STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Acres Living and Rehabilitation Center	2525 Centerville Rd Dallas, TX 75228

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 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** 47690 Based on observations, interviews, and record review the facility failed to ensure the resident has the right to reside and receive services in the facility with accommodation of resident needs and preferences for 1 of 30 residents (Resident #255) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system was within reach of the Resident #255 lying in bed. This failure could place residents in the facility at risk of being unable to have a means of directly contacting caregivers. Findings included: A record review of Resident #255's MDS assessment dated [DATE] reflected Resident #255 was a [AGE] year-old male with a BIMS score 03 of 15, indicating severe cognitive impairment. Resident #255 was admitted to the facility on [DATE] with the diagnoses of Dementia (a progressive loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), seizures disorder, and depression. The review further reflected the resident was totally dependent on staff for the ADL's (activity of daily living). A record review of Resident #255's Comprehensive Care Plan dated 10/28/24 reflected Focus. At risk for falls r/t dementia, seizures, and history of CVA. Goal. Will not sustain serious injury through the review date. Interventions. Be sure the call light is within reach and encourage to use it to call for assistance as needed. Observation on 10/28/24 at 11:39 AM Resident#255 was lying in bed and trying to get up. Resident#255 stated he wanted to pee. Resident#255's call light was on top of the nightstand. Resident#255 could not reach the call light, this state surveyor pressed the resident call light, and LVN E entered the room to answer the call light. This state surveyor pointed to the call light on the nightstand. LVN E stated the call light was not within reach of Resident#255 and took the call light from the nightstand and placed it next to Resident#255 in the bed. LVN E called an aide to take Resident#255 to use the bathroom. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/28/24 at 11:41 AM LVN E stated the call light was not within reach of the Resident#255. LVN E stated the call light should be within residents reach at all times, and risk to the resident not getting help on time could be a fall and possible injury. LVN E stated it was the responsibility of all the staff to make sure the call light was within resident reach before exiting the room. Interview on 10/30/2024 at 2:11 PM the DON stated all call lights needed to be always within reach of the resident. The DON stated the call light in the resident's bathroom should be next to the toilet and within resident use, even if the resident was lying in the floor. The DON stated the call light pull string should be going straight from the wall outlet down, and not hanging or intertwined on the fixtures. The DON stated the risk to the residents, if they cannot reach the call light, they could not call for help, and they will not get the help they needed. Interview on 10/30/24 at 3:44 PM the Administrator stated all the call light pull strings in the secured unit had been fixed, and they were no longer too long and dragging on the floor. He stated the staff had been reeducated to report any issue with the call light system to the Maintenance Supervisor. The Administrator stated the risk to residents, if the call light was not within resident reach or did not work properly, the residents could not call for help. Review of the facility policy titled policy/Procedure-Nursing services. Section: Routine Procedures- Subject: Call Light/Bell, revised 05/2007 revealed It is the policy of(to provide the resident a means of communication with nursing staff . 5. Place the call device within resident's reach before leaving room. If call light/bell defective, immediately report this information to the unit supervisor.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 (Resident #17, Resident #28, Resident #91, and Resident #255) of 16 residents reviewed for ADLs. The facility failed to ensure: 1- Resident #17 had his fingernails cleaned and trimmed. 2- Resident #91 had his fingernails trimmed. 3- Resident #28 had his fingernails cleaned and trimmed. 4- Resident #255 had his fingernails cleaned and trimmed. