STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105979	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Coconut Creek	4125 West Sample Rd Coconut Creek, FL 33073

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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 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 observations, interviews, and record reviews, the facility failed to ensure call lights were within reach for 5 of 25 sampled residents, Residents #28, #138, #72, #13 and #45; and failed to honor shower preferences for 2 of 3 sampled residents, Residents #93 and #124, reviewed for accommodation of needs. The findings included: Review of the facility's policy, titled, Answering the Call Light, dated 12/10/24, included the following: The purpose of this procedure is to respond to the resident's requests and needs.General Guidelines: 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 1. Record review for Resident #28 revealed the resident was admitted to the facility on [DATE] with the most recent readmission on [DATE], with diagnoses that included: Hemiplegia and hemiparesis following Cerebral Infarction affecting left non-dominant side, other abnormalities of gait and mobility, Alzheimer's Disease, Repeated falls, Generalized Anxiety Disorder, Depression, and History of Falling. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] documented in Section C, a Brief Interview of Mental Status (BIMS) score of 7 indicating severe cognitive impairment. Review of the Care Plan dated 09/23/25 documented Resident #28 had Falls and has potential for further falls related to decrease mobility secondary to Hemiplegia and Hemiparesis secondary to Cerebral Infarction; with a recent fall on 09/16/25; with the following intervention in place: call light within reach and functioning well. On 01/12/26 at 4:17 PM, Resident #28 was observed in her room, crying, talking to herself which was heard in the hallway. She was asked if she needed help and she stated yes. She then stated that she wanted to speak with someone. She was asked if she had her call light, she stated no, and was not sure where the call light was. Further observation of the room revealed the call light device was located on the floor beneath the resident's bed. Photographic Evidence Obtained. The call light was not within reach of Resident #28. At this time, the surveyor left the resident's room and found Resident #28's assigned Certified Nursing Assistant (CNA), Staff G, who stated she has worked at the facility for 2 years. She stated she was aware Resident #28 was crying but she was just with the resident providing care, less than 20 minutes ago. She then stated she would check on the resident again. During an interview conducted on 01/12/26 at 4:53 PM with Staff F, CNA, who stated she has worked at the facility for 6 years, Staff F stated part of the protocol for providing care consists of changing the residents at least 3 times per shift. She noted the protocol also includes changing the resident's adult brief, the bed sheets, or if the resident needs a shower, they would provide it; and they would assist the residents into bed, covered with blankets, and place the call light within reach. During an interview conducted on 01/13/26 at 12:51 PM with the Director of Nursing (DON), the DON stated she has worked at the facility since 2005 and has been the DON for 4.5 years. She stated part of the fall interventions includes having the call light within reach of the resident, bed at the lowest position, and frequently monitoring. She acknowledged every nursing staff is responsible for ensuring the call light button is within reach for all residents. (continued on next page)

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	2. Record review revealed Resident #72 was admitted to the facility on [DATE] with diagnoses of Parkinsonism and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #72 with Brief Interview of Mental Status (BIMS) score of 13 which is mild cognitive impairment. Review of the care plan dated 02/06/25 revealed Resident #72 had potential for falls related to decrease mobility, dementia, agitation and Parkison's disease which can greatly impact her risk for falling. The approach revised on 11/19/25 showed to provide assistance devices as needed and keep within reach. In an interview conducted on 01/11/26 at 11:23 AM, Resident #72 stated that she was waiting on staff to help her get cleaned up. Closer observation showed that her call light was not within reach of the resident and was located behind her bed on the floor. Staff D, Housekeeping, who was just outside the room stated that Resident #72 asked him to call staff and that he used the call light for her, because it was too far for Resident #72 to reach. In an observation conducted on 01/11/26 at 12:05 PM, Resident #72 was noted in her bed with the call light on the floor and not within reach of the resident. 