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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455812 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Paradigm at First Colony | | STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Lexington Blvd Missouri City, TX 77459 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669</p> <p>Based on interviews, and record review the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 2 (Resident #2 and #3) of 4 residents reviewed for accuracy and completeness.</p> <p>A. The facility failed to correctly note on Resident's #2's Facesheet that his race was White.</p> <p>B. The facility failed to obtain a psychiatric subsequent assessment (PSA) noting Resident #2's correct demographics.</p> <p>C. The facility failed to add Resident #2 and Resident #3's resident-to-resident altercation to the incident and accident report.</p> <p>This failure could place residents at risk of not having accurate and complete information available to those providing their treatment and care.</p> <p>Findings included:</p> <p>A. 1. Record review of Resident #2's face sheet dated 07/24/2024 revealed a [AGE] year-old African-American male who was admitted on [DATE] with diagnoses that included chronic respiratory failure (narrow airway damage), tracheostomy (surgical procedure to open airway in wind pipe) status, personal history of malignant neoplasm of larynx (throat cancer), chronic obstructive pulmonary disease with (acute) exacerbation (shortness of breath with discolored phlegm), alcohol dependence with withdrawal (symptoms that occur when someone stops using alcohol after a period of heavy drinking), opioid use with withdrawal, moderate protein-calorie malnutrition (weight loss), dependence on supplemental oxygen (oxygen therapy), unspecified viral hepatitis c without hepatic coma (failing liver), anxiety disorder, major depressive disorder, and pain in joints of unspecified hand.</p> <p>A. 2. Record review of Resident #2's quarterly (Minimum Data Set) MDS assessment dated [DATE] indicated he had a Brief Interview for Mental Status (BIMS) score of 14 which indicated he was cognitively intact. The MDS further revealed that Resident #2 was a [NAME] Male.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #2's Care Plan dated 05/29/2024 indicated: Focus: Mood/Behavior: (Resident #2) has a history of alteration exhibition of behavioral symptoms of . Date Initiated: 04/06/2023 Revision on: 03/13/2024. Goals: (Resident #2) dignity will be preserved, quality of life improved by minimizing the risk for agitation, inappropriate behaviors, unmet needs and inappropriate behavioral symptoms will be minimized through the next review period Date Initiated: 04/06/2023 Revision on: 05/09/2024 Target Date: 08/09/2024. Interventions/Tasks: Allow resident time to calm down and reapproach at a later time Date Initiated: 04/06/2023. Focus: Resident #2 was accused of inappropriate behavior towards former roommate and is at risk for further increased episodes. Resident #2 has denied the allegation. Date Initiated: 03/08/2024 Revision on: 03/12/2024. Goals: This episode of inappropriate behavior will be reduced and will be free from injury over the next 90 days Date Initiated: 03/12/2024 Revision on: 05/09/2024 Target Date: 08/09/2024. Interventions/Tasks: Explain procedures using terms/gestures the resident can understand Date Initiated: 03/12/2024 . Monitor and chart behaviors as they occur and report progress/declines to medical doctor (MD) Date Initiated: 03/12/2024 . Observe for early warning signs of behavior - approach in a calm manner, call by name, remove from unwanted stimuli Date Initiated: 03/12/2024 . Provide psych consult as ordered Date Initiated: 03/12/2024.</p> <p>B. Record review of Resident #2's PSA dated 03/07/2024 revealed that the resident was miss identified as an African American Female. The PSA further revealed that Resident #2 adamantly denies hitting or touching the roommate but said it was hard not to hit him. Encouraged Pt to let staff immediately know if roommate (or potential roommates) are causing issues for overall well-being. Pt verbalizes understanding. He denies worsening of depression or anxiety. He states he's in a bad mood due to poor sleep last night and having to hear his roommate accuse of hitting him. Denies si/hi (suicidal/homicidal ideation), avh (auditory/visual hallucinations), or paranoia.</p> <p>Record review of Resident #2's Assessments noted no skin assessment dated for 03/07/2024, 03/08/2024, or 03/09/2024.</p> <p>Record review of Resident #2's records revealed there was no resident skin, SBAR, risk management, or incident assessment documented from the incident on 03/07/2024.</p> <p>C. Record review of facilities Incidents and Accidents report dated 02/01/2024 - 07/25/2024 did not list Resident #2 and Resident #3's 07/07/2024 resident-to-resident altercation.