STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
Ok ✓ Lg	Correction Date 6-25-24 The following deficiencies resulted from the facilities annual recertification conducted on May 28, 2024 to May 30, 2024. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility policy review, the facility failed to provide wound care treatments as ordered for 1 of 3 residents reviewed. Resident #6 had pressure wounds on her coccyx and inner ankle, in an observation it was discovered that the treatments were not in place. The facility reported a census of 43 residents.	F 686		✓

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6-20-24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
✓	Correction Date 06/25/2024 The following deficiencies resulted from the facilities annual recertification conducted on May 28, 2024 to May 30, 2024. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility policy review, the facility failed to provide wound care treatments as ordered for 1 of 3 residents reviewed. Resident #6 had pressure wounds on her coccyx and inner ankle, in an observation it was discovered that the treatments were not in place. The facility reported a census of 43 residents.	F 686	**Elements detailing how you will correct the deficiency as it relates to the individual:** On 05/30/2024 treatments were applied to Resident # 6 by charge nurse verified by DCS. On 05/30/2024, DCS completed verbal education to charge nurse that treatments are to be completed as ordered, and documented after completion of treatment. **How you will act to protect residents in similar situations:** On 05/30/2024 DCS completed a visual audit of pressure wound treatments to ensure treatments were applied and intact, no adverse findings. Education will be completed by 06/25/2024 by DCS or designee with charge nurses about wound care and documentation. **Include measures you will take or systems you will alter to ensure that the problem does not recur:** Education will be completed by 06/25/2024 by DCS or designee to all nursing staff to notify charge nurse if dressings are not in place during cares. Education will be completed by 06/25/2024 by DCS or designee with charge nurses about wound care and documentation. On 06/17/2024 Administrator emailed Telligen QI to set up additional training opportunities on pressure ulcer care and prevention for the IDT team.	06/25/2024

			On 06/19/2024 Telligen QI sent addition tools and training for pressure ulcer care and prevention. By 06/25/2024 IDT team will complete the NPUAP Pressure Injury Prevention video. **How you plan to monitor performance to make sure that solutions are permanent:** DCS or Designee will audit pressure wound treatments to ensure treatments are applied, intact, and documented after completion of treatment 5 times a week for 2 weeks, 3 times a week for 2 weeks, weekly for 2 weeks, and then monthly for 2 months. The audits will continue as needed. Results of the audits will be reviewed in QAPI.	

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE
F 686	Continued From page 1 Findings include: According to the Minimum Data Set (MDS) dated 12/7/23 Resident #6 was unable to complete a Brief Interview for Mental Status, indicating severe cognitive deficits. She had limited range of motion in the lower extremities and was totally dependent on staff for toileting hygiene, dressing, transfers and bed mobility. She was always incontinent of bowel and bladder. The Care Plan last reviewed on 5/1/24, showed that Resident #6 had self-care deficits related to intellectual disability, and she had poor balance with bilateral lower extremity deformity and weakness. The resident was unable to ambulate. She had the potential for pressure ulcers with impaired skin integrity and a history of resolved pressure ulcers. Resident #6 had an unstageable area to right inner foot with a treatment order for calcium alginate and Tegaderm every 3 days and as need to pressure wound on right ankle. According to the order tab in the electronic chart, Resident #6 had a treatment order dated 12/11/23 to apply Calmoseptine and cover with Mepilex every other day, and as needed, to the coccyx. The resident also had an order dated 4/26/24, for calcium alginate and Tegaderm (transparent medical dressing used to cover and protect wounds) every 3 days and as needed to the right inner ankle. According to the Treatment Administration Record (TAR) the treatment to the coccyx had been changed on 5/27/24. On 5/29/24 at 9:38 AM, observed Staff A Certified Nurse Aide (CNA) and Staff B, CNA changing the	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE
F 686	Continued From page 2 soiled brief for Resident #6. The resident had two treatment patches on her bottom, one on the coccyx dated 5/25 and the written date on the patch on the gluteal was faded and not readable. Staff A and Staff B removed the protective boots and socks from the resident's feet and the sore on the inside of her right ankle was not covered with a bandage. On 5/30/24 at 9:57 AM, the Director of Nursing (DON) stated Resident #6 should have had the Tegaderm on her ankle. She acknowledged that it had been documented that the Mepilex on her coccyx was changed on 5/27 and said she that would talk to the nurse who had documented as completed. According to a facility policy titled: Wound Care: Prevention, Assessment, Treatment and Documentation dated 9/2020. Treatment and intervention would be established according to facility wound protocols and physician order and documented. For example: turning schedule, dressing type, topical antibiotic powder/aerosol/ointment, antibiotic systemic, or other treatments.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690	**Elements detailing how you will correct the deficiency as it relates to the individual:** On 05/30/2024, the Administrator completed education with the Dietary Manager that all fluid intake residents consume at meals is to be documented daily by the dietary department. On 05/30/2024, the DCS added a Nursing order for output monitoring in Matrix every shift for resident 41. On 05/30/2024, verbal education was provided to on-site nursing staff and on the 24-hour	06/25/2024

