STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056499	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Little CO of Mary Transitional Care Ctr	4320 Maricopa Street Torrance, CA 90503

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 90) received a self^administration assessment, education, and a physician order prior to self^administering an albuterol puff inhaler (a medication used for shortness of breath). This failure resulted in Resident 90 keeping and using an albuterol inhaler at the bedside and placed the resident at risk for improper medication use and potential unsafe clinical outcomes.Findings:During a review of Resident 90's admission Record, the admission Record indicated, Resident 90 was admitted to the facility on [DATE], with diagnosis including chronic obstruction pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), cataract (chronic disease-causing blurred vision) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing)During a review of Resident 90's History and Physical (H&P), dated 4/27/2026, the H&P indicated, Resident 90 was alert and oriented.During a concurrent observation and interview on 4/29/2026 at 9:35 a.m. in Resident 90's room, Resident 90 was observed holding an albuterol puff inhaler in her hand. Resident 90 stated she used the inhaler at least one to three times per day and described it as her lifeline, stating it helped her feel safe. Resident 90 stated she became very nervous when she did not have the inhaler with her because she relied on it when experiencing difficulty breathing.During a concurrent interview and record review on 4/30/2026 at 2:57 p.m. with Registered Nurse 1 (RN 1), Resident 90 did not have a self^administration of medication assessment or a physician order for an albuterol puff inhaler in the medical record. RN 1 stated residents may self^administer medications only after being assessed for their ability to safely do so and after receiving education on the facility's self^administration process. RN 1 stated Resident 90's safety was at risk because she had not been properly assessed or educated prior to self^administering the medication.During an interview on 4/30/2026 at 2:39 p.m. with the Director of Nurses (DON), the DON stated she was aware Resident 90 had not been properly assessed to keep an albuterol puff inhaler at the bedside. The DON stated nursing staff were required to complete an assessment with the resident prior to allowing a resident to store or self^administer their medication to ensure the resident does not overuse or improperly use the medication.During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medication dated 3/2024, the P&P indicated, self-administration of medications by patients may be allowed when ordered by a physician/ provider and for medications deemed appropriate for safe self-administration. Patients or designated caregivers must be assessed by licensed patient care providers and felt to be competent to be allowed to self-administer medications. Patients must be able to understand and properly perform self-administration procedures. All self-administered medications must be documented on the patient's Medication Administration Record [MAR]) by the nurse or other licensed care. The P&P indicated, medications not ordered and/or approved by pharmacy to be stored at bedside will be stored in the proper medication storage area on the patient's nursing unit.and will be accessed by nursing or another authorized licensed patient care provider.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a comfortable and safe environment when the overhead light in Resident 17's room was found to be non-functional, providing inadequate lighting for daily activities.This failure resulted in Resident 17's having limited visibility during evening hours, increasing the risk of falls, injury, or difficulty accessing the call light.Findings:During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was admitted to the facility on [DATE].During a review of Resident 17's History and Physical (H&P) dated 4/16/2026, the H&P indicated Resident 17 with diagnoses of hypertension (HTN-high blood pressure) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 17's Minimum Data Set (MDS- a resident assessment tool) dated 4/22/2026, the MDS indicated Resident 17 cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 17 required touching assistance (helper provides verbal cues and/or touching assistance as resident completes the activity) with activities of daily living (ADLs- routine tasks such as bathing, dressing, and toileting a person performs daily to care for themselves).During a review of Resident 17's Work Order dated 4/25/2026, the Work Order indicated Resident 17's overhead light was not working. The Work Order also indicated the overhead light was completed as requested on 4/27/2026 by Plant Operations and Maintenance (POM).During a concurrent observation and interview on 4/27/2026 at 11:26 a.m., in Resident 17's room, Resident 17 stated she informed the staff her overhead light had not been working. Resident 17 stated she would prefer it if her overhead light worked so at night she could read her paperwork.During a concurrent observation and interview on 4/27/2026 at 1:17 p.m., with Registered Nurse (RN) 5, in Resident 17's room, RN 5 tried turning on Resident 17's overhead light but it did not turn on. RN 5 stated the light should be working for Resident 17's safety when it's dark.During a concurrent interview and record review on 4/29/2026 at 9:45 a.m., with POM, POM stated the Work Order indicated Resident 17's overhead light was completed. POM stated he made a mistake and thought it was the other rooms bed overhead light that needed to be fixed and marked as completed. POM stated Resident 17's overhead light not working could cause Resident 17 to feel unhappy because she is unable to see properly.During an interview on 4/30/2026 at 2:35 p.m., with the Director of Nursing (DON), the DON stated Resident 17's overhead light not working could cause Resident 17 to feel frustrated that her needs are not being met because she likes to read the paper.During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 5/2024, the P&P indicated, The resident has the right to a safe, clean, comfortable, and homelike environment. The facility must provide adequate and comfortable lighting levels in all areas.