</p> <p>Record review of Resident #3's face sheet dated 07/24/2024 revealed a [AGE] year-old male who was initially admitted on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), acute kidney failure (difficulties filtering waste products from the blood), acute respiratory failure with hypoxia (impairment of gas exchange from the blood to the lungs causing shortness of breath), acute metabolic acidosis (buildup of body toxins causing nausea, vomiting, fast breathing, and lethargy), left ventricular failure (difficulty pumping blood in the heart), hemiplegia and hemiparesis (Muscle weakness or partial paralysis) following cerebral infarction affecting left non-dominant side, hypothyroidism (deficiency of thyroid hormone disrupting the heart rate and body temperature) , depression, other insomnia (inability to sleep), generalized anxiety disorder, bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), acute on chronic diastolic (congestive) heart failure, muscle weakness, lack of coordination, and abnormal posture.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #3's quarterly (Minimum Data Set) MDS assessment dated [DATE] indicated he had a BIMS score of 10 which indicated he was moderately impaired. The MDS further revealed that the resident was a [NAME] Male.</p> <p>Record review of Resident #3's Care Plan dated 05/21/2024 Focus: CANCELLED: PSYCHOTROPIC MEDICATION: (Resident #3) is currently taking psychotropic medication and is at risk for adverse reactions and episodes of (behavior type) driven behavior as evidence by (AEB) Anti-depressant Anti-anxiety Date Initiated: 10/24/2022 Revision on: 05/21/2024 Cancelled Date: 05/21/2024. Goals: CANCELLED: (Resident #3) will not experience any adverse reactions and will be free from episodes of (Behavior Type) driven behaviors over the next 90 days Date Initiated: 10/24/2022 Revision on: 05/21/2024 Target Date: 06/25/2024 Cancelled Date: 05/21/2024. Interventions/Tasks: CANCELLED: Give medication as ordered, check for effectiveness, report to MD if medication is ineffective Date Initiated: 10/24/2022 Revision on: 05/21/2024 Cancelled Date: 05/21/2024. CANCELLED: Monitor for episodes of anxiety driven behaviors such as paranoia, hypersensitivity, sense of impending danger, rapid breathing/hyperventilation, etc. report any noted to MD/RP and document in the clinical record Date Initiated: 10/24/2022 Revision on: 05/21/2024.</p> <p>Record review of Resident #3's SBAR dated 03/07/2024 at 04:01 PM revealed Incident Location: Resident's Room. Incident Description: Nursing Description: Resident reported that his roommate punched on his face yesterday at night when he was lying on his bed. Resident Description: Immediate Action Taken: Description: Head to toe assessment done, no injuries, no swelling or bruise noted. Checked resident's face no injuries, no swelling or bruise noted. Resident denies pain or discomfort. Vital obtained: Temperature 97.6, Pulse, 77, Respiratory 18, Blood Pressure 122/75. Notified Nurse Practitioner (NP), RP, Director of Nursing (DON), Social Worker (SW). Resident taken to Hospital? No. Injuries Occurred at Time of Incident: Injury Type: No Injuries observed at time of incident.</p> <p>Record review of Resident #3's Progress Notes dated 03/07/2024 at 04:01 PM revealed Nursing Note Text: Resident reported that his roommate punched on his face last night when he was lying on his bed. Head to toe assessment done, no injuries, bruises or swelling noted, checked resident's face no bruises, injuries or swelling noted. Resident denies pain or discomfort.</p> <p>Record review of Resident #3's Progress Notes dated 03/10/2024 at 03:47 PM revealed Nursing Note Late Entry: Note Text: No redness/bruising observed to face. Denying pain or discomfort.</p> <p>Record review of facility's Provider Report dated 03/07/2024 revealed: Incident details Resident#3 stated that roommate punched him in the left jaw. Date and time learned of allegation: 03/07/2024 at 04:10 PM. Date and time the incident occurred- investigating to find out Resident #3 was in living room all day, did not tell anyone until late afternoon. Alleged Perpetrator: Roommate, Resident #2 denied the allegations and said he never touched Resident #3. Resident #2 said Resident #3 was screaming all night and Resident #2, told Resident #3 to stop screaming. Assessments Nurse conducted head to toe assessment and found no marks or evidence of abuse or the skin being hit. Psych came in to talk with Resident #3 and increased medication to help calm bipolar disorder. Facility notified RPs, MDs, Law Enforcement, room relocation of Resident #3 and increased supervision.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 07/24/2024 at 10:51 AM, the DON stated that she was not aware that Resident #2 was listed as a [AGE] year-old African American female on his PSA nor as an African American on his Facesheet. She stated the resident was a [NAME] Male. She stated she would correct the resident's race on his Facesheet and get with the service provider for a corrected assessment for it to accurately reflect the resident's assessment.</p> <p>During an interview on 07/24/2024 at 02:42 PM, the Administrator stated that psychiatric services was contacted to provide an updated/corrected psychiatric subsequent assessment for Resident #2.