STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing and Rehabilitation Center	8647 Fenwick Street. Sunland, CA 91040

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) was involved in determining and assessing whether the self-administration of medications was clinically appropriate for one of five sampled residents (Resident 4) who was not assessed for self-administration of the medications stored at the resident's bedside.This deficient practice had the potential to result in Resident 4 unsafely administering medications and unsafely accessing medications stored at bedside.Findings:During a review of Resident 4' admission Record, the admission Record indicated the facility admitted the resident on 7/29/2025 with diagnoses that included type two (2) diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), lumbar spine disc degeneration (when the cushioning in your spine begins to wear away), hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), and history of malignant neoplasm (cancer) of bronchus (large airway that leads from the windpipe to a lung) and lung.During a review of Resident 4's History and Physical (H&P) dated 8/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 8/5/2025, the MDS indicated Resident 4's cognition (ability to think and make decisions) was intact. The MDS further indicated Resident 4 required set up assist with eating, moderate assistance with toileting hygiene, showering, upper body dressing, putting on/taking off footwear, personal hygiene.During a concurrent interview and observation on 9/10/2025 at 4:20 p.m., with Resident 4, upon entering Resident 4's room, Resident 4 was observed organizing medications into a daily pill organizer. Resident 4 stated that Resident 4 had just returned from an outside pharmacy and Resident 4 was organizing her medications for the month. Resident 4 stated that Resident 4 had been taking her own medications since admission to the facility. Resident 4 recently informed the psychiatric (of or relating to the study of mental illness) nurse practitioner that Resident 4 was taking her own medications. Resident 4 was observed with medication bottles located next to Resident 4's bed. Resident 4 stated that the facility staff had not completed an IDT meeting with her regarding self-administering medications.During an interview on 9/11/2025 at 9:30 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that Resident 4 will normally refuse the medications that are prescribed by the facility physician. LVN 1 stated that LVN 1 did contact the physician a few days prior and notified the physician that Resident 4 continues to refuse the facility mediations and LVN 1 stated the physician instructed LVN 1 to continue to encourage Resident 4 to take the prescribed medication. LVN 1 stated that LVN 1 was unaware Resident 4 was self-administering Resident 4's own medications. LVN 1 stated that LVN 1 would inform the Registered Nurse Supervisor right away to discuss with Resident 4.During an interview on 9/11/2025 at 4:30 p.m., with the Director of Nursing (DON), the DON stated that Resident 4 had been self-administering her own medication while being admitted to the facility. The DON stated that an IDT should have been conducted with Resident 4 following her refusal of facility medications to understand why Resident 4 was not taking her medication. The DON stated that an IDT should be conducted prior to any resident self-administering medications and the physician should have been contacted to discuss Resident 4's medications and obtain a physician order for self-administration of medications.During a review of the facility's policy and procedure (P&P) titled, Medication-Self Administration, dated 5/14/2025, the policy indicated it is the policy of the facility that residents have the right to self-administer medications if the interdisciplinary team determines that this practice is clinically appropriate. On admission or shortly thereafter, each resident will be assessed to determine if they want to self-administer their medications. It is the responsibility of the IDT to determine if it is safe for the resident to self-administer drugs before the resident may exercise that right. The IDT must determine where the resident or the nursing staff will be responsible for storge and documentation of the administration of the medications, as well as, the location where the medications will be administered. These determinations should appear on the resident's comprehensive plan of care. The residents will be assessed quarterly to determine their ability to continue to self-administer their medications. The determination of whether it is safe for the resident to self-administer medications should be completed within seven days of the completion of the resident's comprehensive assessment.