STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105219	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boca Raton Rehabilitation Center	755 Meadows Road Boca Raton, FL 33486

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to monitor and reassess the nutritional needs of 1 of 1 residents reviewed for tube feeding (Resident #19). The findings included: A review of the facility's policy titled Weight Management dated January 2021 showed the following: The dietitian and/or authorized designees will assist the team with identifying significant weight changes and pertinent trends as needed based on the facility process. 1 week 2%, 1 month 5%, 3 months 7.5% and 6 months 10%. The dietitian will reassess the nutritional needs and intake of the Resident with a weight change. Appropriate recommendations will be documented in the medical record via a dietitian recommendation form. Resident #19 was readmitted on [DATE] with diagnoses of Muscle Weakness and Severe Protein-Calorie Malnutrition. The Minimum Data Set, dated [DATE] showed a Brief Interview Mental Status score of 15, which is cognitively intact. A review of the weight logs showed the following weight history for Resident #19: 1/7/2025, a weight of 126.2 pounds. 5/7/25, a weight of 98.4 pounds. 05/14/25, a weight of 98.7 pounds. This showed a 22% weight loss from 1/7/2025 to 5/7/2025. Resident #19's Initial admission to the facility was on 4/28/23, and he was discharged from the facility on 3/26/25 and readmitted again on 4/8/25. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nutrition Evaluation Comprehensive, dated April 9, 2025, showed the following: Resident #19 has been refusing to be weighed since January, which makes monitoring changes in nutritional status difficult. The Registered Dietitian (RD) used 126.2 pounds from 1/7/2025 to assess Resident #19's needs. The estimated energy needs were calculated at 1710-1995 calories, 71-85 grams of protein, and 1425-1710 milliliters (ml) of fluids. A tube feeding Glucerna 1.5 (tube feeding formulary) at 65 ml an hour for a total of 1300ml. Resident #19's Basal Metabolic Index (BMI) was noted at 16.2, which indicated an underweight status. A follow-up nutritional note dated 05/09/25 showed the following: Resident #19 has been pulling his tube feeding out, and it was recommended to switch to bolus feeding to ensure the Resident's intake of feeding meets his estimated needs. It was recommended to change the tube feeding to Jevity 1.5 (tube feeding formulary), with five cans per day, for a total of 1,185 mL. In this note, the RD did not address the weight loss from 126.2 pounds to 98.4 pounds. A Progress note dated 5/19/2025 showed Resident #19 refused his bolus feeding at 9:00 AM and 1:00 PM. A follow-up nutrition note dated 5/30/25 showed Resident's weight was documented at 100 pounds with a favorable gain of 2 pounds from the last weight. In this note, the RD did not reassess Resident #19's nutritional needs related to the weight loss of 27.8 pounds identified on 05/07/25. In an interview conducted on June 4, 2025, at 9:00 AM with Staff C, the Registered Nurse (RN) stated that Resident #19 is receiving a bolus feeding tube with Glucerna 5 times a day. She is responsible for the feeding times at 9:00 AM and 1:00 PM, which is on her shift. Staff C further stated that Resident #19 was tolerating his tube feeding well. On June 4, 2025, at 1:45 PM, Staff C was preparing to administer the bolus tube feeding to Resident #19. Resident #19 said, I am full of poop, and told Staff C that he did not want the bolus tube feeding at this time. An interview conducted on 6/4/25 at 1:39 PM with the facility's clinical RD stated that she completes a monthly nutritional assessment for residents on tube feeding. She will also address any significant weight loss of 5% in one month, 7.5% in 3 months, and 10% in 6 months. For any residents with unknown weights, she will use the prior weights until she gets a more current weight. When asked if she reassessed Resident #19's needs after the new weight was identified on 5/7/2025, she said no. The RD acknowledged that Resident #19 had a significant weight loss, and she did not complete the monthly nutritional assessments. In an interview conducted on 6/04/2025 at 3:00 PM with Resident #19, he stated that he did not understand why he could not eat by mouth and asked this Surveyor why he had to be on a feeding tube. The Care plan dated 5/13/25 showed that Resident #19 was at high nutritional risk and required maintaining nutritional intake without significant changes.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet 24 hour staffing requirements on weekends for the period of 10/1/24 to 12/31/24. The findings included: The CMS Payroll Based Journal (PBJ) report for the facility for the First Quarter of 2025 for the period from October 1, 2024 to December 31, 2024, indicated the facility had excessively low staffing on the weekends for the quarter. This report was run on 05/27/25. On 06/02/25 at 12:13 PM, an interview was conducted with Resident #63. Resident #63 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates she was cognitively intact. Resident #63 had her most recent MDS assessment dated [DATE]. This was the resident's Annual Assessment. Resident #63 stated that there were not enough staff, especially on weekends. Resident #63 stated that it could take hours for anyone to come to the room (respond to the call light) on weekends and overnight. Resident #63 