</p> <p>During an interview on 07/25/2024 at 03:42 PM, the DON stated that she began working at the facility on 05/01/2024. She stated she was not aware of the physical resident-to-resident altercation on 03/07/2024 between Resident #2 and Resident #3. She stated she was not aware that there were no progress notes or an SBAR in Resident #2's electronic chart related to the 03/07/2024 incident with Resident #3. She stated she was not aware that Resident #2 and Resident #3's names did not appear on the Incidents and Accidents Report for the date of 03/07/2024. She stated that it would have been the responsibilities of the charge nurse on duty at the time of the incident to complete an SBAR/change of condition or risk management assessment, enter progress notes that summarized the incident and update the resident's care plans. She stated that the progress notes were linked from the completion of the risk management assessment and pulled over on the facility's 24-hour incidents and accidents report the following day. She stated during the facility's morning meeting the department heads review the 24-hour report which would show that the resident's had an incident and know to continue behavior monitoring. She stated roommates involved in a physical altercation was considered a state reportable incident. She stated the residents would immediately be separated and a physical head-to-toe assessment for injuries would be performed by the charge nurse, and notification would be made to the resident's MD and RP. She stated if injuries or pain were present the MD would order the residents to be sent out to the hospital for further assessments. She stated the Administrator or SW would complete and report the incident to the state and the facility investigation would begin. She stated this was important to document on both the aggressor and receiving resident to track repeat offences and incidents and make necessary changes. She stated the residents would receive alternative rooms and behavioral monitoring would begin. She stated if the aggressor was a repeat offender the facility would complete 1:1 monitoring, order labs, seek higher level of care such as psych services, and potentially look for alternative placement for the resident.</p> <p>During interview on 07/25/2024 at 03:42 PM, the ADON stated that she was aware of the resident-to-resident incident between Resident #2 and Resident #3. She stated that she did not complete any of the assessments or reports on the incident that it was completed by the previous DON.</p> <p>During interview on 07/25/2024 at 04:55 PM, RN J stated that she was the charge nurse on shift during the 03/07/2024 altercation between Resident #2 and Resident #3. She stated that she completed the SBAR and updated the progress notes for Resident #3 after Resident #2 hit him. She stated that she only completed documentation on Resident #2 because he was the resident who received the hit. She stated she was not sure if the aggressive resident should have had a SBAR completed, or progress notes and care plans updated. She stated she was trained to only complete notes on the resident who received the hit. She stated that she could only remember completing a physical assessment on Resident #3 but had contacted the families and physicians of both residents regarding the incident. She stated that the SW would then have taken over with any follow-ups needed. RN J then concluded that the incident occurred along time ago and that she no longer works for the facility as of the end of June 2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During interview on 07/25/2024 at 06:09 PM, the Interim Administrator stated that she began assisting with the facility on 05/20/2024. She stated she was not aware of the physical resident-to-resident altercation on 03/07/2024 between Resident #2 and Resident #3. She stated she was not aware that there were no progress notes or the SBAR in Resident #2's electronic chart related to the 03/07/2024 incident. She stated she was not aware that Resident #2 and Resident #3's names did not appear on the Incidents and Accidents Report dated for 03/07/2024. She stated when a resident-to-resident altercations occurred a head-to-toe assessment would have been performed for all residents involved. She stated the residents would be separated, and law enforcement, RP's, MD's, and the DON notified. She stated the SBAR would be completed for all residents involved. She stated that a physical resident-to-resident altercation could be considered an incident and she would add the resident's incident to the incidents and accidents report. She stated SBARs, progress notes, and updated care plans should be completed and updated for all residents involved. She stated the DON would follow-up after receiving the facility's 24-hour report the following day in the department heads morning meeting. She stated that the SBARs were completed by the charge nurses and then it triggers them to add the resident's names to the 24-hr report. She stated by reading the SBAR report for Resident #3 it would have been known there were two individuals involved and someone should have gone back and completed the SBAR for Resident #2.