STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER: The Lodge at Taylor		STREET ADDRESS, CITY, STATE, ZIP CODE: 22950 Northline Rd Taylor, MI 48180	

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on observation, interview and record review, the facility failed to act promptly on a consistent grievance received from residents at ten consecutive monthly Resident Council Meetings resulting in residents not having water passed to them on a regular basis and feelings of frustration due to not having their needs met. Findings include: On 12/10/24 at 1:44 PM R9 was observed in bed without water or water cup on their bedside or over-the-bed table. There was no type of hydration visible in the resident's room. R9 could not say if there had been water available to them at their bedside earlier. On 12/11/24 at 9:03 AM R9 was observed in bed without water or water cup on their bedside or over-bed table. There was no visible hydration in the resident's room. R9 was asked if water was offered to them earlier. R9 was unable to be meaningfully interviewed due to cognition impairment, but did ask for a drink of water. According to R9's Electronic Health Record (EHR) the resident had resided at the facility since 2011 and had severe cognition impairment with a Brief Interview for Mental Status (BIMS) Score of 4/15. On 12/11/24 at approximately 9:35 AM R57 was observed in her room without a water cup on her over-bed table. R57 said that residents had been complaining of not receiving water pass on a regular basis for months now. R57 said, We bring it up in every resident council meeting, but it never gets fixed. Sometimes we get water, sometimes were don't. I can ask for it, but others can't. According to R57's EHR the resident had resided at the facility since 7/7/22. The Minimum Data Set (MDS) dated [DATE] indicated the resident had a BIMS score of 15/15 (intact cognition.) On 12/11/24 at 9:37 AM R64 was observed without water or a water cup at bedside. R64 said that concerns have been brought up at the council meeting regularly. The resident stated, Some staff remember to bring us water, and some don't. R64 said they were independent and able to walk to the kitchen and ask for water. According to R64's EHR the resident admitted to the facility on [DATE]. The MDS indicated the resident had a BIMS score of 15/15. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at approximately 9:45 AM Certified Nursing Assistant (CNA) M, who was the assigned CNA for R9, R57 and R64, was interviewed. CNA M said they had not passed water to any residents yet because they thought the midnight shift had done it before they left. A review of the facility's Resident Council Meeting (RCM) minutes from 2/6/24 - 11/12/24 included the following resident's concerns: 2/6/24; no water or ice being passed, mostly on the afternoon shift. 3/1/24; no water being passed. 4/9/24; water pass is not consistent, not getting water on the midnight shift. 5/7/24; water pass is still not getting passed on the midnight shift. 6/12/24; water pass getting better, but not on the week-ends. 7/11/24; no water pass on the week-end is on new business. 8/13/24; old business section reports ' no water pass'. There is no resolution reported. 9/10/24; no water pass - it depends on who is working. 10/8/24; no water pass on the afternoon shift. 11/12/24; unresolved old business; no water pass. On 12/11/24 at 11:37 AM during an interview with the Nursing Home Administrator (NHA) the RCM notes from 2/6/24 - 11/12/24 were reviewed. The NHA acknowledged that residents had concerns regarding not getting water pass on certain shifts at every RCM since 2/6/24. The NHA said that staff had received in-services in October and water was getting passed to residents. The NHA said, We did an education and then audits to check if water pass had been done in October and it showed that resident's were getting water. Then staff changes occurred and water pass wasn't being done consistently. We need to start monitoring it again. The NHA presented the in-services and audits for water pass dated 10/14/24, 10/16/24 and 10/17/24. The NHA was asked if anything had been done to resolve the concerns for water pass prior to October 2024 and replied no. The NHA could not explain why no resolutions had occurred regarding water pass since February 2024. On 12/11/24 at 11:42 AM the Director of Nursing (DON) reviewed the audits for water pass on 10/16/24 and 10/17/24 and acknowledged that some residents had still not received water pass even after in-services had been provided to staff. The DON said, Some of our staff has changed since then and we need to complete another in-service for water pass to residents. The DON said she had only been in the this position for a short time and could not provide any documented in-services or audits for water pass prior to 10/16/24. The DON acknowledged that residents had been expressing their concerns with lack of water pass since 2/11/24. According to the facility's policy for Resident Hydration last revised on 1/1/2022 in part reads; (continued on next page)