indicated that her roommate, Resident #55, who is also her spouse, was more impacted because he required more assistance than she did. On 06/12/25 at 12:13 PM an interview was conducted with Resident #55, roommate and spouse of Resident #63. Resident #55 was re-admitted to the facility and had his 5-day MDS assessment dated [DATE]. Resident #55 had a BIMS of 13, which indicated he was cognitively intact. Resident #55 expressed agreement with Resident #63. Resident #55 stated he needed to be moved out of bed by using a lift, which requires 2 people to operate. Resident #55 stated that on weekends it takes longer for staff to get him out of bed to his wheelchair because the staff often needs to wait until there are two of them available. On 06/03/25 at 11:54 AM an interview was conducted with Resident #9, who had a BIMS of 15. Resident #9 had her Quarterly MDS assessment dated [DATE]. Resident #9 stated that there could be better service on the weekend. Resident #9 clarified that she did not believe there was enough staff on the weekend. Resident #9 did not wish to elaborate further. On 06/04/25 at 11:43 AM, an interview was conducted with the Business Office Assistant (BOA). The BOA stated he is responsible for documenting and reporting Payroll Based Journal data. The BOA explained that the PBJ data is loaded directly to the CMS system from the computerized payroll system. The BOA stated that hours worked are calculated based upon when the employee punches in punches out. The BOA acknowlodged that there have been times that the facility has been understaffed in the past. On 06/05/25, calculations were performed for weekend staffing from October 2024 through December 2024. The calculations were performed for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs). The calculations involved totaling reported hours for nurses (RNs and LPNs) and dividing by the number of residents reported for the day. The results revealed 12 weekends with a ratio of nursing hours per resident to be less than 1.0. This included the following dates: 10/26, 10/27, 11/2, 11/3, 11/10, 11/30, 12/01, 12/07, 12/14, 12/15, 12/28, and 12/29.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, interviews, and record review, the facility failed to follow the Pureed diet consistency for 1 of 2 visits to the main kitchen. This has the potential to affect 9 residents on a Pureed diet out of 103 current census residents. The findings included: A review of the facility ' s policy titled Pureed Diet, dated 11/2017, showed the following: Pureed means that all food has been grounded, pressed, and/or strained to a soft, smooth consistency like pudding. An observation conducted on June 4, 2025, at 11:45 AM during the lunch tray line revealed a container of pureed turkey on the tray line. Closer observation revealed pieces of green particles in the pureed turkey. Staff A, Cook, said that she made the pureed turkey and added sweet relish for flavor. In an interview conducted on June 4, 2025, at 11:55 AM with the Food Service Director, he acknowledged the green particles in the pureed turkey. In an interview with Staff D, the speech-language pathologist, on June 4, 2025, at 12:00 PM, it was stated that a pureed diet should have a mashed potato-like consistency with a uniform texture and no lumps or pieces.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide food choices and preferences for 2 of 4 residents reviewed for nutrition (Resident #88 and Resident #95). The findings included: 1. A chart review revealed that Resident #88 was admitted on [DATE] with diagnoses of Hypertension and Hyperlipemia. The Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 14, indicating cognitive intact. On 06/02/25 at 12:35 PM, an observation was conducted, and Resident #88 was found in her room eating her lunch tray. The meal ticket noted the following: large portion, 5 ounces pulled pork, plantains, yellow rice, mango mouse, mighty shake, and a peanut butter and jelly sandwich. The lunch meal plate was noted with the magic cup, but it did not contain a large portion of the 5 ounces of pulled pork, plantains, or yellow rice, as indicated on the meal ticket. The Care Plan for Resident #88 showed nutritional problems and to provide diet and supplements as ordered. 2. A chart review revealed Resident #95 was admitted to the facility on [DATE] with diagnoses of Chronic Anemia and Adult Failure to Thrive. The admission MDS dated [DATE] revealed a BIMS score of 13, which indicated the resident is cognitively intact. On 06/03/25 at 8:41 AM, an observation was conducted, and Resident #95 was eating his breakfast tray. The meal ticket was noted as follows: a large portion of ham and cheese Frittata, cereal of choice, wheat toast, juice of choice, 2% milk, and a fresh fruit cup. The breakfast meal plate was missing the fresh fruit cup and the 8 ounces of milk. Closer observation revealed that Resident #95 did not receive a large portion of his breakfast meal either. In this observation, Resident #95 said he did not get his milk or fresh fruits this morning. The Care plan dated 2/27/2025 showed that weight gain would be favorable for this Resident and to provide large portions as ordered. In an interview conducted on June 3, 2025, at 3:00 PM with the Food Service Director, he stated that the meal tray is checked for food accuracy and that the correct diet order is provided. Two staff members on the tray line check for the accuracy of the trays and any orders of large portions.

