STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenview Nursing and Rehabilitation	401 Owen LN Waco, TX 76710

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on observation, interview and record review that facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is (A) significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). On 5/11/2024 Resident #1 was admitted into the hospital due to a decline in health. Resident #1 was lethargic, unable to stand, skin was pale in color and fingertips were turning purple. Resident #1 was diagnosed with severe dehydration and non-traumatic rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood). The facility failed to identify there was a decrease in Resident #1's meal intake and notify the nutritionist, NP, or PCP to address nutritional or hydration concerns for Resident #1 This failure could place residents at risk of not getting the medical treatment required that could lead to other adverse health consequences. Findings included: Review of Resident #1's undated face sheet reflected an [AGE] year-old male with an admitted [DATE]. Diagnoses included: UNSPECIFIED DEMENTIA (a group of thinking and social symptoms that interfere with daily functioning), Parkinson's disease (a disorder of central nervous system that affects movement, often including tremors), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and depression (a group of conditions associated with the elevation or lowering of a person's mood). Review of Resident #1's admissions MDS assessment dated [DATE] reflected incomplete. Only the identification page of the assessment had been completed no other sections of the assessment were completed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
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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 0580 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's care plan dated 5/2/2024 reflected Resident # 1 was an elopement risk and was placed on the secure unit at the facility when he admitted to the facility. Resident # 1 was at risk for falls and had previous falls in the home prior to admitting to the facility. The care plan did not reflect any interventions to address the nutritional or fluid intake needs for Resident #1. Review of Resident #1's physician orders for Resident #1 reflected, the facility did not have a physician's order for Resident #1's diet or fluid intake. Record review of hospital medical records dated 5/11/2024 reflected Resident #1 was admitted to the hospital on 5/11/2024 from the nursing facility. Resident # 1 was diagnosed with non-traumatic rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) and severe dehydration. Resident #1 was currently in the hospital receiving fluids and has suffered acute kidney injury. In an interview via phone on 5/14/2024 at 7:40 am with Resident #1's RP, revealed when she showed up on 5/11/2024 to take Resident #1 home she stated he was very weak, pale in the face, fingers were turning purple, and he could not get up out of the wheelchair into the car. She stated she had them call 911 and he was taken to the hospital where he was diagnosed as being severely dehydrated and having rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood). The RP stated she was not aware of what could have happened in this short period of time to cause this decline in his health. She stated when he admitted to the facility, he was using his walker to walk, eating, and talking. The RP stated she admitted Resident #1 to the facility on [DATE] because they were having some renovations completed at their home. She stated he was previously at another facility closer to their home but had continued to have elopement issues so that was the reason he was transferred to this facility. The RP stated Resident #1 was on the secure unit at this facility, but stated she just does not understand the decline in his health from the time he admitted to the time he discharged . In an interview on 5/14/2024 at 10:00 am with hospital RN staff reported Resident #1 stated that he had not had anything to eat or drink for the past three days. Hospital RN staff reported the resident admitted to the hospital with severe dehydration and rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) she stated this could cause the dehydration. In an interview on 5/14/2024 at 11:15 am with PCP, revealed he never saw Resident #1 while at facility he stated the NP met with the resident. He stated he was never contacted or made aware of any issues related to this resident. The PCP stated there were no additional treatment services for this resident and there were no medication changes ordered for this resident. (continued on next page)

