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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BATESVILLE	154 WOODLAND ROAD BATESVILLE, MS 38606

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 12/04/23 through 12/07/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M 500, M 610 M 640, and M 650. The facility held a license for 130 beds at the time of the survey, and the facility census was 102.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		1/4/24

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M 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the	M 500		

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M 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail	M 500		

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to complete and document a resident self-administration of	M 500	1. Resident #28 was assessed on 12/7/2023 by Registered Nurse. There were no negative findings. Resident #28 was assessed for capabilities to perform medication self administration safely with completion of self medication	

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M 500	Continued From page 4 medications evaluation for one (1) of 1 resident reviewed for self-administration of medications. (Resident # 28) Findings Include: Record review of the facility policy revealed that the facility has adopted "Clinical Nursing Skills and Techniques, Perry & Potter" as supplementary policy and procedure. A record review of "Clinical Nursing Skills and Techniques, Skill 44.6, Teaching Medication Self-Administration" , page 1133 revealed "Assessment ...2. Assess the client's cognitive, sensory, and motor function ...4. Assess client's learning readiness and ability to concentrate ...and learning style preference..." During an observation of Resident #28's room and interview on 12/4/23 at 11:07 AM, revealed two (2) plastic vials laying on the overbed table. Resident #28 revealed that the 2 vials were her breathing treatment medications and she prefers to give herself the breathing treatment at a later time, so the nurses leave them for her. During an observation and interview with Licensed Practical Nurse (LPN) #3 on 12/4/23 at 11:11 AM, she confirmed that the 2 plastic vials laying on Resident #28's overbed table were the medications for the resident's breathing treatment. LPN #3 stated that Resident #28 did not like to take the medications when they were due so she left them in the room so the resident could give them to herself when she was ready. LPN #3 verified the medications were Arformoterol Tartrate 15 micrograms (mcg) per two 2 milliliters (ml) and Budesonide 1 milligram (mg) per two 2 ml. LPN #3 revealed that Resident #28 should have	M 500	administration evaluation reflected in medical record on 12/7/2023. Care plan was updated on 12/7/23 to reflect resident desires to perform self medication administration and is able to safely perform. 2.All residents performing or desiring self medication administration in the facility are at risk for the deficient practice. 3. 100% audit of all residents by the interdisciplinary Team was completed on 12/8/2023 to identify any resident that desires to perform medication self administration. Any residents identified will complete evaluations an competences to ensure protocol is in place. Interview all direct care nursing staff was conducted by the Director of Nursing Services on 12/08/2023 to identify and missed opportunities with identifying residents wishing to self administer medications. Initiated 100% education with all nursing staff on 12/7/2023 by the Director of Nursing and Director of Clinical Education on the process of evaluation of medication self administration, competence check off with residents and notification to management of any residents wishing to self administer medication. 4. Interdisciplinary Team will perform audits on medication self administration of medication evaluations on all residents who self administer medication 12/7/2023 once weekly for 4 weeks, then monthly for two months. All new admissions will be reviewed for performing self medication administration during daily clinical start up	

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M 500	Continued From page 5 an evaluation and observation performed to make sure she could administer the medication herself and verified that Resident # 28 did not have a completed evaluation for self-administration of medications. A record review of the facility evaluation forms for Resident #28 revealed no Self-Administration of Medication forms, dated prior to 12/3/23 (date of entry of State Agency). During an interview on 12/5/23 at 3:25 PM, with the Director of Nursing (DON) she stated that if the resident expressed that they wanted to self-administer their medication an evaluation is completed. She stated the resident's Brief Interview for Mental Status (BIMS) score is checked to make sure the resident can understand how to self-administer medications and an observation of the resident administering the medication is performed. The DON revealed if the resident meets the criteria, they can self-administer the medication. The DON stated that she had been told, that in the past, Resident #28 preferred to self-administer her breathing treatments. During an interview with the DON on 12/7/23 at 8:10 AM, she verified that Resident #28 did not have a Self-Administration of Medication evaluation completed prior to 12/4/23 at 11:59 AM and agreed that she should have already had one. A record review of Resident #28's Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 10/13/23, revealed a BIMS score of 15, indicating that the resident is cognitively intact.	M 500	meeting beginning on 12/8/2023. This will be discussed and documented in Quality Assurance and Performance Improvement. The deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times 3 months. Any variance to procedure will be corrected immediately and addressed by IDT.	

