STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of all medications to meet the needs of the residents and establishes a system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation for 1 of 1 resident reviewed for pharmaceutical services in that: The facility failed to have a system in place to ensure proper reconciliation of medications that would prevent missing medications for Resident #1. This failure could place residents at risk of having their medications diverted and/or receiving the incorrect dosage because due to staff not counting mediations in the narcotics refrigerator.Findings included: Record review of Resident #1's face sheet dated 03/30/2026, revealed Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: Unspecified diastolic (congestive) heart failure (heart's left ventricle becomes stiff, impairing its ability to fill properly, while still maintaining normal pumping function), acute respiratory failure, acute kidney failure, and generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #1's orders, dated 03/30/2026, revealed an order for Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) (benzodiazepine, used primarily for the management of anxiety disorders and for short-term relief of anxiety symptoms), give 0.25 ml by mouth every 4 hours as needed for anxiety. Start date 03/18/2026. Record review of Resident #1's Medication Administration Record dated 03/31/2026, revealed an order for Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) as needed for anxiety with a start date of 03/18/2026. The MAR further revealed Resident #1 was not administered Lorazepam from 03/18/2026 to 03/31/2026. Record review of the pharmacy shipment summary for Resident #1, dated 03/18/2026, revealed the facility received an order on 03/18/2026 for Lorazepam Oral Concentrate 2 MG/ML (Lorazepam), with a quantity of 30 ML. During an interview on 03/30/2026 at 9:30 AM, the ADM stated he was notified on03/24/2026, after an audit of the narcotic medications in the facility, a bottle of Lorazepam Oral Concentrate 2 MG/ML belonging to Resident #1 was missing. The ADM stated the audit was conducted by the DON and nursing staff. The ADM stated the prescription box for the Lorazepam was present in the narcotics refrigerator, but the bottle of medication was missing out of the box. The ADM stated there were seven nurses who had access to the narcotics refrigerator, and the seven nurses were suspended, pending an internal investigation. The ADM stated the seven nurses were sent for drug testing at the request of the facility. The ADM stated, to his knowledge, Resident #1 was never administered the medication, Lorazepam Oral Concentrate 2 MG/ML, as it was a medication prescribed as needed and Resident #1 did not request or have a need for the medication after the date the medication was received, 03/18/2026. The ADM stated this was a new medication ordered for the resident. The ADM stated the facility replaced the bottle of Lorazepam Oral Concentrate 2 MG/ML immediately, at the facility's expense, for Resident #1, and Resident #1 did not miss a dose of the medication. The ADM stated all seven nurses received disciplinary action for failing to count narcotics in the narcotics refrigerator. During an interview on (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/30/2026 at 11:00 AM, the DON stated during an audit of the narcotics held in the facility, LVN D found a prescription box of Lorazepam Oral Concentrate 2 MG/ML for Resident #1, but the bottle of medication was not in the box. The DON stated the medication was received on 03/18/2026 for Resident #1 to be administered as needed for anxiety. The DON stated the medication was stored in a secured and locked narcotics refrigerator that was locked in the medication storage room. The DON stated Resident #1 never received a dose of the medication as Resident #1 did not request the medication, and there was not a need for the medication at that time. The DON stated Resident #1 did not miss any doses of the medication, and the medication was replaced at the expense of the facility. The DON stated there were seven nurses who had access to the narcotics refrigerator. The DON stated each nurse held a key, during their shift, to the narcotics refrigerator. The DON stated these keys were passed to their replacement nurse during shift change, so both day and night shift nurses had access to the narcotic's refrigerator. The DON stated, upon internal investigation, it was determined the nursing staff were not counting the narcotic refrigerator, as required. The DON stated a full audit was conducted of all medication carts and medication storage, and this was the only medication found to be missing. The DON stated the missing medication for Resident #1, Lorazepam Oral Concentrate 2 MG/ML, was a PRN narcotic that was a new order for the resident. During an interview on 03/31/2026 at 9:00 AM Resident #1 stated he never took Lorazepam Oral Concentrate 2 MG/ML as needed or on a daily basis. Resident #1 stated it was not medication he needed. Resident #1 stated he did not know when the medication was prescribed to him. Resident #1 stated he has not felt like he needed the medication. The interview was ended due to Resident #1 no longer responding to questions. Resident #1 was asked if he wanted to speak to the surveyor at a later time and he mouthed his response, no and shook his head, no. During an observation on 03/31/2026 at 1:00 PM the narcotics refrigerator was observed in the medication storage room. The narcotics refrigerator was observed to be locked. The DON opened the narcotics refrigerator. A sealed bottle of Lorazepam Oral Concentrate 2 MG/ML was observed in a prescription box for Resident #1.The issue date on the prescription label showed 03/26/2026. During an interview on 03/31/2026 at 1:57 PM, LVN A stated she worked day shifts at the facility. LVN A stated upon arriving at the facility, a count was completed of all narcotics on her assigned nursing station with the nurse who was leaving for the day. LVN A stated a count was completed at the end of each shift as well with the oncoming nurse. LVN A