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F 0580 Level of Harm - Minimal harm or potential for 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** Based on interviews, and record review the facility failed to ensure one of three sampled residents (Resident 69) had timely physician notification and appropriate nursing interventions when Resident 69's experienced a change of condition([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) when Resident 69 blood pressure (a measurement of the force exerted by circulating blood against the wall of the arteries) dropped to 98/43 millimeters of mercury (mm/Hg) on [DATE] at 3:57 p.m.This failure resulted in a delay in care and led to Resident 69 becoming nonˆresponsive, requiring Cardiopulmonary Resuscitation (CPR-an emergency lifesaving procedure performed when the heart stops beating or breathing ceases), and being pronounced dead on [DATE] at 10:30 p.m.Findings:During a review of Resident 69's admission Record (Face Sheet-front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 69 was admitted to the facility on [DATE].During a review of Resident 69's History and Physical (H&P) dated [DATE], the H&P indicated Resident 69 was admitted to the facility with diagnoses of hypertension (HTN-high blood pressure), coronary artery disease (the blood vessels that supply the heart with blood, oxygen, and nutrients become damaged or diseased), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia(difficulty swallowing) and acute kidney injury (a sudden episode of kidney damage or failure that happens within a few hours or a few days) on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). The H&P indicated the plan for Resident 69 was Physical therapy (PT, licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function), Occupational therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities), and Speech therapy (ST-assessment and treatment of communication, language, voice, fluency, and swallowing disorders) secondary to dysphagia.During a review of Resident 69's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 69 usually had the ability to understand and express ideas and wants. The MDS indicated Resident 69 usually had the ability to understand others. The MDS indicated Resident 69 was dependent (helper does all the effort) on nursing staff dressing, personal hygiene, toileting, and rolling from left to right. The MDS indicated Resident 69 needed substantial to moderate assistance (helper does more than half the effort) from nursing staff with eating, and oral hygiene.During a concurrent interview and record review on [DATE] at 8:47 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 69's vital signs dated [DATE] at 3:57 p.m. were reviewed. The vital signs indicated a blood pressure of 98/43 mm/Hg, temperature of 95.7 degrees Fahrenheit (F), heart rate of 96 beats per minute, respirations of 18 breaths per minute, and an oxygen saturation (O2 sat-a measurement of how much oxygen the blood is carrying as a percentage) of 98%. LVN 1 stated the blood pressure was abnormally low. LVN 1 stated she did not see any documentation in Resident 69's medical record indicating the physician had been notified of the low blood pressure. LVN 1 stated licensed nurses were required to notify the registered nurse supervisor immediately of any change of condition. LVN 1 stated when vital signs are low, the nurse should notify the physician right away, elevate the resident's legs, offer fluids, wait for medical orders, recheck the blood pressure, and transfer the resident to general acute care hospital (GACH) emergency room if necessary. LVN 1 stated Resident 69 was in danger of dying with a blood pressure that low.During an interview on [DATE] at 9:47 a.m. with Registered Nurse (RN) 7, RN 7 stated certified nursing assistants (CNA) obtain residents' vital signs at the start of the shift, and if the physician was not notified of an abnormally low blood (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure, the issue will not be properly addressed. RN 7 stated Resident 69 was on dialysis, was fragile, and required prompt medical orders and interventions. RN 7 stated medication or other interventions should have been administered to address the low blood pressure, or it would continue to drop.During an interview on [DATE] at 1:50 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 69's blood pressure reading of 98/43 mm/Hg was abnormally low and required immediate reporting to the charge nurse because such a low blood pressure could lead to breathing problems and potentially result in a Code Blue (a lifeˆthreatening medical emergency). CNA 4 stated he reported the blood pressure to Licensed Vocational Nurse (LVN) 2, who stated he would check on Resident 69. CNA 4 stated he did not recheck the resident's blood pressure. CNA 4 stated the next time he saw Resident 69, the resident appeared pale, and he informed LVN 2. CNA 4 stated LVN 2 then called a code blue and initiated chest compressions (the application of rapid, forceful pressure to the chest to manually circulate blood when the heart has stopped) to