

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Wesbury United Methodist Commu		STREET ADDRESS, CITY, STATE, ZIP CODE 31 North Park Ave Ext Meadville, PA 16335	
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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on review of the hospice/facility agreement and clinical records, and staff interview, it was determined that the facility failed to maintain current information related to Hospice services for three of 28 residents reviewed (Residents R27, R77, and R122). Findings include: The Skilled Nursing Facility Inpatient Care Services Agreement dated 3/21/23, revealed that: Article II section 2.2 Plan of Care indicated the plan of care should be maintained in consultation with Skill Nursing Facility (SNF) representatives during the period the patient is admitted to the SNF, hospice shall communicate to the SNF any changes in the condition of patient which require updating the Plan of Care for each patient, and provide SNF with the updated Plan of Care; section 2.4 Manner of Communication all communication between the Hospice and SNF pertaining to the care and services provided to the patient shall be documented in the patient's clinical record. Article III section 3.2 Coordination of Services indicated that the SNF will obtain the most recent hospice Plan of Care specific to each patient. Resident R27's clinical record revealed an admission date of 6/08/20, with diagnoses that included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), difficulty swallowing, difficulty walking, and aphasia (language disorder that affects how you speak and understand language. A physician's order dated 5/22/26, indicated he/she was admitted to hospice services effective 11/17/2025. Further review of Resident R27's clinical record revealed that the most recent hospice staff visit notes were dated 6/18/26, and that the hospice plan of care ended on 7/14/26. Interviews on 7/22/26, at 2:13 p.m. with Licensed Practical Nurse (LPN) Employees E3 and E5, confirmed that Resident R27's hospice care plan was not current and that the clinical record lacked recent hospice staff visit notes. Resident R77's clinical record revealed an admission date of 9/17/25, with diagnoses that included adult failure to thrive (happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), Parkinsonism (clinical syndrome characterized by the four motor signs that are found in Parkinson's disease: tremor, bradykinesia (slowed movements), rigidity, and postural instability.), aphasia, and stroke. A physician's order dated 5/22/26, indicated he/she was admitted to hospice services effective 10/03/25. Further review of Resident R77's clinical record revealed that the most recent hospice staff visit notes were dated 7/01/26, and that the hospice plan of care ended on 5/29/26. Resident R122's clinical record revealed an admission date of 3/16/22, with diagnoses that included psychosis (loss of contact with reality that affects the mind and causes delusions, hallucinations, and other symptoms), difficulty swallowing, Alzheimer's Disease, and Barrett's Esophagus (condition in which the flat pink lining of the swallowing tube that connects the mouth to the stomach (esophagus) becomes damaged by acid reflux, which causes the lining to thicken and become red). A physician's order dated 5/22/26, indicated that he/she was admitted to hospice service effective 1/24/24. Further review of Resident R122's clinical record revealed that the most recent hospice staff visit notes were dated 6/20/26. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/21/26, at 1:57 p.m. LPN Employee E2 confirmed that Resident R77's hospice care plan was not current and that the clinical record lacked recent hospice staff visit notes, and that Resident R122's clinical record lacked recent hospice staff visit notes. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.5(f)(iii) Medical records28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy, clinical records, observation, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment and failed to help prevent the spread of infection regarding respiratory care equipment for six of 28 residents (Residents R2, R12, R81, R92, R133, and R138). Findings include: Review of facility policy entitled Oxygen Therapy and Equipment dated 5/1/26, indicated All nasal canula tubing (oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery), mask, extension tubing, and zip lock style bags will be changed every week by night shift. Review of facility policy entitled Hand Held Nebulizer (HHN) Therapy dated 5/1/26, indicated Those residents with orders for HHN treatments will be issued the proper equipment that will be kept in the resident's room and dated when open. After each treatment, the equipment will be rinsed with tap water, allowed to air dry, and then stored in a zip-lock style bag. HHN apparatus, including T-pipes and mask, will be changed bi-weekly and prn. Resident R2's clinical record revealed an admission date of 6/28/23, with diagnoses that included gastrostomy (a tube that enters that digestive system to provide nutrition), congestive heart failure (CHF - when the heart muscle is weak and not able to pump blood throughout