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1- Resident #17 Review of Resident #17's Quarterly MDS assessment dated [DATE] reflected Resident #17 was an [AGE] year-old male with initial admitted to the facility on [DATE]. His diagnoses included cerebral infarction (a loss of blood flow to part of the brain, which damages brain tissue), hemiplegia (paralysis of one side of the body) affecting left side, diabetes mellitus (high blood glucose levels), and cognitive communication deficit. Resident #17 had a BIMS score of 12 which indicated he had moderate cognitive impairment. Resident #17 required maximal assistance with personal hygiene. Review of Resident #17's Comprehensive Care Plan, revised 07/09/24, reflected the following: Focus: [Resident #17] at risk for an ADL self-care performance deficit. Goal: [Resident #17] will maintain current level of function in . personal hygiene. Will safely perform bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. An observation and Interview on 11/28/24 at 10:37 AM revealed Resident #17 was sitting in his wheelchair. The nails on both hands were approximately 0.3 centimeter in length extending from the tip of his fingers. The nails were discolored tan and the underside had dark brown colored residue. Resident #17 stated he did not like his nails long and dirty. He stated he did not tell anybody about his nails. 2- Resident #91 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #91's Quarterly MDS assessment dated [DATE] reflected Resident #91 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebral infarction (a loss of blood flow to part of the brain, which damages brain tissue), hemiplegia (paralysis of one side of the body) affecting left side of the body, and cognitive communication deficit. Resident #91 had a BIMS score of 15 which indicated Resident #91's cognition was intact. He required extensive assistance with personal hygiene. A record review of Resident #91's Comprehensive Care Plan, revised 04/29/24, reflected the following: Focus: ADL self-care performance deficit related to hemiplegia. Goal: Will maintain current level of function or improve in . personal hygiene An observation and interview on 10/28/24 at 10:45 AM revealed Resident #91 was laying in his bed. The nails on the right hand were approximately 0.4 centimeter in length extending from the tip of his fingers. Resident#91's left hand contracted, fingernails were approximately 0.4 cm. 4 of the fingernails pressing on the resident's palm of hand. No injury noticed. Resident#91 stated he would like his fingernails taken care of and he stated he would ask the nurse. In an interview with LVN H on 10/29/24 at 11:30 AM, she stated that she had not offered nailcare to Resident#17 and #91 recently. She stated that nailcare should be provided by the nursing staff as needed. She stated Resident #17's fingernails were long and dirty, and she offered to clean them after the interview. She stated she would trim resident #91's nails. She stated the risk of not providing adequate nail care was increased infections and skin break down issues. 3- Resident #28 A record review of Resident #28's annually MDS assessment dated [DATE] reflected Resident #28 was a [AGE] year-old male with a BIMS score 01 of 15, indicating severe cognitive impairment. Resident#28 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis of diabetes mellitus (elevated blood sugar), anxiety, depression, cerebrovascular accident, and muscle weakness. The review further reflected the resident was totally dependent on staff for ADL's (activity of daily living). A record review of Resident #28's Comprehensive Care Plan dated 10/08/24 reflected Problem: (Resident #28). ADL Self-care Performance deficit r/t CVA Goal: (Resident#28) will maintain current level of function in . Grooming ., Personal Hygiene . An observation on 10/28/24 at 11:25 AM revealed Resident#28 up in wheelchair in his room, wearing daytime attire. Resident#28's right hand with fingernails approximately 0.4 centimeter in length extending from the tip of his fingers and dirty. Resident#28's left hand severely contracted, the first, second, 3rd, and 5th fingernails approximately 0.4 centimeter in length extending from the tip of his fingers, with dirty matter underneath the 1st, 2nd, 3rd, and 5th fingernail. Resident#28's 4th finger hiding under the 3rd and 5th fingers. Some of the fingernails were chipped in both hands. Resident#28 denied pain in the left hand. Resident#28 stated he would like his fingernails trimmed and cleaned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 10/28/24 at 11:49 with LVN E revealed, LVN E looked at Resident#28's fingernails and stated the fingernails were long and needed to be cleaned. LVN E stated he would clean, and trim Resident#28's fingernails. LVN E stated the risk to the resident was he could cut himself, and development of infection. LVN E further stated it was the responsibility of the unit charge nurse to check, and make sure residents' fingernails were cleaned and trimmed all the time. 4- Resident #255 A record review of Resident #255's MDS assessment dated [DATE] reflected Resident #255 was a [AGE] year-old male with a BIMS score 03 of 15, indicating severe cognitive impairment. Resident#255 was admitted to the facility on [DATE] with the diagnosis of Dementia (a progressive loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), seizer disorder, and depression. The review further reflected the resident