Residente 69.During an interview on [DATE] at 2:27 p.m. with LVN 2, LVN 2 stated on [DATE] at approximately 3 p.m., Resident 69 had just returned from dialysis and appeared weak. LVN 2 stated at 3:57 p.m. the resident's blood pressure was 98/43 mm/Hg. LVN 2 stated he did not remember calling the physician and did not document the change of condition or complete an Situation, Background, Assessment, Response (SBAR a structured communication tool which enhances the communication between members of the healthcare team) in the progress notes. LVN 2 stated licensed nurses are required to recheck low vital signs and notify the physician because the resident is experiencing a change of condition and could die.During a review of Resident 69's Nursing Progress Notes, dated [DATE], the Nursing Progress notes indicated on [DATE] at 9:10 p.m. Resident 69 was non-responsive, cold clammy, not breathing and pulseless. The Nursing Progress Notes indicated Resident 69 was a full code and CPR was started. The Nursing Progress Notes indicated 911 was called and arrived at 9:30 p.m. The Nursing Progress Notes indicated Resident 69 was pronounced dead at 10:30 p.m.During an interview on [DATE] at 2:59 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse should have made sure Resident 69 was stable and rechecked the vital signs and notified the Resident 69's doctor immediately. During a review of the facility's policy and procedure (P&P), titled Transitional Care Center: Notification of Change in Resident Status, dated 7/2025, the P&P indicated .The physician shall be notified promptly of the following types of events in the facility. Any sudden and/or marked adverse change in signs, symptoms of behavior exhibited by a resident, such as abnormal vital signs, signs of redness, bloody stool, sputum or urine, drainage from wounds, sleeping too much, lethargy, signs of upper respiratory infection.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure effective and appropriate pain management for one of one sampled residents (Resident 40). The facility failed to:1.Ensure pain medications were administered according to the physician's orders and pain level parameters.2.Ensure appropriate assessment and communication with the physician regarding the resident's pain.This failure placed Resident 40 at risk for receiving medication stronger than clinically indicated and experiencing adverse side effects (unwanted, uncomfortable, or dangerous reactions to medication). Findings:During a review of Resident 40's admission Record (Face Sheet-front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 40 was admitted to the facility on [DATE].During a review of Resident 40's Physician Orders, the Physician Orders indicated Hydrocodone-acetaminophen (Norco-a brand name prescription that combines hydrocodone and acetaminophen used to treat severe pain) 5-325 milligrams (mg-unit of measurement) every four hours as needed for pain level of 4-6 (numeric pain scale/moderate pain,) was discontinued on 4/15/2025.During a review of Resident 40's History and Physical (H&P), dated 4/17/2026, the H&P indicated Resident 40 was admitted to the facility with diagnoses of but not limited to thoracic 3 (T3) toT4 compression fracture (third and fourth vertebrae of the upper to mid back [the thoracic spine] collapse or break), prostatitis (inflammation or infection of the prostate gland), and urinary retention (inability to completely or partially empty the bladder).During a review of Resident 40's Minimum Data Set (MDS-a resident assessment tool), dated 4/22/2026, the MDS indicated Resident 40 had the ability to understand others and express wants and ideas. The MDS indicated Resident 40 used a walker and a wheelchair. The MDS indicated Resident 40 needed partial to moderate assistance (helper does less than half the effort) from nursing staff with lying down, sitting, and transferring from a bed to a chair. The MDS indicated Resident 40 needed supervision or touching assistance (helper provides verbal cues and or touching, steadying, and or contact guard assistance as resident completes activity) with toileting, dressing personal hygiene and rolling from left to right. The MDS indicated Resident 40 described his pain as mild.During an interview on 4/27/2026 at 11:37 a.m. with Resident 40, Resident 40 stated he gets Tylenol (brand-name for acetaminophen, a medication used for pain relief and fever reduction) and hydrocodone (an opioid medication used to treat severe pain) for pain to his right leg. Resident 40 stated the nursing staff does not follow the manufacturers recommendations for his pain medication. During an interview on 4/30/2026 at 10:39 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 40 complained of pain in the morning. CNA 3 stated Resident 40 stated his pain level was a 7/10 on the pain scale (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9- severe pain, and 10- the worse pain possible) rating from zero to ten all over his body and received pain medication on 4/30/2026.During a concurrent interview and record review on 4/30/2026 at 10:53 a.m. with Registered Nurse (RN) 3, the