stayed in his bed the remainder of the shift. On 02/25/2025 at 3:48 PM V2 (Director of Nursing) stated V7 (Licensed Practical Nurse) would have had a nurses note in R3 's medical records if an assessment was performed after he fell . V3 (Assistant Director of Nursing) stated a fall assessment, nurses note, incident report, and vital signs should all be documented in R3 's medical record along with notation of whether there was a loss of consciousness, complaints of pain, or changes in range of motion after a resident's fall. R3's medical records did not include documentation of a fall assessment, nurses note, or incident report that included his vital sign measurements, level of consciousness, pain status, or assessment of his range of motion, or physician notification after his fall on 02/14/2025. 2. R4 is an [AGE] year-old female with a diagnoses history of Dementia, Hallucinations, Stroke, Anxiety Disorder, Malignant Cancer of Left Breast, Metabolic Encephalopathy, and Repeated Falls who was admitted to the facility 09/02/2022. R4's Physician Order history includes an active order effective 10/12/2024 for 1 mg Anastrozole (Hormone Based Chemotherapy) Tablet to be given by mouth one time a day related to Breast Cancer. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R4's February 2025 Medication Administration Record reviewed to document Anastrozole scheduled to be given once daily in the morning was not administered on 9 different days from 02/01/2025 - 02/11/2025. R4's medication administration progress note dated 2/1/2025 documents her Anastrozole Oral Tablet (Hormone Based Chemotherapy) to be given by mouth one time a day related to Breast Cancer is awaiting delivery. 3. R5 is a [AGE] year-old male with a diagnoses history of Quadriplegia, Heart Failure, End Stage Renal Disease, Chronic Kidney Disease, Dependence on Renal Dialysis, Urinary Tract Infection, Metabolic Encephalopathy, Partial Paralysis following Stroke, and Dehydration (02/15/2025) who was admitted to the facility 01/31/2025. R5's Physician Order history includes an order effective from 02/01/2025 - 02/26/2025 for one Lanthanum Carbonate Oral Tablet Chewable 1000 MG tablet to be given by mouth three times a day with meals to reduce Phosphates level, in kidney disease; and an order effective from 02/01/2025 - 02/13/2025 for 5ml Nystatin Mouth/Throat Suspension to be given by mouth four times a day for oral anti-fungal, swish and swallow for 10 days. R5's February 2025 Medication Administration Records documents his Lanthanum Carbonate Oral Chewable tablet to be given by mouth three times a day with meals was not administered as ordered from 02/01/2025 - 02/24/2025 and his Nystatin Mouth/Throat Suspension medication to be given by mouth four times a day for oral anti-fungal was not administered as ordered on multiple days across multiple shifts from 02/01/2025 - 02/09/2025. R5's medication administration progress note dated 2/3/2025 at 05:35 AM documents his Nystatin Mouth/Throat Suspension antifungal was on order. R5's Physician Progress Note dated 2/4/2025 at 12:15 PM documents his phosphorus levels were 3.8. R5's blood labs dated 02/04/2025 document abnormalities including high phosphorus levels at 6.9. R5's progress notes did not include documentation of physician notification of abnormal blood labs. On 02/26/2025 at 12:00 PM V2 (Director of Nursing) stated according to R4's February 2025 Medication Administration record she was not receiving her chemotherapy medication as ordered based on all the 9's documented. V2 stated she had to in-service V5 (Licensed Practical Nurse) on ordering and passing medications. V2 stated R5 should have received his Lanthanum Carbonate Oral Chewable 1000 MG (Phosphorus Lowering) tablet during dialysis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 02/26/2025 at 1:16 PM V2 (Director of Nursing) stated since Lanthanum Carbonate (Phosphorus Lowering) and Nystatin Mouth/Throat Suspension (Antifungal) was ordered for R5 he should have received it however he didn't receive it. In response to being asked by surveyor what are the risks from R5 not receiving his Lanthanum medication, V2 replied abnormal labs and phosphorus levels. V2 stated R5's high phosphorus levels documented in his lab report dated 02/04/2025 could indicate he was not receiving dialysis, not being properly dialyzed, or not receiving his Lanthanum medication. V2 stated R5 was admitted to the facility on Friday 01/31/2025. In response to surveyor asking what the risks from R5 not receiving his Nystatin medication, V2 replied possibly thrush on his tongue. When asked by surveyor what are the risks of R4 not receiving her Anastrozole Oral Tablet (Hormone Based Chemotherapy), V2 replied R4 needs her chemotherapy medication for cancer but could not explain what the risks are from not receiving her chemotherapy medication. V2 stated everyone should receive their medications. V2 stated indications of dehydration include high BUN (Blood Urea Nitrogen) and High Creatinine levels. V2 stated R5's lab work from 02/04/2025 were obtained from the dialysis nurse and should have been reported to the floor nurse and urologist. V2 stated there should be follow up from abnormal labs including consulting with the physician to determine if additional labs should be repeated, if there any changes needed in medications or with dialysis treatment. On 02/26/2025 at 1:57 PM V2 (Director of Nursing) stated the dialysis nurse V17 (Registered Nurse) explained R5 did not receive his initial dialysis until Monday 02/03/2025. V2 stated the purpose of R5's Lanthanum Carbonate medication is to keep his phosphorus levels down and agreed his levels would elevate if he were not receiving his medications or not receiving dialysis. The facility's Fall Risk and Post Fall Assessment Policy and Procedures received 