the heart and body efficiently), chronic obstructive pulmonary disease (COPD - when your lungs do not have adequate air flow), muscle weakness, and dysphagia (difficulty swallowing). Resident R2's physician orders revealed an order for oxygen at two liters per minute (LPM) via nasal cannula every shift dated 10/06/25. Resident R2's clinical record lacked evidence of a physician order to change the oxygen tubing and that the oxygen tubing was changed. Observations on 7/20/26, at 2:00 p.m. and 7/21/26, at 9:30 a.m. revealed Resident R2 receiving oxygen at two LPM via nasal cannula with a date of 7/26, written on Resident R2's nasal cannula tubing. Review of Resident R12's clinical record revealed an admission date of 3/16/21, with diagnoses that included, COPD, and acute respiratory failure (a condition where your lungs don't exchange air properly). Review of Resident R12's physician orders revealed an order for oxygen at two LPM via nasal cannula at bedtime daily dated 4/28/26. Review of Resident R12's clinical record lacked evidence that the nasal cannula was changed. Observations on 7/20/26, at 1:10 p.m., 2:30 p.m. and again on 7/21/26, at 10:00 a.m. revealed a date of 6/17/26, written on Resident R12's nasal cannula tubing. Review of Resident R81's clinical record revealed an admission date of 4/16/26, with diagnoses that included COPD, chronic respiratory failure, and asthma (a long-term lung disease that causes the airways to narrow and make it difficult to breathe). Review of Resident R81's physician orders revealed an order for Albuterol Sulfate 2.5 mg / 3ml solution for nebulization via HHN three times a day dated 4/16/26. Review of Resident R81's clinical record lacked evidence that the HHN was changed. Observations on 7/20/26, at 12:10 p.m., 2:20 p.m. and again on 7/21/26, at 9:58 a.m. revealed a HHN lying on Residents R81's bedside stand dated 6/26 and was not in a zip lock type bag. Review of Resident R92's clinical record revealed an admission date of 1/31/23, with diagnoses that include pneumonia (an illness that causes respiratory distress, congestion and cough), and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R92's physician orders revealed an order for Ipratropium 0.5 mg Albuterol 3mg /3ml nebulization solution via HHN four times a day as needed dated 12/5/25. Review of Resident R92's clinical record lacked evidence that the HHN was changed. Observations on 7/20/26, at 2:29 p.m. and again on 7/21/26, at 9:55 a.m. revealed an HHN in a zip lock type bag taped to Resident R92's bedside stand dated 6/26. Review of Resident R133's clinical record revealed an admission date of 2/18/21, with diagnoses that include asthma, and obstructive sleep apnea (a condition when a person repeatedly stops and starts breathing when they (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are sleeping). Review of Resident R133's physician orders revealed an order for oxygen at two LPM at bedtime daily dated 8/5/21. Review of Resident R133's clinical record lacked evidence that the nasal cannula was changed. Observations on 7/20/26, at 2:38 p.m. and again on 7/21/26, at 10:10 a.m. revealed Resident R133's nasal cannula in a zip lock type bag dated 7/26. Resident R138's clinical record revealed an admission date of 2/19/24, with diagnoses that included COPD, urinary tract infection, muscle weakness, and dependence on supplemental oxygen. Resident R138's physician orders revealed an order for oxygen at three LPM Q.S. [every shift] dated 9/20/24. Resident 138's clinical record lacked evidence of a physician order to change the oxygen tubing and that the oxygen tubing was changed. Observations on 7/21/26, at 10:35 a.m. revealed Resident R138 receiving oxygen at three LPM via nasal cannula with a date of 7/26, written on Resident R138's nasal cannula tubing. During an interview on 7/21/26, at 11:00 a.m. the Director of Nursing (DON) confirmed that Resident R12's nasal canula was dated 6/17/26, Resident's R 81 and R92's HHN's were dated 6/26, and Resident R133's nasal cannula was dated 6/26. He/she also confirmed that the nasal cannulas and HHNs should have been changed per facility protocol for all above noted residents. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of facility policy and clinical records, observations, and staff interviews it was determined that the facility failed to prevent the potential for cross contamination (the spreading of germs/microorganisms from one surface to another) during the care of a wound for one resident (Resident R11), maintaining sanitary respiratory equipment for two residents (Residents R58 and R114) and implement infection prevention measures for one resident of 28 residents (Resident R129). Findings include: A facility policy entitled Wound Care Procedure for Wounds dated 5/01/26, indicated to remove the soiled dressing; remove gloves and discard in the bag; wash your hands, put on clean gloves, and clean the wound; place soiled gauze used for cleaning in the bag; remove your gloves and place in the bag; wash your hands, put on new gloves; and apply clean dressing. A facility policy entitled Enhanced Barrier Precautions dated 5/01/26, indicated that personal protection equipment (PPE [gloves, gowns, etc.]) for