Medication Administration Record (MAR) for 4/2026 was reviewed. The MAR indicated that on 4/26/2026, Resident 40 received Norco 10/325 mg, which was ordered for severe pain rated seven to ten. RN 3 stated Resident 40 had a pain level of 5 and should not have received Norco 10/325 mg for that level of pain. RN 3 stated the licensed nurse should have notified the physician that the resident's pain level was 5 and requested a different medication appropriate for that level of pain. RN 3 stated Resident 40 received a stronger dose of pain medication than warranted, which could cause side effects such as respiratory distress (a condition in which the body cannot get enough oxygen and requires immediate medical attention) and increase the resident's pain tolerance.During an interview on 4/30/2026 at 2:12 p.m. with the Director of Nursing (DON), the DON stated the nurse should have contacted Resident 40's physician to obtain an order for the appropriate pain medication based on the resident's reported pain level. The DON stated licensed nurses were not following the physician's (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders and were administering a higher dose of pain medication that did not match the resident's pain level.During a review of the facility's policy and procedure (P&P), titled Pain Management Standards of Care, dated 12/2022, the P&P indicated The licensed independent practitioner will ensure an effective pain management plan is in place and is documented. All healthcare providers will coordinate and initiate interventions as ordered within their scope of practice to prevent/relieve pain. These interventions may include but are not limited to. pharmacological as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection control measures were observed for one of three sampled residents (Residents 87). The facility failed to:1.Ensure facility staff wore required personal protective equipment (PPE-equipment used to prevent or minimize exposure to hazards) prior to providing care to Resident 87, who was on enhanced barrier precautions (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO], microorganisms resistant to one or more classes of antimicrobial agents) for a pressure injury (PI-injury to the skin and underlying tissue caused by prolonged pressure).This failure put Resident 87 at risk for cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products).Findings:During a review of Resident 87's admission Record, the admission Record indicated, Resident 87 was admitted to the facility on [DATE], with diagnosis including anemia (a condition where the body does not have enough healthy red blood cells), hypertension (HTN-high blood pressure) and osteoarthritis (degenerative joint disease)During a review of Resident 87's History and Physical (H&P), dated 4/29/2026, the H&P indicated Resident 90 was alert and oriented to person, place and time.During a review of Resident 87's Minimum Data Set (MDS -resident assessment tool) dated 4/4/2026, the MDS indicated Resident 87 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 90 needs substantial/ maximal assistance (helper does more than half the work) with activities of daily living (ADLs] daily self-care activities like toileting, dressing and personal hygiene).During a review of Resident 87's Active Order Summary dated 4/30/2026, the Active Order Summary indicated, Resident 87 had an order for a sacral spine (lower back) PI, clean with normal saline (NS-wound cleanser) apply foam (soft material) dressing daily.During a review of Resident 90's Care plan titled On Enhanced Barrier Precautions dated 4/9/2026, the Care Plan indicated, Resident 90 was on EBP for a Stage II (a partial-thickness skin loss involving the outer layer and part of the inner layer of the skin) sacral (tail bone) PI.During an observation on 4/28/2026 at 11:10 a.m. in Resident 87's room, Registered Nurse 2 (RN 2) and RN 3 were observed changing Resident 87's gown and bed linen after Resident 87 vomited (throw up). RN 2 and RN 3 were observed not wearing PPE (gown).During an interview on 4/28/2026 at 11:25 a.m. with RN 2, RN 2 stated Resident 87 was on EBP for a Stage II pressure injury. RN 2 stated she should have been wearing appropriate PPE, including a gown, when providing direct care or touching Resident 87 because of the resident's Stage II pressure injury. RN 2 stated PPE should be used to help prevent the spread of infection and reduce the risk of crossˆcontamination.During an interview on 4/28/2026 at 11:32 a.m. with RN 3, RN 3 stated Resident 87 was on EBP for a Stage II pressure injury. RN 3 stated she should have been wearing appropriate PPE, including a gown, when cleaning Resident 87 to prevent the resident from being exposed to germs that could potentially cause an infection.During an interview on 4/30/2026 at 2:39 p.m. with the Director of Nurses (DON), the DON stated Resident 87 was on EBP for a pressure injury and nursing staff were required to wear PPE whenever providing direct care to the resident. The DON stated EBP is used as a preventive measure to reduce the spread of infection.During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions dated 9/2024, the P&P indicated, Enhanced Barrier Precaution is the practice used for the prevention of the spread of MDROs. EBP is used during high resident care activities of residents with indwelling medical devices (e.g., central line, urinary catheter, feeding tube), wounds, colonization or infection with a MDRO regardless of their diagnosis and continues even when Standard and/or Transmission-Based Precautions are implemented. EBP is intended to reduce the risk of transmission of resistant microorganisms through healthcare workers and healthcare environment in a long-term care setting.