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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 0580 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/14/2024 at 12:38 pm with the DON she reported they did keep fluid intake records for Resident #1 she stated when the resident had some coughing issues when eating and drinking, they contacted the RP on 5/6/2024 who advised that Resident #1 had a swallowing problem. She stated they were advised to cut his food smaller and encourage smaller bites, drink and swallow slowly, and monitor the resident. The DON stated they do not track fluid intake for residents unless there was an order. However, she stated if the resident was eating below 50% of their meals, they were provided with a supplemental shake with each meal. She stated it was standard facility protocol, however reported they do not document if the shake supplement was provided or if the resident consumed the shake. She stated they did not add this intervention to the care plan because it was standard to do and not an order. She stated she did not address the eating or drinking issues with the NP or PCP because they spoke with the RP and were doing what the RP advised them to do for the resident. The DON stated she did send the resident out to the hospital because she stated he did not look right. She stated the resident was assessed at the hospital and returned to the facility the same day. She stated the hospital called and stated the resident was stable and ready to be picked up. The DON stated they never received any discharge paperwork from the hospital from the 5/9/2024 visit due to a breach in their system. The DON stated she did contact the director of OT/PT to have a swallow assessment completed for the resident. The DON stated all staff had been trained on abuse/neglect and the protocol. She stated all CNA staff had been trained to report any changes in condition to their nurse and they would discuss in their morning meeting for steps to take and treatment. The DON stated the facility did not have a hydration policy. In an interview on 5/14/2024 at 3:17pm with the NP revealed, Resident #1 admitted to the facility on [DATE] for respite care. She stated she normally did not see the residents if they were at the facility for respite care. She stated she did not know how long Resident #1 was going to be at the facility, so she saw Resident #1 on 5/6/2024. The NP stated Resident #1 was not getting any additional treatment and, stated no medications were changed. She stated the resident was confused and appeared to have already had a cognitive decline requiring to be on a secure unit. She stated she was contacted by the facility indicating that Resident #1 was having some hip pain. She advised the facility to check with the RP about getting some x-rays and stated she was advised that Resident #1 would be discharging on 5/10/2024 to return home. She stated she was not aware of any other issues regarding Resident #1. In an interview on 5/15/2024 at 12:15 pm with the hospital treating physician reported that rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) could be caused from a fall and being left in that spot for a prolonged period of time or it can be caused by not getting the nutrition and hydration needed. She stated the resident reported lying in the bed and not having anything to eat or drink for three days. She stated the cause of rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) would be consistent with lying in a bed and not having anything to eat or drink for three days. The physician reported there was no other way that the rhabdomyolysis could be caused except for one of these two ways. Record review of facility abuse/neglect policy dated March 2018 reflected the following: All residents will be free from abuse/neglect. Record review of facility Intake, Measuring and Recording policy dated October 2010 reflected the following: (continued on next page)

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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 0580 Level of Harm - Actual harm Residents Affected - Few	Review the resident care plan to assess for any special needs of the resident. Verify there is a physician's order for this process. In an interview with the DON on 5/14/2024, she stated the facility did not have a dehydration/ hydration policy.

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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 - 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 44526

Based on interview and record review the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that was not possible or the resident preferences indicated otherwise for 1 of 13 residents (Resident #1) reviewed for nutrition and hydration.

On 5/11/2024 Resident #1 was admitted into the hospital due to a decline in health. Resident #1 was lethargic, unable to stand, skin was pale in color and fingertips were turning purple. Resident #1 was diagnosed with severe dehydration and non-traumatic rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood).

The facility failed to identify there was a decrease in Resident #1's meal intake and notify the nutritionist, NP, or PCP to address nutritional or hydration concerns for Resident #1.

This failure could place residents at risk of nutritional deficit, dehydration, and other adverse health consequences.

Findings included:

Review of Resident #1's undated face sheet reflected an [AGE] year-old male with an admitted [DATE]. Diagnoses included: UNSPECIFIED DEMENTIA (a group of thinking and social symptoms that interfere with daily functioning), Parkinson's disease (a disorder of central nervous system that affects movement, often including tremors), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and depression (a group of conditions associated with the elevation or lowering of a person's mood).

Review of Resident #1's admissions MDS assessment dated [DATE] reflected incomplete. Only the identification page of the assessment had been completed no other sections of the assessment were completed.

Review of Resident #1's care plan dated 5/2/2024 reflected Resident # 1 was an elopement risk and was placed on the secure unit at the facility when he admitted to the facility. Resident # 1 was at risk for falls and had previous falls in the home prior to admitting to the facility. The care plan did not reflect any interventions to address the nutritional or fluid intake needs for Resident #1.

Review of Resident #1's physician orders for Resident #1 reflected, the facility did not have a physician's order for Resident #1's diet or fluid intake.