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M 500	Continued From page 6 A record review of the Admission Record for Resident #28 revealed that the resident was admitted on 3/7/2017, with diagnoses that include Chronic Obstructive Pulmonary Disease and Malignant Neoplasm of Right Main Bronchus.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident , family, and staff interviews, record review, and facility policy review, the facility failed to provide oral care for a resident (Resident # 44) and failed to shave a resident (Resident #48) for two (2) of 28 residents reviewed for activities of daily living (ADL's). Findings include: Record review of "Clinical Nursing Skills and Techniques, Perry & Potter, page 457 documented under "Oral Care" the following: "Maintenance of daily oral hygiene, including brushing, flossing, and rinsing, is essential for the prevention and control of plaque-associated oral	M 610	1. Certified Nursing Assistant completed oral care for resident #44 on 12/06/2023. Resident #48 had facial hair removed by Certified Nursing Assistant on 12/6/2023. 2. All residents requiring assistance with activities of daily living are at risk for the deficient practice. 3.100% audit all residents to identify any in need or oral care or facial hair removal was conducted on 12/06/2023 by the Director of Nursing and Assistant Director of Nursing. Care was provided immediately if need identified. 100% in service conducted with licensed nursing staff and Certified Nursing aids on	1/4/24

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M 610	Continued From page 7 diseases..." The facility did not provide a policy directly related to shaving a resident. Resident #44 An observation on 12/04/23 at 2:10 PM, revealed Resident #44's front lower teeth with yellow and white substance attached to gum line and between teeth. It did not appear that mouth care was being completed on this resident. An observation on 12/05/23 at 8:40 AM, revealed Resident #44's lower teeth appeared dirty with yellow and white substance observed on the lower teeth and gum line and when asked about mouth care, the resident said no one had brushed her teeth. On 12/05/23 at 4:00 PM, an observation and interview with Lead Certified Nursing Assistant (CNA), revealed that oral care was supposed to be done on all residents every day. She revealed that this was basic care and just common sense to do this every day. Lead CNA observed Resident #44's teeth and stated, "Naw they (Resident's teeth) haven't been brushed." On 12/05/23 at 4:05 PM, an interview with Licensed Practical Nurse (LPN) #3 confirmed the yellow substance on Resident #44's teeth and revealed that it didn't look like the resident's teeth had been brushed. On 12/05/23 at 4:15 PM, an interview with LPN #2 revealed that failure to brush and clean resident's teeth could cause a lot of things and lead to tooth decay and infection.	M 610	12/6/2023 by Director of Clinical Education for providing ADL care to residents with focus of oral care and facial hair. Interdisciplinary team will review completion of assigned documentation to include ADL care provided daily during Clinical Start Up starting 12/08/2023 4. Interdisciplinary Team will audit four residents four times a week for two weeks, then weekly for two months to assure activities of daily living with increased focus of oral hygiene and facial hair removal is performed starting 12/8/2023. All variances will be immediately corrected and addressed in Quality Assurance and Performance Improvement. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months.	

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M 610	Continued From page 8 On 12/06/23 at 8:15 AM, an interview with Assistant Director of Nursing (ADON) revealed that they did not have a policy on Activities of Daily Living which included oral care. She revealed that the facility adopted "Clinical Nursing Skills and Techniques, Perry & Potter," as a supplementary policy and procedure guide effective January of 2023. Record review of Resident #44's Comprehensive Admission Minimum Data Set (MDS) with Assessment Reference Date of 09/05/2023 under Section GG was documented under GG0130 Self Care B. that Resident #44 was dependent with the ability to use suitable items to clean teeth. Section C revealed that she had a Brief Interview for Mental Status (BIMS) score of 03 which indicated that resident had severe cognitive deficits. Record review of Resident #44's Admission Record documented admission date of 08/29/2023 and the following diagnoses to include: Alzheimer's Disease, Weakness, and Need for Assistance with Personal Care. Resident #48 An observation during the initial tour on 12/04/23 at 12:42 PM, revealed Resident #48 had facial hair approximately 2 inches long on his face. An interview with Resident #48's daughter at the same time revealed a CNA was in earlier trimming her father's beard with scissors. She stated that her father likes to be clean shaven and have his hair cut close to his head. An observation of Resident #48 and interview on 12/5/23 at 10:30 AM, with CNA #3 revealed that	M 610		