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) for one of five sampled residents (Resident 5) addressing Resident 5's behavior of spitting.This deficient practice had the potential to result in failure to deliver the necessary care and services. Findings:During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 3/28/2020 with diagnoses that included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (a condition characterized by high levels of fats in the blood), dementia (a progress state of decline in mental status), and dysphagia (difficulty swallowing). During a review of Resident 5's History and Physical (H&P) dated 3/4/2025, the H&P indicated Resident 5 does not have the capacity to understand and make decisions.During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 6/12/2025, the MDS indicated Resident 5's cognition (ability to think and make decisions) was severely impaired. The MDS further indicated Resident 5 requires set up assist with eating, maximal assistance with oral hygiene, toileting, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. Resident 5 is dependent on staff for showering. During an interview on 9/11/2025 at 1:00 p.m., with Certified Nursing Attendant 1 (CNA 1), CNA 1 stated that Resident 5 has a long history of spitting and will provide her (Resident 5) with a small trash located next to her bed or place the small trash can by her wheelchair when she is out of bed. CNA 1 stated that she (CNA 1) will remind Resident 5 to spit into the trash can instead of the floor.During a concurrent interview and record review on 9/11/2025 at 4:00 p.m., with the Director of Nursing (DON), reviewed Resident 5's care plans. The DON stated that she (DON) was unaware of Resident 5 having episodes of spitting. The DON confirmed by stating that Resident 5 should have a care plan in place to address Resident 5's episodes of spitting. The DON stated that she has directed staff to provide Resident 5 with a basin to use during the episodes of spitting.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Planning, dated 5/14/2025, the policy indicated it is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.The comprehensive care plan will provide specific information to include resident strengths, goals, left history and preferences discharge planning and will be completed withing seven days of care area assessment completion. Based upon the resident assessment the care plan may include addressing oral care, skin integrity, medical treatment/diagnostic testing based on the resident's choices/directives, symptom management, nutrition and hydration and activities/psychosocial needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and Individual Count Sheet Record (accountability record of medications that are considered to have a strong potential for abuse) coincided per facility policy for one of three sampled residents (Resident 6).This deficient practice had the potential for medication errors and drug diversion (illegal distribution or abuse of prescription drug). Findings:During a review of Resident 6's admission Record, the admission Record indicated the facility readmitted Resident 6 on 7/31/2025 with diagnoses that included metabolic encephalopathy (underlying systemic conditions or substances that disrupt the brain's chemical balance, leading to brain dysfunction), type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (a condition in which the blood glucose (sugar) levels are abnormally high), and encounter for palliative care (specialized approach to medical care that focuses on improving the quality of life for people with serious illnesses).During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 8/8/2025, the MDS indicated Resident 6's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was moderately impaired. The MDS indicated Resident 6 required partial/moderate assistance from staff with eating and oral hygiene, required substantial/maximal assistance from staff with personal hygiene, and was dependent with toileting hygiene.During a review of Resident 6's physician's orders dated 8/4/2025 timed 10:43 a.m., the physician's orders indicated an order for lorazepam oral concentrate two (2) milligram/milliliters (mg/mL - units of measurement), give 0.25 mL orally four (4) hours as needed for anxiety (intense, excessive, and persistent worry and fear about everyday situations) for 14 days manifested by restlessness leading to distress.During a review of Resident 6's MAR for 8/2025, the MAR indicated Resident 6 was administered lorazepam oral concentrate on 8/11/2025 at 10:04 a.m.During a review of Resident 6's Individual Count Sheet Record for lorazepam, the Individual Count Sheet Record indicated there was no documented evidence that Resident 6 was administered lorazepam on 8/11/2025 at 10:04 a.m.During a concurrent interview and record review on 9/10/2025 at 10:15 a.m., with the Director of Nursing (DON), reviewed Resident 6's MAR for 8/2025 and Individual Count Sheet Record for lorazepam. The DON stated that Resident 6's MAR indicated that Resident 6 was administered lorazepam oral concentrate on 8/11/2025 at 10:04 a.m. The DON was unable to find documented evidence on Resident 6's Individual Count Sheet Record indicating Resident 6 was administered lorazepam on 8/11/2025 at 10:04 a. m. The DON stated that when passing narcotic medications (a drug or other substance that affects mood or behavior), the licensed nurse should assess for pain first, document on the