Record review of meal intake records dated 5/2/2024- 5/11/2024 reflected on 5/6/2024 ,5/7/2024, 5/8/2024, and 5/10/2024 Resident #1 consumed less than 25% of his dinner on the days listed. On 5/2/2024 reflected no record of dinner eaten.

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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 - Actual harm Residents Affected - Few	Record review of progress note dated 5/2/2024 at 5:27 pm by LVN A reflected, Resident #1 refused to eat dinner because he had anxiety and was worried about being at the facility. The note reflected LVN A redirected Resident #1, however does not indicate if he ate his dinner. Record review of progress note dated 5/6/2024 at 2:18 pm by LVN A, reflected he contacted the RP regarding Resident #1 observed coughing and after eating and drinking. The RP stated Resident #1 had swallowing problems due to his Parkinson's disease. The RP stated Resident #1 had a swallow study in January 2024, she advised for the resident to take small bites and to encourage to swallow in between bites. Record review of hospital medical records dated 5/11/2024 reflected Resident #1 was admitted to the hospital on 5/11/2024 from the nursing facility. Resident # 1 was diagnosed with non-traumatic rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) and severe dehydration. Resident #1 was currently in the hospital receiving fluids and has suffered acute kidney injury. In an interview via phone on 5/14/2024 at 7:40 am with Resident #1's RP, revealed when she showed up on 5/11/2024 to take Resident #1 home she stated he was very weak, pale in the face, fingers were turning purple, and he could not get up out of the wheelchair into the car. She stated she had them call 911 and he was taken to the hospital where he was diagnosed as being severely dehydrated and having rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood). The RP stated she was not aware of what could have happened in this short period of time to cause this decline in his health. She stated when he admitted to the facility, he was using his walker to walk, eating, and talking. The RP stated she admitted Resident #1 to the facility on [DATE] because they were having some renovations completed at their home. She stated he was previously at another facility closer to their home but had continued to have elopement issues so that was the reason he was transferred to this facility. The RP stated Resident #1 was on the secure unit at this facility, but stated she just does not understand the decline in his health from the time he admitted to the time he discharged . In an interview on 5/14/2024 at 10:00 am with hospital RN staff reported Resident #1 stated that he had not had anything to eat or drink for the past three days. Hospital RN staff reported the resident admitted to the hospital with severe dehydration and rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) she stated this could cause the dehydration. In an interview on 5/14/2024 at 11:15 am with PCP, revealed he never saw Resident #1 while at facility he stated the NP met with the resident. He stated he was never contacted or made aware of any issues related to this resident. The PCP stated there were no additional treatment services for this resident and there were no medication changes ordered for this resident. (continued on next page)