</p> <p>During interview on 07/25/2024 at 07:02 PM, the SW stated that she had been working for the facility for nearly 2-years. She stated that she was aware of the resident-to-resident altercation between Resident #2 and Resident #3 on 03/07/2024. She stated it was reported that Resident #2 punched Resident #3 in the jaw. She stated Resident #2 was interviewed and denied the allegations. She stated since Resident #2 was allegedly the aggressor he was immediately moved away from Resident #3 and sent out the same day on a psychiatric services referral. She stated that the facility called law enforcement who did not pursue the matter. She stated that the resident's received a head-to-toe assessment and their families and physicians were notified. She stated that she was in the process of assisting Resident #3 with a transfer to a facility closer to his family. She stated that the incident expedited Resident #3's transfer. She stated that the previous Administrator completed the reportable incident sent to the state. She stated, I guess I should have added progress notes relating to the incident adding that she normally would have added notes. She stated she was not involved in any follow-up assessments or monitoring for either of the residents.</p> <p>Record review of the facility's policy Policies and Procedures Abuse, Neglect, and Exploitation (ANE) Prohibition dated 4/2024 revealed: The Nursing Facility strictly prohibits abuse, neglect, exploitation, or any mistreatment of residents by anyone at the Facility, including: staff, residents, volunteers, visitors, and others, this policy includes 7 key components: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. The Administrator or appointed designee serves as the ANE Prohibition Coordinator, overseeing the policy and investigations . Training: o The Facility will train each employee on this policy during orientation, and annually thereafter, and may provide additional training if deemed necessary by the Facility. o The Facility will provide training to staff regarding related policies and procedures pursuant to applicable state and federal regulations.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>o The Facility will provide training to residents and responsible parties pursuant to applicable state and federal regulations . Prevention: . The Facility will instruct staff to report any signs of stress from employees, family, and other individuals involved with the resident that may lead to abuse, neglect, injuries of unknown origin, or misappropriation of resident property, and to intervene as appropriate, as required by state and federal regulations. The Facility will implement an appropriate plan of care for residents with a history of self-injurious or abusive behaviors and update the plan of care as needed.</p> <p>Record review of the facility's policy Nursing Policies and Procedures. Subject: Change in Condition Communication undated revealed: Policy: To improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition. Procedures: 1. Complete assessment of the patient/resident which may include but is not limited to: A. Patient/resident name, age, primary diagnosis. B. Current physical condition C. Patient's/resident's previous condition {declining, improving, stable) D. Previous and current mental status E. Vital signs, TPR, BP, 1/0, Lung Sounds, N/V Abdominal Assessment, Pain, Last BM, Blood Glucose F. Recent labs, x-ray results G. Medications H. Allergies I. Code status J. Hospital of choice. K. Patient/resident/family wishes L. Any interventions/first aide provided to the patient/resident 2. Complete SBAR</p> <p>Record review of the facility's policy Environmental Resident Room's / Resident Rights with a revised date of 6/2019 revealed: It is the policy of this facility that the Facility provides the resident with an environment that preserves dignity, privacy and contributes to a positive self-image. Resident rooms are designed and equipped for adequate. Nursing care comfort and privacy of residents. Promoting and preserving resident independence and self-sufficiency should be considered when arranging the resident living space.</p> <p>Record review of facility's ANE in-service dated 03/18/2024 presented by the SW.</p> | | |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918</p> <p>Based on observations, interviews, and record review, the facility failed to have an adequately equipped system that allowed residents to call for staff assistance through a communication system for 1 (Resident #1) of 5 residents reviewed for call light button placement.</p> <p>The facility failed to ensure that Resident #1 ' s call light was functioning properly.</p> <p>This failure put residents at risk of not being able to call for assistance when needed.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 07/25/24 revealed she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: diabetes mellitus (body does not produce enough insulin or cannot use it properly), end stage renal disease (the final stage of chronic kidney disease when the kidneys can no longer function on their own), dependence on renal dialysis (removes waste and excess fluid from the blood when the kidneys are not work properly), and legal blindness (if the better eye has a 20/200 or worse even with the best possible correction).</p> <p>Record review of Resident #1's annual MDS assessment dated [DATE] revealed a BIMS score of 15 of 15 which indicated moderate impaired cognition. Further review revealed the resident had severely impaired vision under section B100.</p> <p>Record review of Resident #1's care plan dated 07/11/24 revealed the resident had ADL self-care deficits and was at risk for further decline in ADL functioning and injury. Interventions: ensure call light was within reach and answer in a timely manner.