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M 610	Continued From page 9 she shaved the resident this morning. She stated that she had to cut his beard down and then shave him. She stated she let Resident #48 see himself when she finished, and he was so happy and smiling. An interview, on 12/06/23 at 09:51 AM, with the Director of Nursing (DON) revealed that Resident #48 will put his hand up to his face when staff are attempting to help him, but it is like a natural reflex. She stated they are working with the staff on residents' individual preferences and the need to make more than one attempt at care. She confirmed Resident #48 should have been shaved. Review of Section GG- Admission with an effective date of 10/16/23 revealed in section I1. Personal Hygiene: 02. Substantial/maximal assistance. Review of the facility Admission Record revealed Resident #48 was admitted to the facility on 10/13/23 with diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side and Aphasia following Cerebral Infarction. Review of Section C of the Admission MDS with an ARD of 10/20/23 revealed a BIMS was not conducted due to Resident #48 was rarely/never understood.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent	M 640		12/21/23

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M 640	Continued From page 10 accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on resident and staff interview, record review, and facility policy review, the facility failed to put safety measures in place to prevent an accident during van transport for one (1) of five (5) residents reviewed. Resident #66 Findings include: Record review of the facility policy titled, "Inspections, Repairs, and Maintenance", with an effective date of September 1, 2019, revealed, "Statement: It is the policy of (Proper Name of Facility) to keep all vehicles well maintained and in safe, efficient operating condition at all times ... Rules of vehicle operation ...7. All passengers must be seated in vehicle seats with occupant restraint ..." Record review of the facility policy titled "Vehicle Safety Guidelines" with a revision date of January 1, 2023, revealed "The safety of our patients/residents, passengers, team members, the public and the protection of the property of others is important to the company ..." An interview on 12/04/23 at 1:15 PM, with Resident #66 revealed that she was in an accident in the facility van a few months ago and suffered a fractured leg. She stated that her wheelchair was secured in the van, but the shoulder strap/seatbelt was not working, so she did not have it on and when the driver made a	M 640	1. 911 called immediately 10/09/2023 by the van driver and the resident was transported to the hospital by Emergency Medical Services. Interview with reenactment by the van driver witnessed by the administrator and social Services Director completed on 10/09/2023. Van Driver was scheduled a drug screen on 10/09/2023 at a Clinic. Van Driver placed on administrative leave pending outcome of investigation on 10/09/2023 by Administrator. Personnel file of van driver reviewed by administrator on 10/10/2023, to assure abuse and neglect and van training was completed prior to incident. Regional Vice President, Director of Clinical Operations, and Senior Director of Clinical Operations notified on 10/09/2023 by the Administrator. Root Cause and Analysis of incident performed during reenactment. Van to be taken out of service on 10/09/2023 until sanitizing and assessed for proper fit and function of the restraints. Incident reported to State Agency on 12/21/2023. 2. Any resident being transferred by the van can be potentially affected. 3. The Administrator completed 100% of transfers for the past 3 months to assure no other prior incidents on 10/10/2023. 100% Education regarding safe van transfers completed on 10/10/2023 to be provided to alternate van drivers prior to	