02/26/2025 states: The purpose of the policy is To conduct appropriate assessments after falls. Post Fall Assessment Procedures include: conduct physical and mental status assessment, assess resident's airway breathing and circulation, note level of consciousness and perform neuro checks whenever there is potential for actual head injury, assess limb strength and motion by asking the resident if he has pain and the location of said pain; ask if he can do active range of motion. The facility's Fall Policy and received 02/27/2025 states: Observed and reported by staff member. Licensed nurse should conduct assessment immediately, including events leading up to the fall to determine when possible causative factors. Assess for respiratory difficulties, bleeding and fractures. Additional Measures include: Notify Physician. Document all assessment findings and observations, physician and family notifications in the resident's clinical record in accordance with the assessment guidelines. The facility's Medication Administration Policy and received 02/26/2025 states: Medications must be administered in accordance with a physician's order. The facility's Physician Orders Policy received 02/26/2025 states: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	These guidelines are to ensure that: Changes in resident status/condition are assessed and physician notification is based on assessment findings; Any orders given by Physician are carried out. Any calls to physician will be documented in the nurse's notes indicating information conveyed and received.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to follow their policy and procedures for hydration by not ensuring a nutrition assessment was completed, not ensuring a hydration care plan was developed or interventions implemented, and not notifying the physician of abnormal labs related to hydration for a newly admitted resident assessed to be at risk for dehydration. This failure applied to one of four residents (R5) reviewed for hydration. Findings include: R5 is a [AGE] year-old male with a diagnoses history of Quadriplegia, Heart Failure, End Stage Renal Disease, Chronic Kidney Disease, Dependence on Renal Dialysis, Urinary Tract Infection, Metabolic Encephalopathy, Partial Paralysis following Stroke, and Dehydration (02/15/2025) who was admitted to the facility 01/31/2025. R5's Current Care Plan initiated 02/17/2025 documents he is at possible risk for dehydration with signs and symptoms related to a history of dehydration with interventions including: Encourage resident to drink all fluids offered at all meals and during activities attended and follow up with RD for proper hydration. R5's admission Dehydration Risk Review dated 02/01/2025 documents he is at risk for dehydration. R5's admission Nutrition Risk Review created by V12 dated 02/01/2025 is not completed and has no information documented for fluid requirements. R5's nursing progress note dated 2/1/2025 documents he is a new admission on an oral antibiotic for UTI (Urinary Tract Infection) and sepsis. R5's Physician Progress Note dated 2/4/2025 at 12:15 PM documents his BUN (Blood Urea Nitrogen) levels were 26 and creatine levels were 3.14. R5's blood labs dated 02/04/2025 document abnormalities including high BUN (Blood Urea Nitrogen) at 26, and high creatinine at 5.05. R5's progress notes did not include documentation of physician notification of abnormal blood labs. R5's progress note created by V5 (Licensed Practical Nurse) dated 2/14/2025 at 2:54 PM documents writer received order for resident to go to the hospital emergency room for medical evaluation and treatment related to EKG results. R5's hospital record dated 02/14/2025 documents he is a [AGE] year-old male sent from the nursing home for abnormal labs and EKG; patient tachycardic; Patient is symptomatic, found to have dry oral mucosa and tachycardia; Labs with AKI (Acute Kidney Injury) consistent with dehydration; treated with IV (Intravenous) fluid. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145927	A. Building B. Wing	02/27/2025

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2025 at 1:16 PM V2 (Director of Nursing) stated indications of dehydration include high BUN (Blood Urea Nitrogen) and High Creatinine levels. V2 stated signs and symptoms of dehydration include dry skin and mouth, increased thirst, poor skin turgor, and sunken appearance. V2 stated R5's lab work from 02/04/2025 were obtained from the dialysis nurse and should have been reported to the floor nurse and urologist. V2 stated there should be follow up from abnormal labs including consulting with the physician to determine if additional labs should be repeated, if there any changes needed in medications or with dialysis treatment. The facility's Hydration Policy received 02/26/2025 states: The purpose of the policy is To establish guidelines to ensure each resident receives sufficient fluid intake to maintain proper hydration in accordance with calculated need. It is the policy of the Nursing Department to monitor the resident's fluid balance in accordance with assessed needs or problems. The Dietary Manager or R.D. (Registered Dietitian) will calculate fluid requirement for each resident admitted to the facility and will record fluid needs on the Nutritional Assessment tool. Fluid Needs will be calculated. At the time of admission and periodically a licensed nurse will assess the residents need for hydration monitoring. Fluid needs will initially be calculated by the Dietary Manager or Dietitian on the nutrition assessment. A care plan will be developed to address hydration needs by Dietary department. Identify fluid needs. Reassessing, modifying and documenting the care plan and assignments will be made in accordance with changes in the resident's response to the plan and changes in condition.