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	235541	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Taylor	22950 Northline Rd Taylor, MI 48180

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Residents will be provided fluids on a daily and routine basis as part of daily care

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 22960 Based on observation and interview, the facility failed to maintain the over-bed tables in 7 resident rooms (#'s B4, C2, E4, G2, I11, I12, and J9). Findings include: On 12/10/24 between 2:00 pm-2:30 PM, in resident rooms B4,C2, E4, G2, J9, I2, I11 and I12, there were over-bed tables observed with missing edging, peeling surface veneer and rough, exposed particle board. The tables were no longer smooth and easily cleanable. During an interview on 12/10/24 at 3:15 PM, Maintenance Director K stated that he relies on staff to let him know when a table needs to be replaced. When shown the over-bed table in room C2 (the whole top surface was lifted away from the particle board) Maintenance Director K stated, It's water warped. It needs to be replaced.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 Based on interview and record review the facility failed to ensure the Preadmission Screening (PAS)/ Annual Resident (ARR) Mental Illness/ Intellectual Disability/ Related Conditions Identification forms DCH-3877 and/or DCH-3878 documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for mental illness needs upon admission for two (R44 and R86) of four residents reviewed for PAS/ARRs, resulting in the potential for residents not to receive care and services appropriate to their mental health needs. Findings include: R86 On 12/10/24 at 2:51 p.m. review of the electronic medical record documented R86 was initially admitted into the facility on [DATE] and readmitted on [DATE] from the hospital with diagnoses that included paranoid schizophrenia, anoxic brain damage, cocaine abuse, and adjustment disorder. According to quarterly Minimum Data Set assessment dated [DATE], R86 had no speech, severely impaired cognition and dependent with all activities of daily living. Review of the Preadmission Screening (Level I Screen, 3877) dated 9/12/24, documented R86 had mental illness and receiving antidepressant/antipsychotic indicated by a checked yes. Review of the Mental Illness/Intellectual Disability/ Related Condition Exemption Criteria Certification (3878) dated 9/12/24, documented R86 had Dementia Exemption checked yes. The 3877 and 3878 were completed by hospital staff on the day of discharge to the facility. Review of hospital records, face sheet, and psychiatric progress note dated 11/6/24 did not document R86 had a diagnosis of dementia. On 12/11/24 at 1:43 p.m. Social Worker (SW)G was interviewed and queried about the 3877/3878 and was a Level II evaluation request sent to the local mental health agency. SW G stated, This was confusing because of the dementia exemption. I don't know why dementia was not put on 3877. It came from another facility. I typically review them (PASARR) upon admission, but I can't remember what happened with this one. A request for a Level II evaluation was not submitted to the local mental health agency based on the 3877 and other pertinent information not reviewed. 22349 R44 According to Electronic Health Record (EHR) R44 admitted to the facility on [DATE] with diagnoses that included unspecified psychosis and metabolic encephalopathy (broad term for a brain disease that alters brain function.) The MDS dated [DATE] indicated the resident had severe cognition impairment and was non-verbal. R44 was prescribed a psychoactive medication; Risperdal 0.5 milligrams every day for paranoia. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Preadmission Screening (Level I Screen, DCH-3877) dated 12/23/2023, documented R44 had mental illness and receiving antidepressant/antipsychotic checked yes. There was no DCH-3877 form completed upon admission to the facility and no Level II Screen, DCH-3878 assessment. On 12/11/24 at 3:49 PM during an interview regarding R44, SW G said that the resident did not have a PASARR assessment completed since admitting to the facility. SW G said, The resident came from another facility and it was missed. We should have reviewed it and updated it. The resident will most likely be exempt for a level II, but we should have done a PASARR. Review of the facility's policy titled, Resident Assessment Coordination with PASARR Program dated 10/23 documented in part: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs . All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . PASARR Level I - initial pre-screening that is completed prior to admission . PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority(cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs . If a resident who was not screened due to an exception and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state designated authority for Level II PASARR evaluation and determination . The Social Services Director shall be responsible for keeping track of each resident's PASARR condition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on interview and record review, the facility failed to administer