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M 640	Continued From page 11 sudden stop, she fell out of the wheelchair. Record review of the Incident Report Form revealed, "Date of incident: 10/09/2023, Approximate time of incident: 4.00 PM Location of incident: ...Hwy 7 of Greenwood, MS while being transported per facility van from a scheduled appointment ...Resident fell face forward to the floor out of the wheelchair in the facility van when driver made a fast stop ... (Proper Name of Resident #66) experienced a fall while seated in her wheelchair on the facility van. Resident was transported by EMS (emergency medical services) to local ER (emergency room). X rays were obtained. (Proper Name of Resident #66) has a broken leg ..." Record review of the History and Physical from the emergency room (ER) visit dated 10/9/23 revealed, "Admitting Diagnosis: Femur fracture ...MVA (motor vehicle accident) ...in a nursing home van in a wheelchair we had a sudden break was applied and she was thrown out of her wheelchair and sustained deep laceration to left shin, EMS (emergency medical services) was called and they reported large amount of blood on scene and she was hypotensive. In the ER she was given IV (intravenous) fluids with improvement in blood pressure ...Of note patient is on Eliquis (blood thinner) ...x-ray left femur showed comminuted impacted distal femoral metaphyseal fracture ..." An interview on 12/5/23 at 10:30 AM, with the Administrator (ADM) confirmed that she did not report the incident to the State Agency (SA) because the resident was not on the premises when it occurred. She looked at it as a motor vehicle accident. She confirmed the facility van driver should have fastened the residents' seat	M 640	any other resident transfer. Abuse and Neglect training to be initiated to all staff on 10/09/2023. Safety checks to be conducted by van driver before each transfer to assure proper function and application of restraints starting on 10/10/2023. Van to inspected on a weekly basis by the maintenance director to assure proper function starting on 10/10/2023. 4.Administrator or Maintenance Director will begin monitoring on 10/12/2023 for proper safety technique compliance with 5 transfers weekly for 4 weeks followed by two transfers weekly for four weeks, including proper securing residents in the van prior to leaving the center to assure the van driver's compliance with safety measures. Any variance will be addressed immediately. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 10/24/2023 monthly times three months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 12	M 640		

belt and, if the seat belt was not working, he should have moved her into the other space in the van. The ADM confirmed the van driver no longer works here.

An interview with Maintenance Staff #1 on 12/07/23 at 9:21 AM, revealed he found out about the incident the next day. He stated they have a check off form the driver should do daily and document. Maintenance Staff #1 confirmed the check off was not done on 11/9/23. He stated he looked at the seat belt the next day and it was not functioning properly. He stated the Seat belt/Shoulder strap would not pull out because the ratchet was not releasing.

A record review and interview with the ADM on 12/7/23 at 9:25 AM, confirmed the check off form was not done by the van driver on the day of the incident, 11/9/23.

Record review of the November 2023 van calendar revealed no documentation was made on 11/9/23.

Record review of the Q'STRAINT user instructions revealed, " ...B Secure Passenger 1. Attach Lap Belts ...2. Attach Shoulder Belt ...."

Review of the "Statement from Van Incident" revealed the ADM interviewed the van driver on October 9, 2023. The van driver revealed he had to make a fast stop due to a vehicle in front of him turned quickly. The fast stop caused a fall to the resident. (Resident #66). The van driver revealed that he did not have the resident secured because the seatbelt didn't pull out far enough. He revealed that he did not use the other seatbelt on the bus because he was in a hurry to get the resident to her appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	54BM	A. BUILDING: _____ B. WING _____	12/07/2023

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M 640	Continued From page 13 Review of the Admission Record revealed Resident #66 was admitted to the facility on 11/10/22 with diagnoses that included unspecified Osteoarthritis, Muscle Weakness, Abnormal Posture, and nondisplaced comminuted fracture of shaft of Left Femur. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #66 was cognitively intact.	M 640		
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed to ensure a resident on fluid restriction was monitored for one (1) of 13 residents on fluid restriction. Resident #12. Findings include: Review of the facility policy titled, "Fluid Restriction," revised 9/2017, revealed Policy Statement: "A fluid restriction will be implemented only as part of a therapeutic diet prescription ...Procedures: 4. The Nursing Services will be responsible for tracking and documenting the total volume consumed in accordance with the facility policy..."	M 650	1. Water Pitcher was immediately removed for the room of Resident #12 on 12/5/2023.Resident #12 was assessed on 12/5/2023 by Director Of Nursing. There were no negative finding for this resident. 2. All residents in the center with fluid restrictions orders are at risk for the deficient practice. 3.100% Audit of residents rooms on fluid restrictions for water pitchers completed on 12/5/2023 by the Director of Nursing Services to identify any opportunities in fluid restriction monitoring. 100% review of all care plans and Kardexs for resident's on fluid restrictions was completed on 12/5/2023. Care plans and Kardexs were	1/4/24