was totally dependent on staff for ADL's (activity of daily living). A record review of Resident #255's Comprehensive Care Plan dated 10/28/24 reflected Problem: (Resident #255). ADL Self-care Performance deficit r/t dementia, history of CVA . Goal: (Resident#255) will maintain current level of function in .Grooming ., Personal Hygiene; ADL score through the review date. Interventions: Bathing (Shower/Bathe self): The Resident#255 x1-2 assistance with .prefers hands wash. An observation on 10/28/24 at 11:39 AM revealed Resident #255 was lying in bed wearing appropriate attire. Both hands fingernails were short with brown matter underneath. Resident#255 was unable to participate in interview. Interview and observation on 10/28/24 at 11:47 with LVN E revealed, he looked at Resident#255 fingernails and stated fingernails had some dirt underneath, and he would clean them. LVN E stated the risk to the resident could be development of infection, other than that hygiene. LVN E further stated it was the responsibility of the unit charge nurse to check, and make sure residents' fingernails were cleaned and trimmed all the time. In an interview with the DON on 10/30/24 at 2:11 PM revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had a diagnosis of diabetes. She stated the charge nurses were supposed to monitor. The DON stated residents having long and dirty fingernails could be an infection control issue, dignity, and skin issues. She stated in-service on resident's ADLS were done as needed and once a year. Record review of the facility policy titled ADL, Services to carry out, revised 07/2015 revealed It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care .2. If a resident is unable to carry out activities of daily living, the necessary services to maintain . grooming, and personal hygiene will be provided by qualified staff . 47690

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observations, interviews, and record review the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #104) of 2 residents reviewed for catheter care. The facility failed to ensure CNA B kept Resident #104's urine catheter bag below the level of the bladder during incontinent care. This failure could place residents at risk for urinary tract infections. Findings included: Record review of Resident #104's Quarterly MDS assessment, dated 10/09/24, reflected an admitted [DATE]. Resident #104 had a BIMS score of 09, meaning her cognition was moderately impaired. She required maximal assist with ADLs. Resident #104's active diagnoses included reflux uropathy (condition where urine flows backward from the bladder into the ureters and sometimes the kidneys), diabetes mellitus, and Alzheimer's disease. Record review of Resident #104's care plan, dated 06/22/23, reflected . [Resident#104] has indwelling catheter . Goal: will show no sign/symptoms of urinary infection . Interventions included .Position catheter bag and tubing below the level of the bladder and away from entrance room door . Review of Resident #104's Physician Orders Report dated 10/30/24 reflected, . Change foley catheter monthly on 15 day of each month . every shift starting on the 15th and ending on the 15th every month. With start date of 08/15/24. Observation on 10/30/24 at 11:08 AM revealed CNA B , and CNA G entered Resident #104's room. Both staff performed hand hygiene, and donned gowns and gloves. CNA G uncovered Resident #104 and unfastened the resident's brief. CNA B cleaned Resident #104's front pubic area with wipes, using one wipe per stroke. CNA B placed Resident #104's urinary catheter drainage bag on the bed by the resident's feet. Both CNAs assisted the resident to turn on her right side. CNA B cleaned the resident's buttocks using peri-wipes, she removed and discarded the dirty brief, and she put a clean brief under the resident. Both CNAs assisted Resident #104 back on her back. Urine was observed backing up in the tubing back toward the resident's bladder. Both CNAs fastened the brief. CNA B hooked the urinary catheter drainage bag, back on the right side of the bed. CNA G covered Resident #104. Both CNA removed gloves and gowns, washed hands, and left the room. In an interview on 10/30/24 at 12:06 PM, CNA B stated the urinary drainage bag was to be always kept below the resident's bladder. CNA B stated she knew better but she worried to pull the tubing. She stated by failing to keep the bag under the bladder level it would put the resident at risk for urinary tract infections. (continued on next page)