nursing report related to thickened liquids being offered and documented in between meals to resident 41.

How you will act to protect residents in similar situations:

On 05/30/2024, DCS completed an audit of all residents with catheters and a nursing order was added for the one other resident with a catheter.

On 05/30/2024, Dietary Manager implemented paper charting for all resident's fluid intakes to be documented on for each meal, effective immediately.

Include measures you will take or systems you will alter to ensure that the problem does not recur:

All staff education will be completed by 06/25/2024 by DCS or designee related to thickened liquids being offered between meals.

Nursing education will be completed by 06/25/2024 by DCS or designee related to reporting decrease in foley output and importance of documentation of outputs.

On 6/03/2024, the DCS and Administrator reviewed dietary staff's electronic access to ensure all dietary staff had access to document electronically.

On 6/19/2024, the DCS added a task on the admission checklist to add nursing order for output on admission for residents with catheters.

On 6/03/2024 Dietary Manager completed education with dietary staff that it is the expectation that dietary staff complete intake fluid documentation for all residents at all three meals.

On 6/04/2024, the DCS added out of range fluids to the daily start-up form for the IDT team to review residents who triggered for low fluid intake in the previous week. Residents who trigger for low fluid intake added to the Scoop all staff communication form so all staff know to offer additional fluids.

How you plan to monitor performance to make sure that solutions are permanent:

			DCS or designee will audit output charting 5 times a week for 2 weeks, 3 times a week for 2 weeks, weekly for 2 weeks, and then monthly for 2 months. The audits will continue as needed. Results of the audits will be reviewed in QAPI. The Administrator or designee will audit fluid intake documentation 5 times a week for 2 weeks, 3 times a week for 2 weeks, weekly for 2 weeks, and then monthly for 2 months. The audits will continue as needed. Results of the audits will be reviewed in QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE

F 690	Continued From page 3 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, resident interview, staff interviews, and facility policy review, the facility failed to provide adequate fluids and failed to monitor and report intake and output for 1 of 1 residents reviewed for urinary tract infections and urinary catheter use (Resident #41). Resident #41 had a history of acute kidney injury and chronic urinary tract infections. He was found to have inadequate fluid intake and urine output and staff failed to monitor and report. The facility reported a census of 43 residents.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE

F 690	Continued From page 4 Findings include: According to the Minimum Data Set (MDS) dated 4/24/24, Resident #41 had a Brief Interview for Mental Status score of 8 (severe cognitive deficit). He needed supervision with eating, and was dependent on staff for toileting and showering. He was admitted to the facility with a urinary indwelling catheter. The Care Plan updated on 5/28/24, showed that he had developed a urinary tract infection (UTI) related to foul odor and cloudy urine in his catheter, staff were to monitor and encourage fluid intake. The resident had a recent hospital stay for urosepsis and aspiration pneumonia and he was at risk for aspiration, staff were directed to encourage intake of fluids (honey thicken). The Nursing Notes documented the following: a. on 4/4/24 at 3:03 PM Resident #41 admitted to the facility from the hospital after having urosepsis. b. on 4/6/24 at 4:05 AM an order to discontinue the Foley catheter due to urosepsis resolved. c. on 4/9/24 at 2:00 PM in the dining room for meals and taking in small amounts of fluids, refused meal intake. d. on 4/10/24 at 1:42 AM moist cough with crackles bilateral lungs. Fax sent to the physician. Elevated head of bed. e. on 4/10/24 at 9:20 AM drank 200 cc of thick liquids from table mate and had a small emesis. f. on 4/11/24 at 3:20 AM vomited X 2 rattling in bilateral lobes temperature of 101.4 oxygen saturation 79%. Sent to the emergency room. According to the Continuum of Care Transfer	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE

F 690	Continued From page 5 Report from the hospital, date 4/18/24, Resident #41 admitted to the hospital on 4/11/24 with the primary reason for admission Acute Kidney Injury (AKI) with complicated urinary tract infection and aspiration pneumonia. The following is observed in an ongoing observation: a. On 5/29/24 at 10:04 AM Resident #41 in the recliner sleeping in his room. The catheter bag hanging from the walker next to his recliner. The urine was dark. No fluids in his room. b. On 5/29/24 at 11:25 AM, resident in his room, no fluids in his room. He has some pudding cups but no liquids. c. On 5/29/24 at 11:41 AM, the resident was at the lunch table, two small glasses of fluid in front of him. d. On 5/29/24 at 1:07 PM, he was sitting in the wheelchair in front of the nurses station. e. On 5/29/24 at 1:56 PM, the catheter tubing has sediment. f. On 5/29/24 at 2:56 PM, no fluids in his room. g. On 5/30/24 at 7:45 AM, the resident sitting at the breakfast table, other residents around him were eating but he didn't have anything in front of him for breakfast yet. No fluids in his room. h. On 5/30/24 at 8:05 AM, he was feeding himself and his thickened water was almost gone, has a juice also. i. On 5/30/24 at 8:23 AM, the resident back in his room, both of his thickened liquids from breakfast had been consumed. According to a dietician note dated 5/13/24 at 9:15 AM, the required amount of daily fluid was between 1795 and 2155 cubic centimeters (cc). Fluid intake should be encouraged.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE

F 690	Continued From page 6	F 690		

The following was found in the Vitals tab, Fluid intake and Urine Output: from 4/1/24 - 5/30/24
a. From 4/8 - 4/10/24 the average daily fluid intake was 350 cc. of fluid daily.
(the census tab showed that the resident was hospitalized from 4/11 - 4/18)
b. No fluids documented from 4/18 - 4/21.
c. From 4/22 - 4/30/24, the daily average fluid intake was 500 cc.
d. From 4/22 - 4/30/24 the average output was 253 cc a day (normal output for adults is 800-2,000 cc a day)
e. From 5/1 - 5/28/24 intake average was 252 cc. a day
f. From 5/1 - 5/28/24 the average output was 525 cc. a day.

On 5/30/24 at 8:28 AM, Staff D, CNA stated Resident #41 did not get fluids in his room because he was on thickened liquids. She said that water was passed after breakfast and at second shift but he didn't get anything.

On 5/30/24 at 8:38 AM Staff C, CNA stated the resident didn't have much urine in his catheter bag that morning. They wanted to get a sample of the urine because they suspect he may have a UTI.

On 5/30/24 08:46 AM, Resident #41 said the staff did not bring him any liquids in his room. He said that he would like to have fluids in his room and he drank both liquids offered to him this morning at breakfast.

On 5/30/24 at 9:07 AM, Staff E, CNA stated Resident #41 did not get water in his room because he was on thickened liquids. She said that she did do the water pass on occasion but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165474	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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) COMPLETION DATE

F 690	Continued From page 7 she said that she hadn't ever given him a cup of thickened water. On 5/30/24 at 9:57 AM, the Director of Nursing (DON) stated they didn't leave thickened liquids in the resident's room because he would take the glass and try to fill it up with regular water. She said that at times, he would sit out by the nurse's station and they would give him the liquids out there so they can watch him. She said that she would look at the intake and output record but was not aware that the averages had been low. On 5/30/24 at 10:09 AM, Staff A, CNA, stated she hadn't ever brought thickened liquids to the resident in his room but they would bring him some if he asked. When they passed water to the residents, they just skipped his room. She said that he needs to be encouraged to drink. On 5/30/24 at 10:10 AM, Staff B, CNA, stated she hadn't ever brought fluids to Resident #41's room but sometimes he would be sitting out by the nurse's station and the nurses will ask her to get a small glass of thickened liquid for him. She said that she had seen a glass of thickened liquids in his room at times but she hadn't ever seen him try to go fill it up with water himself. According to a facility policy titled: Intake and Output dated 6/2016 it was the policy of the facility to provide adequate fluids to each resident. Nursing personnel would provide and monitor the resident's intake and output based on condition and or physicians order.	F 690		