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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 observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety and sanitary conditions and to prevent foodborne illnesses during two of the two visits to the main kitchen. The findings included: 1. A tour of the main kitchen was conducted on 6/2/25 at 9:39 AM with the following issues noted: A bottle of 46 ounces of Thickened Orange Juice from the walk-in refrigerator with a used date of April 30, 2025. The facility's internal thermometer in the walk-in refrigerator indicated 50 degrees Fahrenheit rather than the necessary 41 degrees Fahrenheit or below. A yellow cleaning bucket containing dark-colored water was noted in the food production area. A cup of strawberries near the food tray line showed 59.0 degrees Fahrenheit, not the necessary 41 degrees Fahrenheit or below. A cup of grapes near the food tray line showed 59.4 degrees Fahrenheit, not the necessary 41 degrees Fahrenheit or below. A cup of canned pears near the food tray line showed 58.1 degrees Fahrenheit, not the necessary 41 degrees Fahrenheit or below. The floor in the dry storage room was filled with debris and food wraps all around. 2. A second visit to the main kitchen on 06/4/2025 at 11:30 AM during the lunch tray line showed the following: A cold container of pureed turkey meat with a temperature of 44.5 degrees Fahrenheit and not the necessary 41 degrees and below. A metal container of lettuce with a temperature of 58.8 degrees Fahrenheit and not the necessary 41 degrees and below. A metal container of sliced tomatoes with a temperature of 58.9 degrees Fahrenheit and not the necessary 41 degrees and below. In this observation, the Food Service Director stated that he would return the sliced tomatoes and lettuce to the refrigerator to ensure they cooled to the appropriate temperature. In an interview conducted on 06/05/25 at 3:00 PM with the administrator, he was informed of the findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation and interview, the facility failed to maintain infection control standards, as per protocol, in the Laundry Room and Soiled Utility areas. The findings included: Review of the facility policy titled Laundry Services provided by the Director of Nursing (DON) effective October 2021 documented in the Policy Statement: The facility will strive to protect residents and employees from facility-acquired infections and communicable diseases and to reduce the risk of cross-infection by utilizing hygienic practices for the handling and processing of soiled linens appropriate procedures will be followed to minimize potential healthcare associated and occupational risks associated with soiled linen handling .Standard Precautions will be followed when handling soiled linens. Procedure: 1. Clean washer and dryer .surfaces daily with a disinfectant. 2. Clean lint traps after each load .12. Clean and disinfect all laundry areas routinely. Review of the facility policy titled Description of Steps in the Laundry Process provided by the Administrator revised 09/05/17 documented in the Policy Statement: There are six steps in the laundry process: 1) Pick-up or collection of soiled linen A. Collection of Soiled Linen: Soiled linen containers or barrels should be on each Nursing unit stored in a soiled area so that nursing can deposit soiled linen. These containers should be checked at regular intervals to keep the soiled linen from over-flowing, which may cause odor and infection control problems Soiled linen must be removed from the units for two (2) reasons: 1. Keep the area infection free .B. It is very important to properly transport and store soiled linens to prevent the spread of infection. To do so, all soiled linen and clean linen must be covered during transportation and while being stored on unit or floors .At designated times, laundry workers are to collect soiled linens from each Soiled Linen Room using a large bin with lid, marked For Soiled Linen Use Only 2. Sorting Soiled Linen Soild linens brought down manually must .be placed into the soiled linen bins C. Lint Screens: a lint screen is installed in the bottom compartment of all commercial dryers. Lint that falls from the linen as it dries is caught by the lint screen, preventing lint from moving directly through the vent and blowing all over the outside of the building. These lint screens must be brushed and cleaned after every load or every hour. If not, the screen will be become packed with lint. When this occurs, warm air moving through the system is blocked, raising the temperature in the basket and causing a potentially dangerous situation; i.e., where one spark on lint can cause fire. Torn or improperly fitted screens must be reported to facility maintenance personnel via a work order for immediate repair. Lint may also: a) Build-up between the drum and the sides of the dryer is the root cause of many dryer fires. This may cause a problem because in many dryers there is a heat sensor there. This sensor reads the heat of the basket and is programmed to shut the dryer down if the temperature gets too hot. If this sensor is covered with lint, the lint acts as insulation and fools the sensor into thinking the basket is not as hot as it really may be. So, instead of shutting the dryer down, it allows heat to continue to pour in. It is extremely important that you remove the entire front of the dryer and vacuum the entire interior. b) Build-up on the top compartment of the dryer. This is dangerous because the heat source is