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	675081	A. Building B. Wing	10/30/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 10/30/24 at 02:30 PM she stated the catheter was to be maintained below the level of the bladder. She stated placing the drainage bag on the bed was not maintaining it below the bladder. She stated by not keeping it below the bladder urine could back up into the bladder and increase the risk of urinary tract infections. She stated she would do skills check on nursing staff and the ADON would do random checks to monitor staff. Record review of CNA B's skills verification checklist dated 09/04/24 reflected she was competent in Peri-care-Foley catheter tubing care. Record review of the facility's policy titled, Catheter Care, Indwelling, revised May 2017, reflected, .Purpose: To promote hygiene, comfort, and decrease risk of infection for catheterized residents . Procedure . 12. Keep tubing below level of bladder .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 48560 Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 of 5 Residents (Resident #27, Resident #133, Resident #41) reviewed for respiratory care. 1-The facility failed to ensure Oxygen (O2) in use signage was on Resident #133's doorway. 2-The facility failed to ensure Resident #27's nasal cannula tubing was changed in a timely manner. 3-The facility failed to ensure Resident #41 nasal cannula tubing was labeled or dated. This failure could place residents at risk of not receiving appropriate respiratory care. The findings were: 1- Resident #133 Record Review of Resident#133's Quarterly MDS assessment dated [DATE] reflected, Resident #133 was an [AGE] year-old-male admitted to the facility on [DATE]. His relevant diagnoses included: anemia (low red blood cell count), heart failure (heart is unable to pump enough blood for bodily needs), chronic obstructive lung disease (lung condition that makes it difficult to breathe), asthma, anxiety, and paraplegia (loss of muscle function). It also reflected, Resident #133 had BIMS of 15, which indicated he had intact cognition. Quarterly MDS also reflected Resident #133 was on Oxygen therapy. Record review of Resident #133's physician orders dated 8/23/2024 reflected, Oxygen at 3 liter per minute continuous per nasal cannula every shift related to Asthma. Record Review of Resident #133's Care plan, created on 9/11/24 reflected, Focus: [Resident #133] has oxygen therapy continuous related to Shortness of breath, Labored breathing. Goal: [Resident #133] Will have no signs and symptoms of poor oxygen absorption through the review date. Interventions: Monitor for signs and symptoms of respiratory distress and report to [physician] as needed. In an observation and interview on 10/28/24 at 11:11 AM Resident #133 stated he was on oxygen therapy. Observed that the resident room doorway did not have signage for Oxygen in use outside the door. In an interview and observation with CNA B at 10/28/24 at 11:13 AM stated Resident #133 was on Oxygen therapy. She stated she did not see the Oxygen in use sign on Resident #133's room door. She stated every resident on oxygen therapy should have the sign to ensure safety if flammable objects were bought to the room. She stated that it could also alert staff in case of any emergency or evacuation. She stated she has worked in other units within the facility and had seen the oxygen in use signage used for residents on oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/29/24 at 09:30 AM RN D stated she was new to the facility and had started working about 2 weeks ago. She stated that Resident #133 was on continuous oxygen therapy and needed to have oxygen in use signage outside his room door. She stated the risk of not having appropriate signage was failure to alert staff members regarding resident's need for oxygen in case of emergencies or evacuation. She stated failure to have appropriate signage can lead to decreased quality of care by not meeting resident's care needs. 2- Resident #27 Record Review of Resident#27's Quarterly MDS assessment dated [DATE] reflected, Resident #27 was an [AGE] year-old-female admitted to the facility on [DATE]. Her relevant diagnoses included: Stroke (blood flow to the brain is interrupted resulting in death of brain cells), hypertension (high blood pressure), cognitive communication deficit (difficulty in communication caused by disruption in cognition), and aphasia (loss of ability to express speech). It also reflected, Resident #27 had BIMS of 8, which indicated she had moderate cognitive impairment. Record review of Resident #27's physician orders dated 5/28/2024 reflected, Oxygen at 2 liter per minute via nasal cannula. May titrate up to 5 liter per minute to keep oxygen saturation more than 92 percent. Record review of Resident #27's physician orders dated 2/1/2024 reflected, Change Oxygen Tubing and Humidifier Bottle every night shift every Wednesday. Record Review of Resident #27's Care plan, created on 9/10/24 reflected, Focus: [Resident# 27] has Oxygen Therapy related to Shortness of Breath. Goal: [Resident #27] Will have no signs and symptoms of poor oxygen absorption through the review date. Interventions: Monitor for signs and symptoms of respiratory distress and report to MD as needed. In an observation on 10/28/24 at 02:13 PM with Resident #27 revealed she was in bed and receiving oxygen via nasal cannula at 4 liters per minute. The date on the humidity bottle was marked as 10/17 and the date on the tubing was 10/18. In an observation and interview on 10/28/24 at 2:24 PM with LVN C revealed the date on the nasal cannula tubing was 10/18/24, which was 10 days ago and the date on the humidity bottle was 10/17/24 which was 11 days ago. LVN B stated that nasal cannula tubing and humidity bottle should be changed weekly and was done by the night shift nurses. She stated that failure to change nasal cannula tubing and humidity bottle in a timely manner could cause breathing problems and possibly infection control lapses in residents. 