enhanced barrier precautions (EBP) is only necessary when performing high-contact care activities and include transferring, providing hygiene, and assisting with toileting. Resident R11's clinical record revealed an admission date of 4/15/26, with diagnoses that included hyperosmolality (occurs when the blood contains an unusually high concentration of dissolved particles) and hyponatremia (high sodium in the blood, often stems from losing too much water or gaining too much sodium, leading to an imbalance in your body), urine retention, and difficulty swallowing. Observation of wound care on 7/22/26, at 9:38 a.m. revealed that LPN Employee E6 removed the soiled wound dressing from Resident R144's lower back, changed his/her gloves and failed to perform hand hygiene. Further observation of wound care on 7/22/26, at 9:47 a.m. revealed that LPN Employee E6 removed the soiled wound dressing from Resident R144's right ear, failed to perform hand hygiene and change his/her gloves, dated the tape of the new dressing, cleansed the right ear wound, and applied the new dressing. During an interview on 7/22/26, at 10:00 a.m. LPN Employee E6 confirmed that he/she should have performed hand hygiene and changed gloves when discarding the soiled dressings. Resident R58's clinical record revealed an admission date of 5/19/26, with diagnoses that included stroke, ataxia (difficulty walking), COPD, dependence on supplemental oxygen (oxygen provided by nasal cannula from an oxygen tank or concentrator [medical device that provides supplemental oxygen by taking in room air, removing nitrogen, and delivering oxygen-enriched gas to the patient] to ensure a person's oxygen levels are sufficient), and long-term respiratory failure with hypoxia (low levels of oxygen in your body tissues that can lead to symptoms like confusion, restlessness, difficulty breathing, rapid heart rate and bluish skin). Resident R58's physician orders revealed an order dated 5/19/26, for oxygen at 1-2 liters per minute (LPM) via nasal cannula every shift (QS), and an order dated 5/19/26 for Ipratropium 0.5 mg Albuterol 3mg (milligrams) /3ml (milliliter) nebulization solution via HHN (a medical device that turns liquid medication into mist and is inhaled by a face mask or holding a plastic pipe) as needed every 6 hours. Observation on 7/20/26, at 2:30 p.m. Resident R58's oxygen tubing with a nasal cannula was lying on top of Resident R58's unmade bed, and his/her HHN was observed hanging by the elastic strap over the door of the nebulizer machine and were not in zip lock type bags. There were also two empty zip lock type bags taped to the nightstand and on the oxygen concentrator casing, and the concentrator was turned on. Further observation at 3:11 p.m. Resident R58's oxygen tubing with a nasal cannula was lying on top of Resident R58's made bed, and his/her HHN was observed hanging by the elastic strap over the door of the nebulizer machine and were not in zip lock type bags. There were also two empty zip lock type bags taped to the nightstand and on the oxygen concentrator casing, and the concentrator was turned on. During an interview at that time, Licensed Practical Nurse (LPN) (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee E3 confirmed that Resident R58's oxygen tubing and HHN should be placed in plastic bags when not in use. Resident R114's clinical record revealed an admission date of 5/26/23, with diagnoses that included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), chronic obstructive pulmonary disease (COPD - when your lungs do not have adequate air flow), dependence on supplemental oxygen, and long-term respiratory failure with hypoxia. Resident R114's physician's orders revealed an order dated 1/03/24, for oxygen at three LPM via nasal cannula QS [every shift]. Observation on 7/20/26, at 3:10 p.m. revealed that Resident R114 was self-propelling in his/her wheelchair through the unit common area, proceeded through the unit activity room and his/her oxygen tubing connected to the portable oxygen tank attached to the wheelchair was dragging on the floor, and the portable oxygen tank was turned on. At that time Nurse Aide (NA) Employee E4 picked up the nasal cannula portion of the oxygen tubing and placed it against the resident's face to reapply it to his/her nose. At the time of the observation, NA Employee E4 confirmed that the nasal cannula should be cleansed before reapplying and draped the oxygen tubing over the handle of Resident R114's wheelchair and walked away. During an observation and interview on 7/20/26, at 3:16 p.m. LPN Employee E3 confirmed the position of the oxygen tubing on Resident R114's wheelchair handle and that the oxygen tubing should be replaced. Resident R122's clinical record revealed an admission date of 3/16/22, with diagnoses that included psychosis (loss of contact with reality that affects the mind and causes delusions, hallucinations, and other symptoms), difficulty swallowing, Alzheimer's Disease, and Barrett's Esophagus (condition in which the flat pink lining of the swallowing tube that connects the mouth to the stomach (esophagus) becomes damaged by acid reflux, which causes the lining to thicken and become red). Resident