here. The top panel must be opened and the area must be cleaned daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observational tour of the Laundry Room on 06/03/25 at 9:54 AM, it was observed that for one (1) of two (2) commercial dryers: the Speed Queen, this dryer's inner drum was noted to have multiple surface areas covered with some type of thick caked on rust-colored and whitish gunky substance areas (which contained a heavy/caked on/crusted/peeling amount of potentially- contaminated, melted dark matter/debris, along the inner drums of both dryers, all touching and coming into direct contact with the resident's clean clothing. And, it was also noted in 1 of 2 commercial dryers that the Fagor dryer's lint trap filter basket was full with ripped and torn areas, and caked with hanging lint noted in pieces and piles and the lint trap itself was loosened with the rust colored metal bar noted to be broken hanging down and not attached to the dryer itself; all creating a potential, fire hazard. Photographic Evidence Obtained. On 06/03/25 at 9:54 AM a consecutive interview was conducted with two (2) laundry aides Staff E, and Staff F, in which they were asked if they were aware of when the Speed Queen's dryer drum was last cleaned by Maintenance Department and they both responded that they did not know. On 06/03/25 at 10:15 AM during an interview, the Housekeeping Director stated that she recalled that the Maintenance Director told her that he had spoken to a vendor regarding cleaning the dryer drum and the lint traps. However, the Housekeeping Director indicated that she was unable to recall exactly when or with whom. She added that she was not sure how often the outside company comes in to clean the dryer drums and she acknowledged that she did not have any documentation regarding the cleaning schedule for the dryer drums and the lint traps. The Housekeeping Director stated that she would have to check with Maintenance regarding this. The Housekeeping Director further acknowledged that the Speed Queen dryer's drum did have multiple surface areas covered with some type of thick rust-colored and whitish gunky substance areas. The Housekeeping Director stated that she had not been made aware of this, but she reiterated the fact that she had spoken with the Maintenance Department about it, and she was told that they did not want to order any new machines, and she was also unable to recall how long ago this was. The Housekeeping Director ended by saying that she did not document any of the above conversation with the Maintenance Director. As the laundry room tour progressed on 06/03/25 at 10:25 AM, it was noted that one (1) of two (2) commercial washing machines, Speed Queen, was observed to be non-functional and non-operational with multiple chipped off rust covered areas on the side base and to the rear of the washing machine, to include the very rust-colored door; which was left hanging open. According to the Housekeeping Director, she said that this washing machine has been down and not usable for about thirty (30) days and she said that she told Maintenance about it at the time. She said that the Maintenance Director had spoken with the vendor, to her knowledge, yesterday and she does not know what the outcome was. She acknowledged that this facility (with a current capacity of 111, as of 06/02/25) has been operating on only one (1) washing machine, for the past thirty (30) days, she added that she did not document this conversation with the Maintenance Director, anywhere either. During a subsequent interview conducted on 06/03/25 at 10:35 AM again with the two (2) laundry aides Staff E and Staff F, in which they were asked, how long has the Speed Queen, commercial washing machine not been working, to their knowledge, and both responded, that it has been at least for four (4) weeks, or so. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/03/25 at 11:05 AM during a tour of 100 hallway Soiled Utility Room, it was noted that there was a clear, smaller plastic bag sitting atop the sink and outside of the main clear, soiled laundry bag; both of which contained residents soiled linen, the smaller, clear resident linen bag was not properly bagged and covered, which clearly exposed the soiled linen. Photographic evidence obtained. On 06/03/25 at 11:07 AM, a consecutive interview was conducted in which all of the above was acknowledged by both the Housekeeping Director, and by the Assistant District Manager of Health Care Services. And, the Assistant District Manager of Health Care Services acknowledged that the dryer drums should have been cleaned on a regular monthly basis. Interview on 06/03/25 at 1:52 PM with the Maintenance Director, he stated that the Speed Queen washing machine has been out of service for at least the past two (2) weeks. The Maintenance Director indicated that he had obtained a quote in order to either fix the washing machine motor, or for a new washing machine replacement. He said to this Surveyor that he had just been made aware of both the inner Speed Queen dryer drum with the built up melted materials, as well as of the Fagor dryer's lint trap filter having ripped and torn areas, which were loosened with caked on lint; the the rust colored metal bar was noted to be hanging down and not attached to the dryer itself. The Maintenance Director said that the laundry personnel were responsible for shaking out the linen, prior to putting it in the machines. According to the Maintenance Director, the dryer drums are cleaned out, only on an as needed basis, by the