3- Resident #41 Record review of Resident # 41's Quarterly MDS assessment dated [DATE] reflected Resident #41 was an [AGE] year-old male readmitted to the facility on [DATE]. Diagnoses included, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and chronic respiratory failure (a long-term condition that occurs when the lungs can't exchange oxygen and carbon dioxide properly.) Resident had a BIMS Score of 15, meaning his cognition was intact. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's care plan revised 02/19/2024 reflected, Focus: has oxygen therapy related to chronic obstructive pulmonary disease/chronic respiratory failure . Goal: Will have no sign/symptoms of poor oxygen absorption . Interventions: Provide oxygen as ordered . Record review of Resident #41's Physician order dated October 2024, revealed Oxygen at 2l/min via nasal cannula every shift . with a start date of 08/10/2023. Record review of Resident #41's Physician order dated October 2024, revealed Change oxygen tubing a humidifier bottle every night shift every Wednesday. Observation on 10/29/24 at 8:52 AM revealed Resident #41 was sleeping in his bed. Oxygen concentrator was running at 2L/min and there was no date or label on the nasal cannula tubing. In an interview on 10/29/24 at 9:00 AM Resident #41 stated that he had been on continuous oxygen therapy because of his shortness of breath. Resident did not remember when the oxygen tubing was changed. In an observation and interview on 10/29/2024 at 9:23 AM, LVN H stated nurses were responsible for changing and dating nasal cannula tubing and it was done on weekly basis and as needed. She stated if oxygen supplies were not dated, it could lead to increased risk of infection. She stated she did not check the tubing for the date because she assumed the tubing was dated by the nurse who changed it. LVN H proceeded to change the tubing. In an interview on 10/28/24 01:39 PM with the DON, she stated her expectation was if the resident was on oxygen therapy, then signage for oxygen in use should be on the door. She stated her expectation was the nasal cannula tubing and humidity bottle should be changed weekly or as needed, if soiled or damaged. She stated that night shift floor nurses were responsible for putting up the sign and dating/labeling oxygen equipment weekly. She stated the facility was a non-smoking facility and oxygen in use sign was placed to warn people not to have flammable objects when oxygen was in use. She also stated that the risk of not having appropriate signage on the door was that staff may not be aware that residents were dependent on oxygen therapy. She stated that the risk of not dating the tubing / humidity bottle or not changing it in a timely manner could lead to infection control lapses and decreased quality of care. She stated as a DON of the facility, she or her designee conducted daily resident rounds. She stated that skill checks for nurses were done on a quarterly basis. She also stated that there was no facility policy for oxygen in use signage, however it was a part of standard nursing protocol. Record review of facility policy titled Policy / Procedure - Nursing Clinical: Oxygen Equipment revised 5/2017 reflected, . 3. Cannulas should be replaced every week .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen. 1. The facility failed to ensure food items in the facility walk-in freezer were labeled and dated. 2. [NAME] A failed to ensure to use appropriate hand hygiene during meal prep. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on [DATE] at 10:21 AM in the facility's walk-in freezer revealed 3 big bags of unidentified food items that did not have a date or label on it. Interview on [DATE] at 10:22 AM with the Dietary Manager revealed the unidentified food items were frozen popcorn shrimp. Observation on [DATE] at 10:26 AM along with the Dietary Manager, revealed [NAME] A was prepping for chicken salad sandwiches in the facility kitchen prep room. [NAME] A had donned gloves while mixing the chicken salad ingredients with his hands. Observed Cook's A personal phone placed on a cart in the prep area. [NAME] A reached out for the phone, picked it up, and placed it in his pocket. He then continued to mix the chicken salad mixture with the same gloves without performing adequate hand