Individual Count Sheet Record what medication was prepared, administer the medication, and then document on the MAR. The DON stated that this process is to ensure that the medication count is accurate. The DON stated that the Individual Count Sheet Record should always coincide with the MAR to ensure there is no drug diversion happening in the facility. During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines: Controlled Medications, review date 5/14/2025, the policy indicated medications included in the Drug Enforcement Administration (DEA) classification as controlled substances (medications that are considered to have a strong potential for abuse) are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication and duration record (MAR):1. Date and time of administration.2. Amount administered.3. Signature of the nurse administering the dose on the accountability record at the time the administration is removed from the supply.4. Initials to the nurse administering the dose on the MAR after the medication is administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility staff failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles for one of three sampled residents (Resident 6) by failing to ensure a discontinued bottle of lorazepam (medication used to treat anxiety [intense, excessive, and persistent worry and fear about everyday situations]) was kept safe, secured, and accounted for.This deficient practice resulted in Resident 6's bottle of lorazepam to go unaccounted and had the potential to result in undetected diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes).Findings:During a review of Resident 6's admission Record, the admission Record indicated the facility readmitted Resident 6 on 7/31/2025 with diagnoses that included metabolic encephalopathy (underlying systemic conditions or substances that disrupt the brain's chemical balance, leading to brain dysfunction), type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (a condition in which the blood glucose (sugar) levels are abnormally high), and encounter for palliative care (specialized approach to medical care that focuses on improving the quality of life for people with serious illnesses).During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 8/8/2025, the MDS indicated Resident 6's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was moderately impaired. The MDS indicated Resident 6 required partial/moderate assistance from staff with eating and oral hygiene, required substantial/maximal assistance from staff with personal hygiene, and was dependent with toileting hygiene.During a review of Resident 6's physician's orders dated 8/4/2025, the physician's orders indicated an order for lorazepam oral concentrate two (2) milligram/milliliters (mg/mL - units of measurement), give 0.25 mL orally four (4) hours as needed for anxiety for 14 days manifested by restlessness leading to distress.During a concurrent interview and record review on 9/10/2025 at 9:45 a.m., with the MDS Nurse (MDSN), reviewed Resident 6's Individual Count Sheet Record (accountability record of medications that are considered to have a strong potential for abuse) for lorazepam oral concentrate 2mg/mL. The MDSN stated that Resident 6's Individual Count Sheet Record indicated a prescription number (RX#) of 4005429 dated 8/1/2025.During a concurrent observation, interview, and record review on 9/10/2025 at 9:46 a.m., with the MDSN, observed the MDSN remove a bottle of lorazepam 2mg/mL from the locked refrigerator in the locked medication room. The MDSN reviewed the label on Resident 6's lorazepam oral concentrate 2mg/mL bottle and stated the lorazepam oral concentrate 2mg/mL bottle had an RX# of 4005499 dated 8/18/2025. The MDSN stated that the RX#s on the lorazepam oral concentrate 2mg/mL bottle and the Individual Count Sheet Record did not match. The MDSN was unable to locate the lorazepam oral concentrate 2mg/mL bottle with the RX# 4005429.During a concurrent interview and record review on 9/10/2025 at 10:14 a.m., with the Director of Nursing (DON), reviewed Resident 6's Individual Count Sheet Record for lorazepam oral concentrate 2mg/mL and the lorazepam oral concentrate 2mg/mL bottle. The DON stated that the RX# on the Individual Count Sheet Record and the RX# on the medication bottle should coincide with one another. The DON stated that she will look for the lorazepam oral concentrate 2mg/mL bottle with the RX# 4005429. During a concurrent interview and record review on 9/10/2025 at 10:16 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 6's physician's orders. RN 1 stated that Resident 6's lorazepam order was received on 8/4/2025 and per Resident 6's physician's orders, was discontinued after 14 days later, on 8/18/2025.During an interview on 9/10/2025 at 10:48 a.m., with the DON, the DON stated that after a narcotic medication (a drug or other substance that affects mood or behavior) is discontinued, licensed nurses are to bring the narcotic medication and the Individual Count Sheet Record to the DON. The DON continued to state that once she (DON) received the narcotic medication and Individual Count