3. Record review revealed Resident #138 was admitted to the facility on [DATE] with diagnoses to include unspecific falls and difficulty in walking. A physician order dated 04/27/25 noted for fall precautions. Review of the Quarterly MDS dated [DATE] revealed Resident #138 with Brief Interview of Mental Status (BIMS) score of 13 indicating mild cognitive impairment. Review of the care plan, initiated on 12/11/24, revealed Resident #138 was: at potential for falls related to decrease mobility secondary to deep venous thrombosis (DVT) of the left lower extremity, vision impairment due to glaucoma, depressive disorder with use of high-risk medication. Approach: encourage the resident to utilize call light for assistance with personal care, toileting, and reaching items outside of her reach. Approach: call light within reach and functioning well. In an observation conducted on 01/11/26 at 11:31 AM, Resident #138 was noted in bed with the call light behind the side table and not within reach of the resident. In this observation, Resident #138 said, I cannot reach the call light to let them know I need help to change my cloths. In another observation conducted on 01/11/26 at 12:04 PM, the call light was noted behind the side table and not within reach of the resident. In an interview conducted on 01/13/26 at 9:57 AM, with Staff B, Certified Nursing Assistant, stated that she has to make sure that the call light is always within reach of Resident #138 because it is the only way for her to call for help. 4. Record review revealed Resident #13 was readmitted on [DATE] with diagnoses to include: Hemiplegia and Hemiparesis, Cerebral Infarction, Hypertension, Atherosclerosis, Diabetes, Hyperlipidemia, Anxiety, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview of Mental Status (BIMS) with a score of 07, on a scale of 0 to 15, indicating severe cognitive impairment. Upon further review of the record, it was noted that Resident #13 had a Fall Care Plan dated 08/07/25 which included an approach that stated, Keeps items within reach eg; hydration cup, TV [television] remote, bed control etc. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/11/26 at 12:05 PM, Resident #13 was observed sitting in her chair with the call light on the floor behind her. Photographic Evidence Obtained. At this time, Resident #13 stated the room temperature was too cold, therefore the surveyor attempted to move the call light within the resident's reach, but the cord was too short. The resident could not move her arm to reach it. Photographic Evidence Obtained. The surveyor activated the call light and Staff N, Registered Nurse (RN), responded. The issue with the call light and room temperature was relayed to Staff N who observed how the resident could not reach the call light. 5. Record review revealed Resident #45 was readmitted on [DATE] with diagnoses to include: Chronic Obstructive Pulmonary Disease, Diabetes, Depression, Anxiety, Left Artificial Hip Joint, Need for Assistance with Personal Care, and Hypertensive Heart Failure. Review of the quarterly MDS assessment dated [DATE], documented a BIMS score of 15, on a scale of 0 to 15, indicating cognition was intact. Upon further review of the resident's record, a Fall Care Plan had been initiated on 03/27/25 and was noted with the following approach, call light within reach and functioning well. During an observation on 01/12/26 at 8:43 AM, Resident #45 was noted in bed with the call light hanging on side of bed. When questioned regarding her access to the call light, the resident responded that it was too difficult to reach it and that she had not knocked it off the bed. It was hung there. Photographic Evidence Obtained. On 01/14/26 at 10:30 AM, an interview was conducted with Staff K, CNA. Staff K stated Resident #45 was not at risk for falls. Staff K also stated that call lights were answered immediately, were accessible while the resident was in a wheelchair, and were pinned to the bed so that they would not fall off or hang off the side. 6. Record review revealed Resident #93 was readmitted on [DATE] with diagnoses to include: Multiple Sclerosis, Muscle Weakness, Need for Assistance with Personal Care, Schizophrenia, Anxiety, and Depression. Review of the annual MDS dated [DATE] documented a BIMS score of 15, on a scale of 0 to 15, indicating intact cognition. Upon further review of the resident's record revealed an order dated 01/22/25 indicating that showers were to be provided on Mondays, Wednesdays, and Fridays on the 3:00 PM to the 11:00 PM shift. During an interview conducted on 01/11/26 at 12:27 PM, Resident #93 stated that she was not getting bathed on her scheduled days. On 01/13/26 at 9:53 AM, an interview was conducted with Resident #93. The resident was unable to recall when she was last showered and stated that she had not been showered the day before, which was a Monday. On 01/13/26 at 9:56 AM, Staff L, CNA, who had worked for the facility for about 2 years, was interviewed. When asked about Resident #93's shower schedule, Staff L stated that she is usually not assigned to Resident #93, so she was not sure. Staff L walked over to the Care Cards posted in the unit and showed the surveyor the resident's schedule which stated daily under showers section. Staff L stated that showers are documented in the computer under the Point of Care section. On 01/13/26 at 12:03 PM, Resident #93 stated that she preferred showers and that they hadn't been offering them to her. On 01/13/26 at 12:46 PM, an interview was conducted with the Assistant Director of Nursing (ADON) (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who stated that showers were ordered in the chart and each charting room in the facility had a shower schedule posted on the wall. She then demonstrated the shower schedule on the wall on the first floor. The schedule was indicated by resident's room number, and the days of week the showers were ordered per shift. The ADON further stated that when the residents are showered or refuse to