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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 - Actual harm Residents Affected - Few	In an interview on 5/14/2024 at 12:38 pm with the DON she reported they did keep fluid intake records for Resident #1 she stated when the resident had some coughing issues when eating and drinking, they contacted the RP on 5/6/2024 who advised that Resident #1 had a swallowing problem. She stated they were advised to cut his food smaller and encourage smaller bites, drink and swallow slowly, and monitor the resident. The DON stated they do not track fluid intake for residents unless there was an order. However, she stated if the resident was eating below 50% of their meals, they were provided with a supplemental shake with each meal. She stated it was standard facility protocol, however reported they do not document if the shake supplement was provided or if the resident consumed the shake. She stated they did not add this intervention to the care plan because it was standard to do and not an order. She stated she did not address the eating or drinking issues with the NP or PCP because they spoke with the RP and were doing what the RP advised them to do for the resident. The DON stated she did send the resident out to the hospital because she stated he did not look right. She stated the resident was assessed at the hospital and returned to the facility the same day. She stated the hospital called and stated the resident was stable and ready to be picked up. The DON stated they never received any discharge paperwork from the hospital from the 5/9/2024 visit due to a breach in their system. The DON stated she did contact the director of OT/PT to have a swallow assessment completed for the resident. The DON stated all staff had been trained on abuse/neglect and the protocol. She stated all CNA staff had been trained to report any changes in condition to their nurse and they would discuss in their morning meeting for steps to take and treatment. The DON stated the facility did not have a hydration policy. In an interview on 5/14/2024 at 3:17pm with the NP revealed, Resident #1 admitted to the facility on [DATE] for respite care. She stated she normally did not see the residents if they were at the facility for respite care. She stated she did not know how long Resident #1 was going to be at the facility, so she saw Resident #1 on 5/6/2024. The NP stated Resident #1 was not getting any additional treatment and, stated no medications were changed. She stated the resident was confused and appeared to have already had a cognitive decline requiring to be on a secure unit. She stated she was contacted by the facility indicating that Resident #1 was having some hip pain. She advised the facility to check with the RP about getting some x-rays and stated she was advised that Resident #1 would be discharging on 5/10/2024 to return home. She stated she was not aware of any other issues regarding Resident #1. In an interview on 5/14/2024 at 4:26 pm with LVN A revealed, the CNAs were trained to let their nurse know if there was any change in condition for any resident. LVN A stated the CNA staff are trained to pay attention to the resident's trays if they are not eating or drinking when the get their meals, their urine color, or if they are changing the resident and they are fairly dry they are not getting enough hydration and they would need to push fluids. LVN A stated the resident admitted for respite care and had a decline while at the facility. He stated all staff had been trained on abuse/neglect and the administrator was the abuse/ neglect coordinator he stated he had never seen or suspected abuse/neglect at this facility. (continued on next page)

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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 - Actual harm Residents Affected - Few	In an interview on 5/15/2024 at 7:08 am with RN revealed, he worked with Resident #1 on the secure unit. He stated when the resident admitted to the facility he was doing more. He stated he was using his walker to get around and able to feed himself with some assistance as needed. He stated the resident took water and other hydration with meals and stated his appetite continued to decrease. RN stated he contacted the RP on 5/6/2024 and reported swallowing problems but was told he was still on a regular diet and needed to take small bites. He stated the resident was a 2x person assist for the week that he was at the facility. RN stated he contacted the hospital Resident #1 went to on 5/9/2024 to try to obtain those records however, due to the hospital breach in their system they did not have any records available they could provide. RN stated he let the DON know about the issues Resident #1 was having and they contacted the therapy department to try to get another swallow study for the resident. RN stated they helped with eating and drinking for Resident #1 he stated the resident continued to decline. The RN stated the CNAs are trained to report any changes in a resident's condition to the nurse on duty. He stated they would report to the DON or contact the NP for concerns with a resident. In an interview on 5/15/2024 at 7:32 am with RP, revealed Resident #1 saw two doctors on yesterday and stated they came up with a plan for him to go home on hospice care. She stated the doctor of the supportive and palliative care department attributed his condition to his current diagnosis and progression of the Parkinson's disease and Dementia. She stated she just did not expect this, and stated she wanted someone to blame. The RP stated she felt the hospital did not do what they needed to do on 5/9/2024 before releasing him back to the facility. She stated she did speak with the hospital staff on 5/9/2024, but stated she could not remember what was said regarding Resident #1's condition. The RP stated she would be taking Resident #1 back home to are for him and that he would not be returning to the facility. The RP stated palliative care has been put into place and they will come into the home and provide these services. In an interview on 5/15/2024 at 12:15 pm with the hospital treating physician reported that rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) could be caused from a fall and being left in that spot for a prolonged period of time or it can be caused by not getting the nutrition and hydration needed. She stated the resident reported lying in the bed and not having anything to eat or drink for three days. She stated the cause of rhabdomyolysis (breakdown of muscle tissue that release a damaging protein into the blood) would be consistent with lying in a bed and not having anything to eat or drink for three days. The physician reported there was no other way that the rhabdomyolysis could be caused except for one of these two ways. In an interview on 5/15/2024 at 2:15pm with director of OT/PT revealed, she was advised that Resident #1 was coughing and had problems swallowing during meals. She stated since Resident #1 was a Veteran, and his services were being covered by the Veteran Administrator she contacted the VA to get approval for another swallow study to be completed on Resident #1. She stated she was advised by the VA that this condition was not a new condition for Resident #1 and that a swallow assessment was completed in January 2024 and another one would not be approved at this time. (continued on next page)