stated only the nurses on each shift had access to PRN narcotics. LVN A stated the nurse working the floor was given a key for the narcotic refrigerator. LVN A stated CMAs and CNAs did not have access to PRN narcotics. LVN A stated PRN Lorazepam Oral Concentrate 2 MG/ML would have been kept in the narcotic refrigerator, located in the medication storage room. LVN A stated only nurses had access to the narcotic refrigerator. LVN A stated she did not recall counting Resident #1's Lorazepam Oral Concentrate 2 MG/ML because she was not counting the narcotic refrigerator during each shift. LVN A stated she did not have a reason for not counting the narcotic refrigerator at the beginning or end of each shift. LVN A stated she may have glanced at the medications in the narcotic refrigerator and may have seen the box, but she never picked it up to count it. LVN A stated she assumed based on the medication sheet that the bottle of Lorazepam Oral Concentrate 2 MG/ML was full since the count sheet showed it was full and never used. LVN A stated Resident #1 never asked for Lorazepam Oral Concentrate 2 MG/ML and she never administered it to him. LVN A stated it was a new medication order for Resident #1 and was only administered as needed. LVN A stated to count liquid medications she would hold a light under the bottle to measure the liquid accurately with the markings shown on the bottle to ensure it was counted accurately. LVN A stated she never picked up the bottle of Lorazepam Oral Concentrate 2 MG/ML to measure it because the count sheet showed it was full. LVN A stated she was not aware the bottle of Lorazepam Oral Concentrate 2 MG/ML belonging to Resident #1 was missing or that the prescription box was empty. LVN A stated she received training when she became a nurse on medication reconciliation and counting narcotics as well as ongoing training she received at the facility. LVN A stated it was important for a full count of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	narcotics to be completed each time the narcotic keys were exchanged to ensure medications did not become missing. LVN A stated if medications became missing a resident may miss a dose of medications that were needed. During an interview on 03/31/2026 at 2:25 PM, LVN B stated she worked day shifts at the facility. LVN B stated when she first arrived at the facility for her shift she would receive report from the exiting nurse and they completed a narcotic count of the medication cart together before the exiting nurse exchanged her keys to the medication cart and PRN narcotics. LVN B stated only nurses had access to the medication cart that contained PRN narcotics or the narcotic refrigerator. LVN B stated CMAs and CNAs did not have access to any PRN narcotics as PRN narcotics were only administered by a nurse. LVN B stated she was not aware Resident #1's Lorazepam Oral Concentrate 2 MG/ML was missing until she was notified by her ADM. LVN B stated she made sure to count the narcotic refrigerator now, when coming on for her shift and any time the keys were exchanged during her shift, for breaks or lunches, as well as at the end of her shift. LVN B stated this was not being done regularly, prior to the medication being missing,, as she trusted her coworkers and did not think someone would take the medication before. LVN B stated narcotic counts were documented on a count sheet when keys were exchanged between nurses. LVN B stated the count sheet did not previously include the narcotic refrigerator but had a count for all medication bottles combined. LVN B stated the count sheet was updated to include the narcotic refrigerator to be accounted for separately. LVN B stated she received ongoing training on counting narcotics and medication reconciliation. LVN B stated all nurses working the floor shifts were responsible for counting narcotics at the beginning and end of each shift with he oncoming or exiting nurse. LVN B stated she was aware she should have counted the narcotic refrigerator in her previous counts. LVN B stated she was not counting the narcotic refrigerator prior to the medication becoming missing. LVN B stated Resident #1 never requested the PRN Lorazepam Oral Concentrate 2 MG/ML, and she never administered the medication to him. LVN B stated, to her knowledge, Resident #1 never missed a dose of the medication due to it being missing. LVN B stated it was important to ensure narcotic counts were being completed to ensure medications didnt come up missing or residents did not miss medications. During an interview on 03/31/2026 at 2:47 PM, LVN C stated she worked day shifts at the facility. LVN C stated upon arriving for her shift, she counted medication carts with the exiting nurse or medication aide. LVN C stated this included counting all narcotics in the carts as well as in the narcotic refrigerator. LVN C stated she always counted all narcotic refrigerators and she never saw an empty box of Lorazepam Oral Concentrate 2 MG/ML belonging to Resident #1. LVN C stated she always picked up all bottles in the narcotic refrigerator to count them, and she never saw an empty box of medication or a missing bottle. LVN C stated only the nurse working the floor had access to the keys for the medication carts containing PRN narcotics or the narcotic refrigerator. LVN C stated all nurses working the floor shifts were responsible for counting narcotics at the beginning and end of each shift with he oncoming or exiting nurse. LVN C stated she had never administered Lorazepam Oral Concentrate 2 MG/ML to Resident #1, and Resident #1 never requested this medication. LVN C stated she did not believe the medication was needed at the time and the order was to be administered as needed. LVN C stated she received training on medication administration/reconciliation and counting narcotics through her nursing training as well as when she was hired at the facility. LVN C stated it was important to count all narcotics at the beginning and end of each shift to ensure residents' medications did not become missing. During an interview on 03/31/2026 at 3:08 PM, LVN D stated she completed an audit of the