shower, it is documented in the Point of Care Section (POC) of the electronic health record (EHR). She went into Resident #93's record and it revealed that three showers were offered during the entire month of December 2025 and thus far two in the month of January 2026 when she had been scheduled for five. Photographic Evidence Obtained. The second-floor shower schedule sheets revealed Resident #93 was scheduled for showers on the correct days but incorrect shift. Photographic Evidence Obtained. On 01/13/26 at 1:35PM, Resident #93 was interviewed and she stated her last shower was over a month ago. When asked if she told the staff about it, her response was, They couldn't care less. 7. Record review revealed Resident #124 was readmitted on [DATE] with diagnoses to include: Muscle Weakness, Anxiety, Depression, Overactive Bladder, and Fatigue. Review of the quarterly MDS dated [DATE], documented a BIMS score of 09, on a scale of 0 to 15, indicating moderate cognitive impairment. Further review of the record revealed a physician's order dated 01/16/25 for Showers on Monday, Wednesday, and Thursday during the 7-3 shift [7 AM to 3 PM shift]. During an observation on 01/11/26 at 11:05 AM, Resident #124 stated that her bathing schedule was not when she wanted. She wanted to be bathed in the morning. On 01/13/26 at 12:06 PM, Resident #124 stated she did not receive a shower the day before, which was a Monday. On 01/13/26 at approximately 2:00 PM, the ADON came to the conference room and provided a printout of the shower task for December 2025 but was unable to find one for January 2026 for Resident #124. On 01/13/26 at 1:26 PM, Resident #124 was interviewed in her room. She stated, I don't get showers too often, and was unable to recall when she was last showered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure floor mats were properly placed as part of the Fall intervention protocol for 3 of 20 sampled residents reviewed for floor mats, Residents #99, #38, and #13. The findings included: Review of the facility's policy titled, Falls-Clinical Protocol, dated 12/10/24, included the following: Treatment/Management1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). 1. Record review for Resident #99 revealed the resident was admitted to the facility on [DATE] with the most recent readmission on [DATE], with diagnoses that included: Dementia with Psychotic Disturbance, Urinary Tract Infection, Contracture of Right and Left Hands, Cerebral Atherosclerosis, Anxiety Disorder, and History of falling. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Review of the physician's orders showed that Resident #99 had an order dated 12/31/25 for: Floor mats on bilateral sides of the patient's bed while patient is in bed, every Shift: Days, Evenings, Nights. During an observation conducted on 01/11/26 at 11:56 AM, Resident #99 was in her room, sleeping in bed. Further review of the room revealed two floor mats resting sideways on the wall by the window. Photographic Evidence Obtained. No floor mats were observed by the bed while Resident #99 was sleeping. On 01/12/26 at 4:16 PM, Resident #99 was observed in bed engaged in a word puzzle. Further observation revealed that there was only one floor mat on the left of the resident's bed and the other mat was resting sideways on the wall by the window. During an interview conducted on 01/12/26 at 4:53 PM with Staff F, Certified Nursing Assistant (CNA), she stated she has worked at the facility for 6 years. She stated part of the protocol for providing care consists of changing the residents at least 3 times per shift; and if the resident has an order for floor mats, they are placed on the floor by the bed, and the bed is placed in the lowest position. During an interview conducted on 01/13/26 at 12:51 PM with the Director of Nursing (DON), she stated she has worked at the facility since 2005 and has been the DON for 4.5 years. She stated Fall interventions include nursing staff being made aware of the individual risks of the residents, providing frequent supervision, and if the residents are alert and oriented, provide safety and fall prevention education. She acknowledged that part of the fall interventions includes having the call light within reach of the resident, bed at the lowest position, frequently monitor to ensure bathroom breaks and landing strips or floor mats are in place. 2. Record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses to include repeated falls, unspecific dementia and hyperlipidemia. Review of the physician's orders (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed an order dated 10/16/24 for fall precaution. An order dated 12/21/25 ordered for floor mats on bilateral sides of the patient's bed while the patient is in bed. Review of the quarterly MDS dated [DATE] revealed Resident #38 is severely cognitive impaired. Observations conducted on 01/11/26 at 11:21 AM, at 12:01 PM, and at 12:41 PM, Resident #38 was noted in the bed with both floor mats on the right side of the bed and no floor mat noted on the left side of the bed. Review of the fall care plan dated 10/16/24 revealed Resident #38 was at risk for further falls related to decrease mobility and multiple falls. Resident #38 is cognitively impaired due to dementia and history of recurrent fall. In an interview conducted on 01/13/26 at 10:02 AM with Staff B, CNA, she stated Resident #38 is at risk of falls because she sometimes tries to get out of bed on her own without calling for help. Staff B reported that the call light needs to be within reach, keeping the bed in the lowest position and making sure that the wheelchair is locked when the resident is in the wheelchair. 