medications as ordered and failed to notify the physician of missed doses for one resident (R250) out of five residents reviewed for medications. Findings include: On 12/10/24 at 10:41 AM, during an interview with R250, it was reported that intravenous antibiotics were not administered during dialysis. A record review of R250's electronic medical record (EMR) disclosed their admission to the facility on [DATE], with a diagnosis of end stage renal failure and osteomyelitis (infection of bone) of left foot and ankle. Review of R250's Minimum Data Set (MDS) dated [DATE], R250 required partial/moderate assist for most activities of daily living (ADLS). Review of R250's Brief Interview for Mental Status (BIMS) dated 11/29/24 revealed intact cognition, with a score of 15 out of 15. Record review of physician orders documented that R250 was to receive Cefepime HCL (antibiotics) . should be administered intravenously once daily on Mondays, Wednesdays, and Fridays until 12/29/24, after completing hemodialysis (HD). Furthermore, it was revealed that Vancomycin HCL (antibiotic) was prescribed for osteomyelitis. The order indicated that 500 mg(milligrams) of Vancomycin HCL should be administered intravenously daily on Mondays, Wednesdays, and Fridays until December 29, 2024. Administer post (after) HD. Review of the Medication Administration Record (MAR) for December 2024 disclosed that Vancomycin was not administered on December 2, 4, 6, and 9. Furthermore, Cefepime was not administered on December 4, 6, and 9. Review of Progress Notes dated 12/4/24, Licensed Practical Nurse (LPN) E documented Pt (patient) in dialysis. No documentation related to administration of antibiotics or that the physician was informed of the missed doses. Review of Progress Notes dated 12/6/24 at 2:12 PM, LPN D documented dialysis to administer to patient for both antibiotics. No documentation related to administration of antibiotics or that the physician was informed of the missed doses. Review of Progress Notes dated 12/9/24. Registered Nurse (RN) F documented both antibiotics were on order. No documentation indicated that the physician was made aware of the missed doses. Review of Communication Report from dialysis provider on 12/2/24, it was documented under Antibiotics Given- 0. On 12/4/24,12/6/24 and 12/9/24 under Antibiotics Given there was no documentation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 10:50 AM, an interview was conducted with Unit Manager (UM) H. At this time UMH was informed that R250 had reported not receiving antibiotics that were ordered to be given at dialysis. UMH reported not being aware of the missed doses and would look into it. On 12/11/24 at 4:00 PM, an interview was conducted with the Director of Nursing (DON), it was confirmed that R250 had missed four doses of Vancomycin and three doses of Cefepime. When questioned about how the antibiotics should have been administered, DON reported that the antibiotics should have been taken to dialysis to be administered and when the antibiotics were not available, nursing staff should have informed the physician. On 12/11/24 at 4:20 PM, an interview was conducted with Physician L, it was reported that nursing staff did not report the missing doses of antibiotics until 12/10/24. On 12/12/24 at 10:02 AM an interview was conducted with LPN E, it was reported that the physician was not informed of the missed doses of antibiotics. On 12/12/24 at 10:15 AM, an interview was conducted with LPN D, It was reported that the physician was not informed of the missed doses of antibiotics. On 12/12/24 at 10:35 AM, an interview was conducted with RN F, it was reported that the physician was not informed of the missed doses of antibiotics. On 12/12/24 at 11:15 AM, a follow-up interview was conducted with DON. When asked the reason that the antibiotics were not available. The DON reported that either the antibiotics were not available in the facility or could not be found. When queried about the communication with the dialysis provider, DON reported that the dialysis staff and nursing staff should have made the DON or the UM aware that antibiotics were not given. Review of facility policy Medication Administration dated 1/17/23, documented, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview and record review the facility failed to provide adequate foot care for one resident (R32) out of four residents reviewed for Activities of Daily Living (ADLS). Findings include: On 12/10/24 at 10:16 AM, R32's feet were observed to have long, jagged, thick, greenish/black-toe nails. Additionally, R32's feet had white patches of dry skin and moist debris encrusted between toes. During an interview, R32 expressed a desire for podiatry services due to the inability to provide nail care independently. A review of the electronic medical records (EMR) revealed that R32 was admitted to the facility on [DATE] with a diagnosis of morbid obesity, type two diabetes, and end stage renal failure. Review of R32's Brief Interview for Mental Status (BIMS) dated 9/20/24 indicated that R32 scored 15 out of 15 (intact cognition). Review of R32's Minimum Data Set (MDS) dated [DATE], it was noted that R32 exhibited dependency with most ADLs. Upon further review of R32's EMR it was discovered that R32 had not been registered or received podiatry care. Additionally, care plans reviewed did not contain any specific interventions for foot care. On 12/11/24 at 11:27 AM, R32's feet were observed and remained in the same condition as the previous day. On 12/11/24 at 2:36 P.M., an interview was conducted with the Director of Nursing (DON) following the observation of R32's feet. It was reported that podiatry services should have been provided, even if the resident did not have a diabetic diagnosis related to the resident's current comorbidities (multiple medical conditions). On 12/11/24 at 2:39 PM, an interview was conducted with the Social Worker (SW) G, regarding the registration of R32's podiatry services. It was reported that R32 was not registered for podiatry services at that time, and the staff member that assists with setting up these services had not done it in a timely manner. On 12/11/24 at 3:10 PM, an interview was conducted with Nursing Home Administrator (NHA), it was reported that residents should be provided with foot care by staff and podiatry services should be provided if residents need that specific service. Review of policy Nail Care dated 8/2024 documented the following: .1. Assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care, if possible. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Report unusual or abnormal conditions of the nails to the physician and the responsible party (e.g., curling, color changes, separation from the nailbed, redness, bleeding, pain, odor, infection, etc.). b. Obtain history and preferences regarding podiatrist. 2. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing Basis. 3. Routine nail care, to include trimming and filing, will be provided on a regular basis and as the need arises. 4. Principles of nail care: a. Nails should be kept smooth to avoid skin injury. b. Only podiatrists, physician/practitioners, or licensed nurse shall trim toenails for residents with diabetes or circulation problems .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on interview and record review the facility failed to effectively communicate with a dialysis provider for one resident (R250) out of three residents requiring dialysis services, resulting in seven doses of antibiotics that were not administered as ordered by a physician. Findings include: On 12/10/24 at 10:41 AM, during an interview with R250, it was reported that intravenous antibiotics were not administered during dialysis. A record review of R250's electronic medical record (EMR) disclosed their admission to the facility on [DATE], with a diagnosis of end stage renal failure and osteomyelitis (infection of bone) of left foot and ankle. Review of R250's Minimum Data Set (MDS) dated [DATE], R250 required partial/moderate assist for most activities of daily living (ADLS). Review of R250's Brief Interview for Mental Status (BIMS) dated 11/29/24 revealed intact cognition, with a score of 15 out of 15 (intact cognition.) Record review of physician orders documented that R250 was to receive Cefepime HCL (antibiotics) . should be administered intravenously once daily on Mondays, Wednesdays, and Fridays until 12/29/24, after completing hemodialysis (HD). Furthermore, it was revealed that Vancomycin HCL (antibiotic) was prescribed for osteomyelitis. The order indicated that 500 mg(milligrams) of Vancomycin HCL administered intravenously daily on Mondays, Wednesdays, and Fridays until December 29, 2024. Administer post (after) HD. Review of the Medication Administration Record (MAR) for December 2024 disclosed that Vancomycin was not administered on December 2, 4, 6, and 9. Furthermore, Cefepime was not administered on December 4, 6, and 9. Review of Communication Report from dialysis provider on 12/2/24, it was documented under Antibiotics Given- 0. On 12/4/24,12/6/24 and 12/9/24 under Antibiotics Given there was no documentation. On 12/11/24 at 4:00 PM, an interview was conducted with the Director of Nursing (DON), it was confirmed that R250 had missed four doses of Vancomycin and three doses of Cefepime. When asked about how the antibiotics should have been administered, DON reported that the antibiotics should have been taken to dialysis to be administered and when the antibiotics were not available, nursing staff should have informed the physician. On 12/12/24 at 11:15 AM, a follow-up interview was conducted with the DON. When queried about the communication with the dialysis provider, DON reported that the dialysis staff and nursing staff should have made the DON or the UM aware that antibiotics were not given. It was further reported that communication with dialysis needs to be addressed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Care Planning Special Needs-Dialysis dated 12/28/23 documented the following: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving dialysis. Further review of policy documented, 4.Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day, and as needed. 5. If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report.