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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 - Actual harm Residents Affected - Few	In an interview on 5/15/2024 at 2:30 pm with LVN B revealed, she worked through an employment agency. She stated she worked the night of 5/9/2024 when Resident #1 was sent out the hospital. She stated she was advised by other staff that he was sent out due a decline, stated the resident was struggling breathing and his blood pressure was low. LVN B stated she received a call that night from the RP. She stated the RP reported that the hospital advised her to put a DNR in place for Resident #1. She stated the RP blamed herself for his decline and stated he had been declining ever since going to the first facility. She stated the RP reported that she felt the resident was declining to due being in unfamiliar surroundings and places. LVN B stated the administrator was the abuse/neglect coordinator and they needed to report any suspected abuse/neglect to the administrator immediately, she stated she had never seen or suspected abuse/neglect at this facility. In an interview on 5/15/2024 at 4:07pm with CNA B, revealed she worked on the MC unit with Resident #1. Stated she was not aware that the resident had any eating issues. She stated she was not aware of why the resident was on the secure unit and thought it was odd. She stated she gave the best care that she could to the resident with the information she was provided. CNA B stated the nurses usually would let them know what was going on with a resident. CNA B stated the RP advised them to cut Resident #1's food up so he could take smaller bites, but stated he should have been on a puree' textured diet. She stated there were a lot of things that the RP stated Resident #1 could do when he admitted but he could not, she stated they had to provide a lot of assistance to Resident #1. CNA B stated she let the nurse on duty LVN A know about the amount of assistance Resident #1 required. She stated when the resident was in the wheelchair, he required two people assist because he was a tall man and required two people to assist him. CNA B stated she had been trained on change in condition, she stated it could be loss of appetite, not participating in activities, or wanting to stay in bed. She stated she was trained to let her nurse know if there were any changes with the residents. She stated if a resident had hydration problems, they were trained to push hydration throughout the day and encourage the resident drink throughout the day. CNA B stated the administrator was the abuse/neglect coordinator and they were required to report immediately if they see or suspected abuse/ neglect to the administrator or their nurse. She stated she had never seen of suspected abuse/neglect at this facility. In an interview on 5/15/2024 at 4:18 pm with CNA C, revealed she worked the 6pm to 6am shift with Resident #1 on the secure unit. She stated when she noticed the resident had a change in condition and was in the bed more, she stated she let the nurse know. She stated she did not assist with any meals, she stated when she arrived, she just turned the resident every two hours to prevent skin breakdown. CNA C stated they were trained to let the nurse know if there were any changes with the residents. She stated she had also been trained on abuse/ and stated the administrator was the abuse/neglect coordinator and they needed to report immediately if they seen or suspected abuse/neglect. She stated she had never seen or suspected abuse/neglect at this facility. CNA C stated if a resident hydration concerns, they would push fluids and monitor the intake throughout the day. Record review of 10 resident's charts who were identified to have fluid restriction/ monitoring, special diet. Each resident's chart reviewed had a care plan to address nutritional needs, an order to monitor hydration intake, meal intake records to monitor the amount of their meal they consumed throughout each day. The records reflected they were monitored and evaluated by the primary care physician and nutritionist regularly. The charts reflected weekly weight monitoring to track any significant weight loss of the residents. (continued on next page)

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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 - Actual harm Residents Affected - Few	Record review of facility in-service on abuse/neglect dated 3/25/2024 reflected staff had been in-serviced on abuse/neglect. Record review of facility in-service on Standard of Care dated 1/11/2024 reflected staff had been in-serviced on standards of care. Record review of facility abuse/neglect policy dated March 2018 reflected the following: All residents will be free from abuse/neglect. Record review of facility Intake, Measuring and Recording policy dated October 2010 reflected the following: Review the resident care plan to assess for any special needs of the resident. Verify there is a physician's order for this process. In an interview with the DON on 5/14/2024, she stated the facility did not have a dehydration/ hydration policy.