hygiene or hanging his gloves between the activities. In an interview on [DATE] at 02:05 PM the Dietary Manager stated that the facility cooks were responsible for dating and labeling all food items in the kitchen. He stated that his expectation was all food items in the kitchen should be marked with received date once they arrive at the facility. He stated that if the box was open, he expected the cooks to individually date each bag with a received date and use by date as well as label it appropriately. He also stated it was his expectation that all kitchen employees follow appropriate hand hygiene in the kitchen that included proper hand washing technique, sanitizing, and changing gloves after and between each task. He stated [NAME] A was an old employee with the facility and should have known the importance of changing gloves and performing adequate hand hygiene while cooking or prepping for meals. He stated that he had [NAME] A throw out the sandwich mixture and asked him to remake it using appropriate hand hygiene technique. He also stated that kitchen employees should not use phones or headphones while in the kitchen area but can utilize it in the break room. He stated the risk of not dating, labeling food items with use by date, and not following adequate hand hygiene while prepping food can cause cross contamination resulting in food borne illness. (continued on next page)

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	675081	A. Building B. Wing	10/30/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:57 AM [NAME] A stated that he had worked in the facility for the last [AGE] years. He stated that cooks were responsible for dating and labeling food items. He stated he did not know about the frozen popcorn shrimp bags that were not dated or labeled. He stated that, all food items were dated with received date for boxed items and use by date for any open items. He stated it was important to date and label each food item to follow the first in first out rule and to prevent residents from getting sick by consuming expired foods. He also stated that he knew to change gloves and wash/ sanitize hands between kitchen tasks. He stated that it was an error to touch the chicken salad with the same gloves after touching his phone. He added the risk of not performing adequate hand hygiene during meal prep was residents could get sick because of infection or cross contamination. Record Review of the facility policy titled Infection Control policy food Service/Procedure revised ,d+[DATE] reflected, It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness .4. D. 1. Wash hands carefully with soap and water whenever they become soiled, immediately before work in the morning, after using the bathroom, after coughing, sneezing, or blowing the nose, after touching the hair, mouth, or cigarettes, after handling raw unwashed food and dirty dishes; before touching food, clean dishes, and silverware. Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE] Preventing contamination from the premise,d+[DATE].11 Food Storage (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . Review of the Food and Drug Administration Food Code, dated 2022, reflected ,d+[DATE].11 Clean Condition. The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the Code. Even seemingly healthy employees may serve as reservoirs for pathogenic microorganisms that are transmissible through food. Staphylococci, for example, can be found on the skin and in the mouth, throat, and nose of many employees. The hands of employees can be contaminated by touching their nose or other body parts. ,d+[DATE].12 Cleaning Procedure. Handwashing is a critical factor in reducing fecal-oral pathogens that can be transmitted from hands to RTE food as well as other pathogens that can be transmitted from environmental sources. Many employees fail to wash their hands as often as necessary and even those who do may use flawed techniques. In the case of a food worker with one hand or a hand-like prosthesis, the Equal Employment Opportunity Commission has agreed that this requirement for thorough handwashing can be met through reasonable accommodation in accordance with the Americans with Disabilities Act. Devices are available which can be attached to a lavatory to enable the food worker with one hand to adequately generate the necessary friction to achieve the intent of this requirement .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 3 residents (Resident #35, Resident #44, and Resident#45) of 8 residents observed for infection control. The facility failed to ensure: 1- CNA I performed hand hygiene between change of gloves during incontinent care for Resident #44. 