Maintenance department. However, he was unable to provide any current paperwork to show the last time that this had been done. The Maintenance Director acknowledged that both the dryer drum and lint trap basket needed to be done now. Resident #57 was admitted to the facility on [DATE]. She had a Brief Interview Mental Status (BIM) score of 12, indicative of moderate impairment. During an interview conducted on 06/04/25 at 11:10 AM with Resident #57 regarding the broken washing machine, she was asked the following three (3) questions, with a response: 1) Are your clothes being laundered on a regular basis? Yes, at least once a week, on a day she chooses, she places her dirty laundry in a bag for the facility to wash. About how long does it take to get your clean laundry back? She stated that it will take more than a week to get her clean clothing back. She said that a CNA will come to her room and gather the bag of dirty clothing and take it to the laundry; then it will come back over a week later. She also said that she had asked the CNA why does it take so long to get her clean clothing back and she said that she was told by the CNA that the washing machine was broken. 2) Does this bother you? Absolutely, yes, it does, according to the resident. 3) How long has this been happening? She said ever since that she has been residing in this facility starting shortly after her admission date of 01/06/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review was conducted of the 04/25/25 quote, provided by the Administrator, labeled Re-build the motor with the sheave/removed to re-build and install and test for proper operation at a quoted cost of $1, 1840, work labor quoted at a cost of $920, for a grand total of $2,760. Both the Administrator, and the Maintenance Director were interviewed, in which both were asked, since they had been aware of the Speed Queen washing machine's mal-function, since this quote, what was the hold-up, with getting this washing machine repaired or replaced, in a timely manner, for the residents in the facility? The Maintenance Director responded first by saying that he verbally told the Administrator about the receipt of the quote to repair the washing machine which had been exhibiting issues, at that time. Then, the Administrator stated that, when the machine finally broke down, he said that he then contacted the vendor, two (2) weeks ago via phone, and he was sent a quote for repair of the current washing machine motor. The Administrator and the Maintenance Director both acknowledged that the facility had been operating with only one (1) machine for their capacity of well-over one-hundred (100) residents; for a period of at least two (2) weeks, or more. Both the dryer drum and dryer lint trap were not cleaned, until after surveyor intervention. The Administrator further recognized and acknowledged on 06/03/25 at 3:45 PM regarding all of the above. He acknowledged that the washer had not been working, since at least the past two (2) weeks. And, the Administrator also indicated that he had just been made aware of the above dryer issues, during this survey, and he added that the dryer drum and dryer lint trap should have been kept cleaned regularly and properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105219	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boca Raton Rehabilitation Center	755 Meadows Road Boca Raton, FL 33486

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 interviews and record review, the facility failed to ensure that a call light was within reach and working for 1 of 30 sampled residents (Resident #76). The findings included: A chart review revealed Resident #76 was admitted on [DATE] with diagnoses of Muscle Weakness and Hypertension. The Annually Minimum Data Set (MDS) dated [DATE] showed that Resident #76 has a Brief Interview Mental Status Score of 13, which indicated the resident is cognitively intact. In an observation conducted on 06/02/25 at 10:17 AM, Resident #76 was noted on bed with the call light noted on the floor and away from Resident #76's reach. In an observation conducted on 06/02/25 at 11:11 AM, Resident #76 was noted in bed with the call light noted on the floor and away from Resident #76's reach. In an observation conducted on 06/02/25 at 11:52 AM, Resident #76 was noted in bed with the call light noted on the floor and away from Resident #76's reach. In an observation conducted on 06/02/25 at 12:30 PM, Resident #76 was noted in bed with the call light noted on the floor and away from Resident #76's reach. In an observation conducted on 6/04/25 at 1:37 PM, Resident #76's call light was noted on the bed within reach. Resident #76 was observed pressing the call light, but no light or noise was illuminated outside Resident #76's room or at the nurses' station, indicating that the call light was being used in Resident #76's room. In an interview conducted on 6/4/25 at 2:45 PM with Staff B, the Certified Nursing Assistant (CNA), she stated call lights need to be working and within reach of residents when needed. She further noted that when a resident uses the call light, a light outside the resident's room will turn on, indicating that the call light has been pressed. In this interview, this Surveyor asked Staff B to try and press the call light for Resident #76. Staff B pressed Resident #76's call light and said that it needed to be looked at since only one side of the call light was working. Staff B stated that she had pressed Resident #76's call light earlier and noticed that it was not functioning properly.