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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** 38208 Based on observation, interview and record review the facility failed to apply a barrier while administering medications for one resident (R15) out of four residents reviewed for medication administration. Findings include: On 12/11/24 at 9:00 AM, Licensed Practical Nurse (LPN) J was observed with two pre-filled syringes containing a long-acting insulin (Glargine) and one syringe containing a short acting insulin (Flasp). LPN J entered R15's room and laid all three syringes on the resident's bedside table with no barrier. R15's bedside table had multiple items and debris scattered on surface. LPN J then proceeded to administer the medications. A record review of R15's electronic medical record (EMR) disclosed their admission to the facility on [DATE], with a diagnosis of type two diabetes mellitus without complications. Review of R15's Minimum Data Set (MDS) dated [DATE], R15 required supervision for most activities of daily living (ADLS). Review of R15's Brief Interview for Mental Status (BIMS) revealed impaired cognition, with a score of 10 out of 15 (impaired cognition.) On 12/11/24 at 1:42 PM, LPN J was interviewed. It was reported that R15's medication should not have been placed directly on the bedside table due to the potential for contamination. On 12/11/24 at 2:26 PM, an interview was conducted with the Director of Nursing (DON). It was reported that nurses should not place resident medications on surfaces without the use of a barrier to prevent contamination and infection from concealed body fluids and other unknown contaminants. Review of facility policy Medication Administration revised 1/17/2023 documented, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235541	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Taylor	22950 Northline Rd Taylor, MI 48180

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** 38230 Based on observation, interview, and record review the facility failed to ensure a bathroom call light was in working order for one (R1) of two residents reviewed for environment resulting in call light not answered in a timely manner, unmet care needs, and the potential delay in responding to emergency situations. Findings include: On 12/10/24 at 10:57 a.m. R1 was observed in the bathroom located in the room. R1 was sitting in a wheelchair attempting to come out of the bathroom. The resident said the staff do not answer the call light. R1 stated angrily, I had to go to the bathroom really bad and couldn't wait for staff to help me, so I got on the toilet myself. I turned on the call light to get help getting off, but no one came so I got off by myself. The resident said they require assistance with going to the bathroom and shouldn't self-transfer to the toilet because of epilepsy, I realize I could have fell . The resident was not sure how long the call light was not working because they usually receive assistance from staff, except today. The bathroom light indicator was activated, however the indicator outside the door was not. When the call light is activated, a blue light illuminates outside of the room that can be seen by in the hall. Unit Manager H overheard talk about the call light and instructed R1 not to use the bathroom call light until it was repaired. On 12/11/24 at 11:41 a.m. review of the electronic medical record documented R1 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral palsy, epilepsy, convulsions, restless legs syndrome, and dementia. According to the annual Minimum Data Set assessment dated [DATE], R1 was cognitively intact (BIMS=15), and required substantial/maximal assistance with toileting. Review of the activities of daily living care plan dated 6/7/24 documented in part: Resident has an activities of daily living self-care performance deficit related to anxiety, behaviors, cerebral palsy, cognitive impairment, dementia, depression, generalized weakness, impaired vision, poor balance, poor coordination, seizures generalized weakness, and history of falls. Intervention: Toileting: 1 person assist. On 12/17/24 at 2:05 p.m. Maintenance Director I was interviewed and queried about call light functioning and monitoring. Maintenance Director I said monthly call light audits are completed. Each room and bathroom's call light functioning are checked. The Maintenance Director said they were not aware R1's bathroom call light was not working. Staff are to use the electronic repair order system to inform when something needs repair.