Sheet Record, she then locks the narcotic medication and Individual Count Sheet Record in a cabinet for safe keeping. The DON stated that the pharmacist comes to the facility monthly and will then destroy narcotic medications together with the DON to be each other's witness. The DON stated that she reviewed her medication destruction log and lorazepam oral concentrate 2mg/mL RX# 4005429 dated 8/1/2025 was not given to her for safe keeping and has not been destroyed. During a follow-up interview on 9/11/2025 at 11:23 a.m., with the DON, the DON stated that the bottle of lorazepam oral concentrate 2mg/mL with the RX# 4005429 dated 8/1/2025 is gone and was not located. The DON further stated that the facility failed to ensure that a bottle of lorazepam was kept safe. The DON stated that licensed nurses should have done their job by making sure they are giving the correct endorsements

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide one of three sampled residents (Resident 7) with meals that accommodated their food preferences and failed to implement their food preference policy by failing to update food preferences during the quarterly review.This deficient practice resulted in Resident 7's food preferences not being honored and had the potential to result in decreased meal intake which could lead to weight loss and malnutrition (lack of sufficient nutrients in the body).Findings:During a review of Resident 7's admission Record, the admission Record indicated the facility admitted Resident 7 on 1/21/2025 with diagnoses that included end stage renal disease (chronic irreversible kidney [organs that remove waste products from the blood and produce urine] failure), type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (a condition in which the blood glucose (sugar) levels are abnormally high), mild protein-calorie malnutrition (lack of sufficient nutrients in the body), and dependence on renal dialysis (the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney function).During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 7/29/2025, the MDS indicated Resident 7's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and sense) was intact. The MDS indicated Resident 7 required set up or clean up assistance from staff with eating, oral hygiene, toileting hygiene and personal hygiene.During a review of Resident 7's Order Summary Report, the Order Summary Report indicated an order for renal (a specialized dietary plan designed for individuals with chronic kidney disease [a condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood])/ no added salt (NAS)/consistent carbohydrate diet (CCHO- helps control blood sugar levels), regular/thin liquid consistency with meals, ordered 1/21/2025.During a review of Resident 7's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for food dislikes, revised on 7/2025, the care plan indicated no carbohydrates (carbs- food consisting of or containing a lot of sugars, starch, or similar substances that can be broken down to release energy in the human body, and make up one of the main nutritional food groups) and indicated an intervention to respect food preferences within the limits of facility resources.During a review of Resident 7's meal card, the meal card indicated for lunch: meat and vegetables; renal; apples or banana; no carbs.a. During a concurrent observation and interview on 9/10/2025 at 1:09 p.m., with Resident 7, observed Resident 7's lunch tray which contained a meat protein, vegetables, and rice. Resident 7 stated that he (Resident 7) is always served carbs, even after kitchen staff have been made aware that Resident 7 dislikes carbs. Resident 7 stated that he does not like carbs because he is diabetic and carbs affect Resident 7's blood sugar.During an interview on 9/10/2025 at 2:15 p.m., with the Director of Dietary Services (DDS), the DDS stated that rice is a carb.During an observation on 9/11/2025 at 12:51 p.m., in Resident 7's room, Resident 7's lunch tray contained meat protein, vegetables, pasta, bread, and cake.During a concurrent observation and interview on 9/11/2025 at 12:51 p.m., with Resident 7, Resident 7 stated that they gave Resident 7 carbs again. Resident 7 stated that the kitchen always gives him carbs, either rice or pasta. Resident 7 stated that Resident 7 will not eat the rice and bread.During a concurrent interview and record review on 9/11/2025 at 1:46 p.m., with the DDS, reviewed Resident 7's meal card. The DDS stated that the kitchen did not honor Resident 7's preferences by serving Resident 7 carbs. The DDS stated that pasta and bread are carbs. The DDS stated that it is important to honor residents' dietary preferences because it is the resident's right and their choice.b. During a review of Resident 7's Dietary Profile dated 4/29/2025, the Dietary Profile indicated Resident 7 dislikes rice.During a concurrent interview and record review on 9/11/2025 at 1:56 p.m., with the DDS, reviewed Resident 7's Dietary Profile dated 4/29/2025. The DDS stated that residents' preferences are updated quarterly and as needed and documented on residents' dietary profile. The DDS stated that the DDS missed the last quarterly update for Resident 7's Dietary Profile, which should have been updated in July 2025. The DDS stated that he (DDS) should have updated and documented Resident 7's dislikes in Resident 7's chart. The DDS stated that he failed to update Resident 7's Dietary Profile dislikes and stated that it is important to update residents' dietary profile because it is their right to choose what they want to eat and what should be served during meals. During a review of the facility's policy and procedure (P&P) titled, Food Preferences, last reviewed 5/14/2925, the policy indicated resident's food preferences will be adhered to within reason. Food preferences will be obtained as soon as possible through the initial resident screen. This screening must be