2- CMA F disinfected the blood pressure cuff in between blood pressure checks for the Resident #35 and Resident #45 These failures could place residents at risk for infection and cross contamination of pathogens and illness. Findings included: 1-Record review of Resident #44's Quarterly MDS assessment dated [DATE] reflected Resident #44 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included reduced mobility, muscle weakness, and cognitive communication deficit. Resident #44 had a BIMS score of 09, which indicated Resident #44's cognition was moderately impaired. The MDS assessment indicated Resident #44 was always incontinent of bladder and bowel. Record review of Resident #44's Care Plan dated 01/04/23, reflected the following: Focus: Has bowel/bladder incontinence . Goal: Will decrease frequency of urinary incontinence . Interventions: Check as required for incontinence. Wash, rinse, and dry perineum. Change clothing as needed after incontinence episodes . Observation on 10/30/24 at 9:03 AM revealed CNA I and CNA J entered Resident #44's room to provide incontinence care. Both CNAs washed hands and donned gloves, CNA H unfastened Resident #44's brief and cleaned the front pubic area. CNA J assisted the resident onto her side revealing she had a small bowel movement. CNA H discarded the dirty gloves, without hand hygiene she donned clean gloves. She cleaned the resident's buttocks area using several wipes. CNA H removed and discarded the dirty gloves, without hand hygiene, she donned clean gloves. She placed a clean brief under resident buttocks. Both CNAs fastened the brief. CNA J covered the resident in the bed. CNA H gathered the dirty clothes and trash. Both CNAs removed their gloves, washed their hands, and left the room. In an interview on 10/30/24 at 9:22 AM, CNA H stated she was supposed to perform hand hygiene between change of gloves and acknowledged she did not do that because she was nervous, and she did not have sanitizer on her. CNA H stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA H stated failing to provide proper care exposed the resident to infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2- Review of Resident #35's Comprehensive MDS dated [DATE] reflect Resident#34 was an [AGE] year-old female with a BIMS score 9 of 15 indicating moderate cognitive impairment. Resident#35 was admitted to the facility on [DATE] with the diagnoses of hypertension (elevated blood pressure) and cerebrovascular accident (type of ischemic stroke resulting from a blockage in the blood vessels supplying blood to the brain). Review of Resident #35's Care Plan dated 08/26/24 reflected the following: .Focus: Has hypertension Goal: Will remain free from sign/symptoms of hypertension through review date. Interventions: . Give anti-hypertensive medications as ordered Review of Resident#35's provider orders dated 09/18/20 reflected the following Lisinopril Tablet 40 MG Give 1 tablet by mouth one time a day for hypertension, Hold if SBP less than 100, DBP less than 60. Amlodipine Besylate Tablet 5 MG Give 1 tablet by mouth one time a day for hypertension, Hold if SBP less than 100, DBP less than 60. Review of Resident #45's Comprehensive MDS dated [DATE] reflect Resident#45 was a [AGE] year-old female no BIMS score indicated. Resident#45 was admitted to the facility on [DATE] with diagnoses of hypertension (elevated blood pressure), aphagia, cerebrovascular accident, and dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). Review of Resident #45's Care Plan initiated 07/02/15 reflected the following: .Focus: Resident#45 has hypertension. Goal: Will remain free of complication related to hypertension through review date. Interventions: . Give anti-hypertensive medications as ordered Review of Resident #45's provider order dated 08/26/23 reflected the following HydrALAZINE HCL Tablet 10 MG Give 1 tablet by mouth every 24 hours as needed for HTN give for SBP greater than 150. Observation on 10/29/24 at 08:20 AM reveled: CMA F checked Resident#35's blood pressure then put the blood pressure device, on the top of the medication cart, and sanitized hands. CMA F gave Resident#35's her medications; exited the room, and sanitized hands. CMA F moved his medication cart in front of Resident#45's room, took the blood pressure cuff without sanitizing it, and checked Resident#45's blood pressure, and then put the blood pressure cuff on top of the medication cart without sanitization. CMA F sanitize hands, then proceeded to prepare and administer medications to Resident#45. Interview on 10/29/24 at 08:33 AM, CMA F checked his medication cart, and stated he did not have the wipes. He stated the risk to residents were a transfer of germs. CMA F further stated just started two weeks ago, and he got training at school. In an interview on 10/30/24 at 2:30 PM, the DON stated she expected the staff to complete hand hygiene before and after care. The DON also stated in between care, the CNA's were to complete hand hygiene and change gloves because her hands were considered dirty after cleaning the resident. The DON stated the staff were to complete hand hygiene during care to prevent the spread of infection and cross contamination. The DON stated she would have