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of four sampled residents (Resident 40) had a functioning call light readily accessible to request assistance.This failure placed Resident 40, who is at high risk for falls, at increased risk for injury due to the inability to summon staff assistance.Findings:During a review of Resident 40's admission Record (Face Sheet-front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 40 was admitted to the facility on [DATE].During a review of Resident 40's History and Physical (H&P), dated 4/17/2026, the H&P indicated Resident 40 was admitted to the facility with diagnoses of but not limited to thoracic 3 (T3) toT4 compression fracture (third and fourth vertebrae of the upper to mid back [the thoracic spine] collapse or break), prostatitis (inflammation or infection of the prostate gland), and urinary retention (inability to completely or partially empty the bladder).During a review of Resident 40's Minimum Data Set (MDS-a resident assessment tool), dated 4/22/2026, the MDS indicated Resident 40 had the ability to understand others and express wants and ideas. The MDS indicated Resident 40 used a walker and a wheelchair. The MDS indicated Resident 40 needed partial to moderate assistance (helper does less than half the effort) from nursing staff with lying down, sitting, and transferring from a bed to a chair. The MDS indicated Resident 40 needed supervision or touching assistance (helper provides verbal cues and or touching, steadying, and or contact guard assistance as resident completes activity) with toileting, dressing personal hygiene and rolling from left to right.During a concurrent observation and interview on 4/27/2026 at 11:37 a.m. with Resident 40 in Resident 40's room, two call lights were observed in the resident's bed. Resident 40 pressed both call light buttons, but the light outside the room did not activate to alert nursing staff and the staff at the nurses station that assistance was needed. Resident 40 stated the call light was not working.During a concurrent observation and interview on 4/27/2026 at 11:46 a.m. with Registered Nurse (RN) 6, RN 6 tested Resident 40's call light. RN 6 pressed both call light buttons and noted that one call light was not plugged into the wall outlet. After plugging it in, the orange light outside of Resident 40's room lit up, indicating the call light was functioning. RN 6 stated the call light was now working.During an interview on 4/27/2026 at 11:49 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 4/27/2026 at approximately 7:30 a.m. Resident 40's call light was not working and she had been informed it needed to be replaced. CNA 1 stated she checked to ensure Resident 40 had a functioning call light and noted CNA 2 conducts call^light checks in the morning. CNA 1 stated call lights must be operational for residents who require assistance, and if a call light is not answered, residents may attempt to get out of bed and potentially fall. CNA 1 stated Resident 40 was high risk for falls.During an interview on 4/27/2026 at 11:56 a.m., with CNA 2, CNA 2 stated on 4/27/2026 at approximately 7:30 a.m., Resident 40's call light was not working. CNA 2 stated she obtained another call light for Resident 40 and placed it on the resident's bed, but the cord repeatedly fell out of the wall outlet. CNA 2 stated without a functioning call light, Resident 40 could attempt to get up without assistance and potentially fall and injure himself.During an interview on 4/30/2026 at 2:09 p.m., with the Director of Nursing (DON), the DON stated the nursing staff would not be able to meet Resident 40's needs if the resident's call light was not functioning properly. The DON stated without a working call light, the resident would be unable to call for assistance when needing to ambulate or when requiring any other help.During a review of the facility's policy and procedure (P&P), titled Transitional Care Center - admission of Patients / Residents, dated 11/2024, the P&P indicated .Use of call light will be explained and call light will be placed within easy reach of resident. Resident will be instructed to press the call light button whenever necessary. All caregivers are aware of importance of timeliness to call light responses. If assistance is not immediately available caregiver will escalate to primary nurse and charge nurse on duty as quickly as possible.Defective call lights will be reported to charge nurse and Plant Operations immediately.