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food handling practices by failing to ensure clear storage cups of gelatin were dated and labeled according to the facility's policy.This deficient practice had the potential to place 109 out of 116 residents who receive food from the facility's kitchen at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages).Findings:During an observation of the facility's kitchen refrigerator on 9/11/2025 at 11:55 a.m., observed open food items not in its original packaging and placed in clear storage cups not labeled.During a concurrent observation and interview on 9/11/2025 at 11:56 p.m., with the Dietary Aide (DA), the DA stated that the clear storage cups are cups of gelatine for the residents. Observed the DA count the clear storage cups. The DA stated 11 of the clear storage cups had no label. The DA stated that the gelatin in clear storage cups were sugar free gelatin for residents who are diabetic. During an interview on 9/11/2025 at 11:57 p.m., with the Director of Dietary Services (DDS), the DDS stated that clear storage cups were sugar free gelatin and should be labeled SF to mean sugar free. The DDS stated that when a food item is not in its original packaging, the food item must be labeled with the name or description of the food item and the date when the food item was opened/prepared. When asked about the importance of accurate labeling, the DDS stated that it is important to label food items to make sure that the food item is what it is and for the safety of the residents.During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods, last reviewed 5/14/2025, the policy indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. All prepared foods need to be covered, labeled and dated.

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	056031	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing and Rehabilitation Center	8647 Fenwick Street. Sunland, CA 91040

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 3) had a functioning call light (a device used by a resident to signal his/her need for assistance from staff). This deficient practice had the potential to result in a delay in meeting the residents' needs for assistance which could have left the resident feeling isolated and at an increased risk for falls or accidents. Findings:During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 9/2/2025 with diagnoses that included hemiplegia (one-sided paralysis [complete or partial loss of muscle function]) following cerebral infarction (stroke- loss of blood flow to a part of the brain) affecting right dominant side, history of falling, and difficulty swallowing.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 9/2/2025, the MDS indicated Resident 1's cognition (ability to think and make decisions) was moderately impaired.During a review of Resident 3's History and Physical (H&P) dated 9/5/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions.During an observation on 9/10/2025 at 9:30 a.m., a test was conducted of Resident 3's call light and was found to be not operating.During a concurrent observation and interview on 9/10/2025 at 9:31 a.m., with Registered Nurse Supervisor 1 (RNS 1), observed Resident 3's call light. RNS 1 confirmed by stating that Resident 3's call light was not working and RNS 1 noted that it had to be plugged in to be operating properly. RNS 1 tested call light after plugging the call light in and the call light was found to be operating properly.During an interview on 9/11/2025 at 4:00 p.m., with the Director of Nursing (DON), the DON stated that all residents should have a functioning call light to alert staff of any needs that they have. The DON stated that Resident 3 had the potential to have a delay in the care provided, increased risk for falls or accidents, and decreased quality of care.During a review of the facility's policy and procedure (P&P) titled, Call Lights, dated 5/14/2025, the P&P indicated it is the policy of the facility to respond to the resident's requests and needs. A newly admitted resident should be shown the call light in the room and in the restroom and how to operate them. The residents should do a return demonstration so that the facility can be sure that the resident can operate the call light. When the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident and can operate the call light.