3. Record review revealed Resident #13 was readmitted on [DATE] with diagnoses to include: Hemiplegia and Hemiparesis, Cerebral Infarction, Hypertension, Atherosclerosis, Diabetes, Hyperlipidemia, Anxiety, and Depression. Review of the quarterly MDS dated [DATE], documented a BIMS score of 07, on a scale of 0 to 15, indicating had severe cognitive impairment. Upon further review of the record, it was noted that Resident #13 had a physician's order dated 08/11/25 that documented: Floor mats on bilateral sides of the bed while patient is in bed. The record also had a Fall Care Plan dated 08/06/25 which included the approach of the floor mats on both sides. During an observation on 01/12/26 at 9:02 AM, Resident #13 was observed in her bed. The floor mat on the left side of the bed was propped up against the wall under the window and the floor mat on the right side had the bedside table on it which created a fall hazard. Photographic Evidence Obtained. During an observation on 01/14/26 at 10:14 AM, Resident #13 was noted in bed. Both floor mats were noted on the left side of the bed, piled on each other. There was no floor mat on the right side of the bed. Photographic Evidence Obtained. On 01/14/26 at 10:32 AM, an interview was conducted with Staff J CNA, who was asked if Resident #13 was at risk for falls. She replied Yes and stated that the interventions for the resident were: bed was to be in the lowest position, mats on both sides of the bed, and the call light within reach. Staff J then entered the resident's room and observed the mats both on one side only.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to address a significant weight loss for 1 of 2 sampled residents reviewed for nutrition, Resident #41.The findings included:Review of the facility's policy titled, Weights, dated 12/09/25 revealed the following: Any resident identified at risk for weight loss will be reviewed with appropriate interventions and plan of care by the Interdisciplinary Team. Any residents identified with significant weight loss of 5% in 30 days, 7.5% in 90 days and 10% in 180 days. Record review showed Resident #41 was admitted to the facility on [DATE] with diagnoses to include Muscle Weakness, Dementia and Unspecified protein-calorie malnutrition. In an observation conducted on 01/11/26 at 12:20 PM, Resident #41 was observed in her bed with her lunch tray consisting of a pot roast, mashed potato, green beans, dinner roll and a Boston cream pie. Staff C, Certified Nursing Assistant (CNA), was in the room setting up the lunch tray for Resident #41. Staff C reported that Resident #41 can eat on her own and you only need to set up the tray for her. At 12:30 PM, Staff C left the room, and Resident #41 was eating on her own. Continued observation revealed Resident #41 attempting to eat her meal with some of the food falling on her lap and on the meal tray. At 12:45 PM, Resident #41 had eaten 15% of her lunch meal.The following weights were noted for Resident #41:01/09/26 at 103 pounds.01/02/26 at 102 pounds.12/24/25 at 102 pounds.12/05/25 at 125.6 pounds.11/07/25 at 125 pounds.This showed a significant weight loss of 18.8% from 12/05/25 to 12/24/25. Review of the physician's orders dated 12/23/25 documented the following: No Added Salt diet/enhanced foods; and on 11/14/25, an order for House supplement 2.0, 120 milliliters once a day.Review of the progress note dated 01/11/26 revealed Resident #41 was transferred to an acute care hospital for low grade fever and malfunctioning of nephrostomy tube. The resident was also hospitalized from [DATE] to 12/23/25.A Mini Nutritional Assessment completed on 12/24/25 showed Resident #41 with severe decrease in food intake, and a weight loss of greater than 6.6 pounds. The Resident scored 2.0 on this assessment indicating malnutrition category. The Nutritional Assessment which was completed on 12/24/25, after Resident #41's return from the hospital, showed the following: 'Resident #41 was readmitted with a weight loss of 18% since 12/05/25. Usually Body Weight of 125 pounds, and averaged intake of meals between 25 to 50% intake.' In this assessment, the Clinical Dietitian, acknowledged the significant weight loss but did not make any nutritional changes or updates to plan of care. In this note, there were no additional supplements recommended, food preferences changes, and no observation of the resident during mealtimes or appetite stimulant. Review of the meal intake percentage for Resident #41 showed that from 12/13/25 to 12/19/25, which was a week before Resident #41 went to the hospital, the following 24 meals were consumed as follows:11 meals were consumed at 25% intake.4 meals were consumed between 26% to 50% intake.8 meals were consumed at 0 intake.1 meal was consumed at 76% to 100% of intake. Review of the hospital progress note dated 12/23/25 revealed that Resident #41 was 120 pounds when admitted to the hospital on [DATE] and 120 pounds when they were discharged from the hospital on [DATE]. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #41 was severely cognitive impaired. Under section GG for eating, Resident #41 needed supervision or touching assistance during eating. In an interview conducted on 01/13/26 at 8:54 AM with the facility's Clinical Dietitian, he stated that a significant weight loss is categorized as follows: 5% in 30 days, 7.5% in 90 days and 10% in 180 days. For any residents with significant weight loss, he would notify the nursing staff/physicians via daily emails or document in the nutritional progress notes. For a resident who is identified with weight loss, he will reassess the resident, go over food preferences, and add additional supplements especially if the supplements they are already on are not effective. He may offer milkshakes or house shakes and recommend an appetite stimulant if needed. According to the Clinical Dietitian, he likes providing nutritional supplements because you can calculate how much a resident is eating compared with intake of meals which may not be as (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurate. He further said that Resident #41' weight loss must have happened while they were in the hospital from [DATE] to 12/23/25. The surveyor stated that the hospital records revealed that Resident #41 was 120 pounds when they came back to the facility on [DATE] and the weight taken in the facility the next day on 12/24/25 showed 102 pounds. An interview was conducted on 01/13/26 at 12:22 PM with Staff E, MDS Coordinator, who stated that when a resident is coded with supervision or touching assistance, it means that staff needs to supervise and be in the room during dining times. The expectation is for staff to be in the room if they need help, which for example can be residents who are unable to bring their fork all the way up or encouragement during the meal. The care plan dated 11/04/24 revealed Resident #41 was at risk for alteration in parameters of nutrition related to decrease intake, weight loss, and low Body Max Index. Approaches in place were to provide meal assistance as indicated, offer meal substitution as needed and notify physician services of significant weight changes.

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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 observations and interviews, the facility failed to ensure it was adequately equipped with functioning emergency call devices in 2 of 11 rooms on the First Floor, 3 Unit. The findings included: Review of the facility's policy titled, Answering the Call Light, dated 12/10/24, included the following: The purpose of this procedure is to respond to the resident's requests and needs.General Guidelines: 7. Report all defective call lights to the nurse supervisor promptly. During the initial tour of the facility conducted on 01/11/26 at 10:27 AM, observation of room [ROOM NUMBER]'s bathroom revealed the emergency call light device was missing the pulling cord by the toilet. Further observation revealed the emergency call light cord was also missing in the shower, Photographic Evidence Obtained.An interview was conducted on 01/12/26 at 9:20 AM with the resident in room [ROOM NUMBER], who stated he does use the bathroom in the room, especially when he has a bowel movement. The resident also stated he is assisted by the nurse's aide and if he needs help in the bathroom, he can use the call light. Further observation of the bathroom revealed no cord attached to the emergency call light device. Photographic Evidence Obtained. On 01/12/26 at 4:33 PM, a medication administration observation was conducted with a nurse in room [ROOM NUMBER]. While the nurse was washing her hands in the bathroom, it was noted the emergency call device was missing the pulling cord Photographic Evidence Obtained. During an interview on 01/14/26 at 9:01 AM conducted with Staff H, Certified Nursing Assistant (CNA), Staff H stated he has worked at the facility for 2.5 months and assigned to the First Floor 3 Unit. He stated if the resident complains of any issues in the room or if he saw any concerns in the resident's room, he would report it to the nurse; then he would fill out the maintenance request slips, which are located at the nurses' station. On 01/14/26 at 9:06 AM, an interview was conducted with Staff I, Registered Nurse (RN) and Unit Manager. She stated any staff member can fill out the maintenance slip for any concern in the rooms or the facility. She stated maintenance does rounds, picks up the slips with the requests and works on them as well. During an interview on 01/14/26 at 9:08 AM conducted with the Director of Maintenance (DOM), he stated he has worked at the facility for 23 years and has been the DOM since 2009. He stated rounds of the facility are conducted every morning and then prior to end of their shift by him and his assistant. During their rounds of the facility, they look at the hallways, the ceilings, and check the residents' rooms if concerns were identified by the staff including any issues with call lights. At this time, a tour of the First Floor 3 Unit was conducted with the DOM. He was first shown room [ROOM NUMBER]'s bathroom and was asked what was missing in the bathroom. He looked around and noticed that the cord for the emergency light device was missing and stated he was not aware of it. He then stated that CNAs, housekeeping staff and nurses received training on making maintenance aware of any concerns. This surveyor and the DOM continued to room [ROOM NUMBER]. Upon entering the room, the toilet was heard flushing and the DOM stated that someone was in the bathroom. Further observation revealed after the resident had left the bathroom in room [ROOM NUMBER] revealed no pulling cord was attached to the emergency call device.