</p> <p>During an observation and interview on 07/25/24 at 4:10 p.m., Resident #1 was lying on her back in bed. She said she was dirty and needed to be changed. Resident #1 reached for her call light and tried to push it, but she said it was of no use. Resident #1 said the button was still missing, and that was why she always called out for help. Resident #1 said that most of the time, the nurse would not come, and sometimes, it took a while. Resident # 1 said it has been months snice she told the staff and up till the call light still did not have the red button.</p> <p>During an observation and interview on 07/25/24 at 4:12 p.m., RN S said she was Resident #1's nurse and checked on Resident #1 around 2:30 p.m. She was in bed, and the call light was within reach. RN S said she did not assess the call light when she made rounds. RN S said that she could see that the red button was not on the call light and that Resident #1 could not call for assistance. RN S said she saw the call light was in place and did not check to see if it was functional. RN S said she was not sure who should be checking on the call light to make sure the call light was working. RN S said Resident #1 would not get the care when she needed until the staff made rounds, and it was also a safety issue. RN S said the nurse should monitor the aides during rounding and ensure the call light was within reach, and the nurse managers monitored the nurses when they made random rounds. RN S said she had an in-service on call lights, and it was about call lights being within reach for the residents.</p> <p>(continued on next page)</p> | | |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an observation and interview on 07/25/24 at 4:14 p.m., CNA B said he made rounds when he came to work. He stated Resident #1 was in bed, and her call light was within reach, but he did not check if the call light had the push button. CNA B said the call light did not have a push button. He stated Resident #1 could not call for help, and the care Resident #1 needed when she could not use the call would not be provided until the CNA or nurse made a round. CNA B said he could not tell how long the call light had been without the button because he only worked PRN, and it had been weeks since he last worked. CNA B said he could not remember if he had worked with Resident #1 the last time he had worked. CNA B said he had training on call lights, and they should be within reach for the resident. CNA B said the maintenance director should ensure the call light was functional. CNA B said the nurse monitored the aides during rounding.</p> <p>During an interview on 07/25/24 at 4:22 p.m., the Maintenance Director said he was not told the call light button fell off Resident #1's call light. The Maintenance director said all the staff members were responsible for checking and ensuring the call light was functional. The Maintenance Director said the nursing staff would notify him if any call lights were not working, and he would fix the call lights. The Maintenance Director did not respond when asked what could happen to Resident #1 if she needed care and could not reach any staff because the call light was not functional.</p> <p>During an interview on 07/25/24 at 4:24 p.m., the Unit Manager said Resident #1's nurse came and told her the call light for the resident did not have the push button, and she told her where to get a new call light cord. She said the nurse and the aides should check that the call light was functional before it was placed within reach for the residents. The Unit Manager said if the call light was not working, the resident would have to wait until the staff made rounds. The Unit Manager said the nurses monitored the aides during rounding and made sure the call light was in place, and the nurse managers monitored the nurses during random rounds.</p> <p>During an interview on 07/25/24 at 4:29 p.m., The ADON said the aides and the nurses should check the call light and ensure it was working before the aide placed the call light within reach for Resident #1. The ADON said if the call light did not have the push button, Resident #1 would not be able to call for assistance, and Resident #1 would not be able to get help for whatever care Resident #1 needed. The ADON said it could also be a safety issue because Resident #1 might have a health issue that may require immediate attention, and the resident may not get timely intervention.</p> <p>During an interview on 07/25/24 at 4:45 p.m., the DON said the call light should be functional before the nursing staff would place the call light within reach for Resident #1. The DON said without the button on the call light, Resident #1 could not call for assistance, and the care she needed would be delayed until the aide and nurse made rounds.</p> <p>During an interview on 07/25/24 at 7:17 p.m., the Administrator said she expected the resident to have a functional call light within close proximity so the resident could call for help when needed. She said Resident #1 could need something, and the staff may not be aware because the light was not functioning.</p> <p>Record review of the facility policy on call lights Revised:12/23 read in part . The Facility will provide a call light system that is accessible, functional, and responsive to meet the needs of the residents. Procedure . call lights will be in working order . call lights will be monitored routinely to assess functionality .</p> | | |