the ADON do random checks to monitor. The DON stated to in order to prevent infection development for residents, the staff should sanitize the equipment like the blood pressure cuff and the blood sugar machine with each use. The DON stated to risk to residents development of infection . The DON further stated she was the IP for the facility, and in service was done quarterly and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Hand Hygiene, dated August 2014, reflected, .7. Use an alcohol-based hand rub ., or alternatively, soap and water for the following situations: . m. After removing gloves . Review of the facility's Policy Titled Infection Prevention and Control Program last revised in December 2023, reflected: .2. Process Surveillance is the review of practices by staff directly related to resident care. Some considerations for this process may include, but are not limited to .g. Cleaning and disinfection production and procedure for environment surface and equipment . 47690

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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. 47690 Based on observations, interviews and record review, the facility failed to ensure residents toileting facilities were adequately equipped to allow residents to call for assistance for 7 Residents (Resident#10, Resident#13, Resident#30, Resident#64, Resident#75, Resident#96, and Resident#134) of 30 residents reviewed for residents' call systems. The facility failed to ensure the call light system was accessible to a resident, lying on the floor in the residents' toilets, located between two adjacent rooms in all female secured unit: . Resident#30 . Resident#75 . Resident#96 . Resident#134 . Resident#64 . Resident#13 . Resident#10 This failure could place residents in the facility at risk of being unable to have a means of directly contacting caregivers. Findings included: Resident#30 -Observation on 10/28/24 at 09:55 AM resident toilet call light pull string was hanging over the toilet paper dispenser. The dispenser was fixed to the wall six feet from the floor. Resident#75/Resident#96 -Observation on 10/28/24 at 09:56 AM Residents shared toilet in the two adjacent rooms call light pull string was hanging over the toilet paper dispenser. The dispenser was fixed to the wall six feet from the floor. Resident#134/Resident#64 -Observation on 10/28/24 at 09:57 AM Residents shared toilet in the two adjacent rooms call light pull string was intertwined on the straight grab bar fixed vertical to the wall in the right side of the toilet. The straight grab bar was two and half feet from the floor. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident#13/Resident#10 - Observation on 10/28/24 at 09:58 AM Residents shared toilet in the two adjacent rooms call light pull string was hanging over the toilet paper dispenser. The dispenser was fixed on the wall six feet from the floor. Interview and observation on 10/30/24 at 09:30 AM the Maintenance Supervisor revealed, he took the call light pull string from the toilet paper dispenser and let it go. The call light pull string ended up laying on the floor, because it was too long, about six feet long. The Maintenance Supervisor stated he would fix it. The Maintenance Supervisor took the call light pull string from the floor, proceeded to adjust it to be going from the wall outlet down, not touching the floor, and cut the extra string. He stated the way it was, the call light could cause a serious problem to residents and declined to elaborate more. Interview on 10/30/2024 at 2:11 PM the DON stated all call lights needed to be always within reach of the resident. The DON stated the call light in the resident's bathroom should be next to the toilet and within resident use, even if the resident was lying in the floor. The DON stated the call light pull string should be going straight from the wall outlet down, and not hanging or intertwined on the fixtures. The DON stated the risk to the residents, if they cannot reach the call light, they could not call for help, and they will not get the help they needed. Interview on 10/30/24 at 3:44 PM the Administrator stated all the call light pull strings in the secured unit had been fixed, and they were no longer too long and dragging on the floor. He stated the staff had been reeducated to report any issue with the call light system to the Maintenance Supervisor. The Administrator stated the risk to residents, if the call light was not within resident reach or did not work properly, the residents could not call for help. Review of the facility policy titled policy/Procedure-Nursing services. Section: Routine Procedures- Subject: Call Light/Bell, revised 05/2007 revealed It is the policy of (to provide the resident a means of communication with nursing staff . 5. Place the call device within resident's reach before leaving room. If call light/bell defective, immediately report this information to the unit supervisor.