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M 650	Continued From page 14 An observation on 12/04/23 at 11:30 AM, revealed Resident #12 drinking from a water pitcher and then placed the pitcher on her bedside table. An interview on 12/05/23 at 2:00 PM, with Certified Nurse Assistant (CNA) #1 and CNA #2, both revealed that Resident #12 was not on any type of fluid restriction. An observation and interview with Licensed Practical Nurse (LPN) #1 on 12/05/23 at 2:10 PM, confirmed Resident #12 had a water pitcher with ice and water sitting on her bedside table and confirmed Resident #12 should not have the water pitcher in her room. After review of Resident # 12's physician's orders LPN # 1 confirmed Resident #12 was on a 1 Liter fluid restriction because she is on dialysis and has End-stage Renal Disease. LPN #1 revealed a possible concern from having the extra fluids in the room is fluid overload. She was unaware if Resident #12 was on Intake and Output (I & O), and she did not know where to look for the documentation. An interview with the Director of Nursing on 12/05/23 at 2:46 PM, she confirmed after review of the physician's orders for Resident # 12 that she was on a 1 (one) Liter fluid restriction and should not have a water pitcher in her room. The DON then revealed after review of the Medication Record for Resident #12 that staff were only documenting the 120 milliliters provided during medication administration for both shifts and were not monitoring the 24-hour total intake for Resident #12 and confirmed that the staff should have been doing so. She then revealed that with the water pitcher in Resident #12's room staff would not know the true amount of fluids taken in	M 650	updated by Director of Nursing, Assistant Director of Nursing, and Unit Managers to reflect fluid restrictions as indicated. Interviews will be conducted starting 12/5/2023 by Director of Nursing or team member with identified residents who are compliant versus residents who are non-compliant of risk. Review and update care plan as needed to reflect compliance. Interdisciplinary Team to monitor residents and update care plan changes in compliance as well as assuring Kardex reflects fluid restrictions. Education was provided by Director of Clinical of Education on 12/5/2023 to Certified Nursing Aides and Licensed nurses on protocol for fluid restriction. 4.Interdisciplinary Team will review all new orders for fluid restrictions for appropriate documentation and implementation during Daily Clinical Start up meeting beginning 12/05/2023. Director of Nursing Services or team member will audit on all residents on fluid restrictions three times weekly for four weeks then once weekly for two months. Any variance to procedure will be corrected immediately and addressed by Director of Nursing. The Deficient practice and the implemented plan correction was reviewed by the Interdisciplinary Team in Quality Assurance and Performance Improvement on 12/27/2023 monthly times three months.	

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M 650	Continued From page 15 by Resident # 12. Review of the electronic medical record revealed a physician's order for Resident #12, dated 2/13/23 "Fluid restriction as directed: 1 (one) L (liter) fluid restriction Nursing to provide: 200 cc (cubic centimeters) fluids on 7a-7p (AM/PM) shift ... Nursing to provide: 200 cc on 7p-7a (PM/AM) shift ... Dietary to provide: 12 oz (ounces) fluids on breakfast tray ... 4 oz fluids on lunch tray ... 4 oz fluids on dinner tray ... two (2) times a day related to Dependence on Renal Dialysis; End Stage Renal Disease." Review of the December 2023 Medication Record for Resident #12, revealed "Fluid restriction as directed: 1 L (liter) fluid restriction Nursing to provide: 200 cc fluids on 7a-7p shift ... Nursing to provide: 200 7p-7a (shift ... Dietary to provide: 12 oz fluids on breakfast tray ... 4 oz fluids on lunch tray ... 4 oz fluids on dinner tray" ... two times a day triggering at 6:00 AM and 6:00 PM" with 120 cc document for both shifts with no documentation of Resident #12's 24 hour total fluid intake. Record review of the Admission Record revealed that the facility admitted Resident #12 to the facility on 12/04/23 with diagnosis of Rend Stage Renal Disease and Fluid Overload, unspecified. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/10/23, revealed that Resident #12 had a Brief Interview of Mental Status (BIMS) score of 7 which indicated that she was cognitively severely impaired. Section I revealed End stage renal disease and Fluid Overload, and unspecified coded as active diagnoses.	M 650		