R122's physician's orders revealed an order dated 5/21/26, for oxygen at two LPM via nasal cannula as needed. Observation on 7/21/26, at 8:30 a.m. revealed Resident R122's oxygen tubing lying on the floor next to his/her oxygen concentrator, and an empty zip lock type bag was taped to the top of the oxygen concentrator casing. During an interview on 7/21/26, at 9:09 a.m. LPN Employee E2 confirmed that the oxygen tubing was lying on the floor and should have been stored in the zip lock type bag. Resident R129's clinical record revealed an admission date of 7/22/24, with diagnoses that included non-Hodgkin lymphoma (type of cancer that affects the lymphatic system), stroke with left-sided hemiplegia (condition that causes paralysis on one side of the body due to brain or spinal cord damage), and COPD. Resident R129's physician's order revealed an order dated 12/08/25, for EBP every shift. Resident R129's care plan entitled infection included an intervention dated 7/06/26, for staff to wear PPE as appropriate. Observation on 7/21/26, at 9:06 a.m. revealed signage on the outside doorframe to his/her room indicated to implement EBP to provide high-contact resident care, and an equipment storage hanging on the back of Resident R129's door included gowns, masks, gloves, etc. Observation on 7/21/26, at 9:07 a.m. of medication administration with LPN Employee E2, Resident R129 was being assisted to his/her chair by NA Employee E1 after assisting him/her in the bathroom, and NA Employee E1 was not wearing EBP. During an interview at that time NA Employee E1 confirmed he/she did not wear a gown to take resident to the bathroom did know that he/she needed to, and that there is usually stuff hanging on the door. NA Employee E1 then confirmed the presence of PPE hanging on the back of Resident R129's room door. Observation confirmed at that time by LPN Employee E2 that NA Employee E1 did not implement EBP by not wearing appropriate PPE during high-contact care for Resident R129 and that staff are required to wear gloves and a gown when assisting Resident R129 in the bathroom. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of clinical records and staff interviews, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) upon or within twenty-four hours of transfer, and failed to ensure that the necessary resident information was communicated to the receiving health care provider for one of 28 residents reviewed (Resident R1). Findings include: Review of Resident R1's clinical record revealed an admission date of 9/22/22, with diagnoses that included left femur fracture (fracture of the longest bone in the body connecting hip and knee), muscle weakness, difficulty in walking, and encounter for orthopedic aftercare (care for fracture of bone). Resident R1 was transferred to the hospital on 4/20/26. The clinical record lacked documentation that Resident R1 and/or their representative were provided with a copy of the facility bed-hold policy, and/or that the necessary resident information was communicated to the receiving hospital. During an interview on 7/23/26, at 9:00 a.m. the Director of Nursing (DON) confirmed that Resident R1 and/or their representative were not provided with a copy of the facility bed-hold policy when transferred to the hospital on 4/20/26, but should have been provided to further explain how long his/her bed could be held during a leave of absence and the cost per day. The DON further confirmed that Resident R1's clinical record lacked evidence that necessary resident information was communicated to the receiving health care provider when Resident R1 was transferred to the hospital on 4/20/26. 28 Pa. Code 201.18(e)(1) Management		

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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. Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current necessary care and services for one of 28 residents reviewed (Resident R95). Findings include: Review of a facility policy entitled, Care Plans (Plans of Service) dated 5/01/26, indicated that care plans are updated whenever a change is necessitated by a resident's change in condition, physician, or when scheduled by the minimum data set (MDS [a standardized tool used in nursing homes to evaluate residents' health, functional status, and care needs] team for a quarterly, change in condition, or annual review. A facility policy entitled Incident/Accident Management Program dated 5/01/26, indicated that when a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and put into place an intervention to prevent this from happening again. Review of Resident R95's clinical record revealed a current admission date of 3/17/26, with diagnoses that included heart disease, muscle weakness, vascular dementia (type of dementia caused by reduced blood flow to the brain, leading to cognitive decline and memory issues), and altered mental status, age-related debility (distinct medical condition that goes beyond normal aging, characterized by a general decline in strength, mobility, and resilience). Resident R95's clinical record revealed that he/she experienced an unwitnessed fall on 4/12/26, at 10:15 p.m. and that continued diagnostic testing on 4/15/26, identified a fractured right clavicle (collar bone). Review of the facility's fall investigation dated 4/12/26, indicated that Resident R95's care plan was updated, and lacked documentation of what items were updated. A care plan entitled Falls included interventions dated 3/17/26, and a goal date of 6/15/26. The care plan lacked evidence that the care plan was updated in reference to Resident R95's fall with major injury on 4/12/26. During an interview on 7/23/26, at 12:40 p.m. the Nursing Home Administrator confirmed that Resident R95's falls care plan did not reflect updates related to the fall with major injury from 4/12/26, and that the goal date for the falls care plan was 6/15/26. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of clinical records and facility policies, and staff interviews, it was determined that the facility failed to completely investigate an unwitnessed fall for one of 28 residents (Resident R95). Findings include: A policy entitled Resident Incident Reporting dated 5/0/26, indicated that the charge nurse will complete a Resident Incident Report which will include all documentation related to interviews or resident, staff members, and any other witnesses. A facility policy entitled Incident/Accident Management Program indicated after evaluating and treating the resident immediately, the registered nurse will investigate the circumstances of the incident and look for all possible causes; the registered nurse should talk with the nursing assistants, residents, and any other witnesses. Review of Resident R95's clinical record revealed a current admission date of 3/17/26, with diagnoses including heart disease, muscle weakness, vascular dementia (type of dementia caused by reduced blood flow to the brain, leading to cognitive decline and memory issues), and altered mental status, age-related debility (distinct medical condition that goes beyond normal aging, characterized by a general decline in strength, mobility, and resilience). Resident R95's clinical record revealed that he/she experienced an unwitnessed fall on 4/12/26, at 10:15 p.m. and that continued diagnostic testing on 4/15/26, identified a fractured right clavicle (collar bone). Review of the facility investigation related to Resident R95's unwitnessed fall on 4/12/26, lacked evidence of resident, staff and other witness interviews. During an interview on 7/23/26, at 12:40 p.m. the Nursing Home Administrator confirmed there was no additional documentation to support that Resident R95's fall was thoroughly investigated. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1))5) Resident care policies		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of clinical records, and staff interviews, it was determined that the facility failed to have complete, accurate, and systematically organized documentation regarding ensuring that additional water ordered for tube feeding is administered per orders for one of 28 residents reviewed (Resident R11).Resident R11's clinical record revealed an admission date of 4/15/26, with diagnoses including hyperosmolality (occurs when the blood contains an unusually high concentration of dissolved particles) and hyponatremia (high sodium in the blood, often stems from losing too much water or gaining too much sodium, leading to an imbalance in your body), urine retention, and difficulty swallowing.Resident R11's physician's orders regarding tube feedings and flushes included:4/15/26, fluid intake mL[milliliters] provided by nursing each shift for hydration.4/16/26, irrigate with 30 mL water before and after medications.4/21/26, flush with 100 mL water every shift for nursing instruction with medications.4/21/26, flush with 100 mL water four times per day for nursing instruction.5/02/26, Jevity 1.5 Cal 0.06 gram-1.5kcal/mL oral liquid at 50 mL per hour enteral tube feeding. Spike and hang bottle at 11:00 a.m. Do not take down until bottle is empty daily regardless of time. Review of Resident R11's Medication Administration Record (MAR) revealed nursing staff documented administration of 100 mL water every shift and four times per day; 30 mL water before and after medication administration; and Jevity infused starting at 11:00 a.m. daily. Review of Resident R11's MAR documentation for fluid intake (mL) provided by nursing each shift lacked direction for staff to include or exclude the 100 mL water flushes every shift and four times per day, Jevity feeding infusion, and 30 mL flushes before and after medication administration resulting in inaccurate and inconsistent documentation of fluid intake provided by nursing staff each shift. Review of Fluid Management Report dated 7/12/26, to 7/21/26, provided by the facility on 7/23/26, indicated Resident R11's 24-hour fluid intake totals ranged between 910 mL to 2340 mL. During an interview on 7/23/26, at 10:30 a.m. the Director of Nursing confirmed 24-hour fluid intake parameters are not clearly written on the MAR, and there is a wide gap in the documentation of the water intake, and that the orders need to be clearer to ensure that Resident R11 is receiving the appropriate amount of water flushes. 28 Pa. Code 211.5(f)(viii)(x) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services		