narcotics in the facility with the DON on 03/24/2026. LVN D stated when she took everything out of the narcotic refrigerator she found an empty box of Lorazepam Oral Concentrate 2 MG/ML belonging to Resident #1. LVN D stated the box contained the prescription information for the medication for Resident #1, but the box did not contain the bottle of liquid Lorazepam Oral Concentrate 2 MG/ML. LVN D stated she immediately informed the DON of the empty box and a full search for the medication was completed. LVN D stated the medication was not found. LVN D stated she only worked shifts as a floor nurse as needed by the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility, as her typical job duties were wound care. LVN D stated she did not work a floor nurse shift during the dates of 03/18/2026 - 03/24/2026. LVN D stated when she worked floor shifts, she always counted all narcotics with the oncoming of exiting nurse working the floor, LVN D stated only floor shift nurses had access to the PRN narcotics. LVN D stated the missing medication for Resident #1, Lorazepam Oral Concentrate 2 MG/ML, was a PRN narcotic and was a new order received for the resident. LVN D stated she was not aware of the empty box of Lorazepam Oral Concentrate 2 MG/ML for Resident #1 prior to 03/24/2026. LVN D stated Resident #1 never requested for this medication to be administered while she was working with him, and she never administered it to him. LVN D stated she did not believe Resident #1 missed a dose of the medication due to the medicine being missing. LVN D stated all nurses working a floor shift were responsible for counting PRN narcotics at the beginning and end of each shift with the oncoming or exiting nurse. LVN D stated it was important for all narcotics to be counted by two staff to ensure counts were accurate and to ensure residents did not miss any medications due to medicine coming up missing. LVN D stated she received training on medication administration/reconciliation and counting narcotics, regularly, at the facility. During an interview on 03/31/2026 at 3:30 PM, LVN E stated she worked day shifts at the facility. LVN E stated at the beginning of each shift she counted all PRN narcotics on the nurse's medication cart with the exiting nurse. LVN E stated she also counted again at the end of her shift with the oncoming nurse. LVN E stated all narcotics were always accounted for during her shifts. LVN E stated all floor shift nurses were responsible for counting the PRN narcotics at the beginning and end of each shift with he oncoming or exiting nurse to ensure all medications were accounted for. LVN E stated she became aware of the missing Lorazepam Oral Concentrate 2 MG/ML for Resident #1 when the ADM notified her of the missing medication. LVN E stated she never saw an empty box of Lorazepam Oral Concentrate 2 MG/ML for Resident #1. LVN E stated when she completed her PRN narcotic counts she only counted the PRN narcotics on the nurse's medication cart. LVN E stated she never counted the narcotics in the narcotic refrigerator in the medication storage room. LVN E was unable to provide a reason for not counting the narcotic refrigerator. LVN E stated Resident #1 did not ask for the PRN Lorazepam Oral Concentrate 2 MG/ML, and she never administered it to him, as there was not a need for it at that time. LVN E stated she received training on medication administration/reconciliation, as well as counting narcotics, while working at the facility. LVN E stated she now planned to count all medications including the narcotic refrigerator at the beginning and end of each shift to ensure accuracy. LVN E stated if narcotic counts were not completed at each shift change, medications could be taken and residents could miss dosages. LVN E stated, to her knowledge, Resident #1 never missed a dosage of Lorazepam Oral Concentrate 2 MG/ML due to the medication being missing. During an interview on 03/31/2026 at 4:50 PM, CMA stated she worked day shifts at the facility. CMA stated she was responsible for administering medications to residents that were scheduled medications. CMA stated she did not administer any PRN narcotic medications, as this was the responsibility of the floor shift nurse. CMA stated she did not have access to the narcotic refrigerator, as only the floor shift nurse had keys to it. CMA stated Resident #1 never requested for his PRN Lorazepam Oral Concentrate 2 MG/ML to be administered to him while she was working with him. CMA stated she had received training on medication administration/reconciliation and counting narcotics, while working at the facility. During an interview on 03/31/2026 at 5:38 PM the DON stated previously all PRN narcotics were supposed to be counted and documented on a count sheet that was supposed to be signed by the oncoming and exiting nurse. The DON stated there were no count sheets found for the date range of 03/18/2026 - 03/24/2026. The DON stated he was not aware these count sheets were not being done. The DON stated that the last full audit he completed on narcotics was in January 2026, and there were no concerns of missing narcotics at that time. The DON stated all of the facility's nursing staff received an in-service training on 03/26/2026 on counting narcotics,. The DON stated it was his expectation that all floor shift nurses count all PRN narcotics any time their medication keys were exchanged. The DON stated this included all breaks, lunches, and shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes. The DON stated if a nurse left the building and had to hand over their keys to a nursing staff, his expectation was that the PRN narcotics were counted prior to the keys being handed over. The DON stated he believed the narcotic refrigerator was not being counted as it should have been. The DON stated all nursing staff were aware prior that the narcotic refrigerator contained PRN narcotics and should have been counted. The DON stated there was no specific system in place prior to ensure the refrigerator was counted. The DON stated the count sheets have since been updated to include the narcotic refrigerator and to specify how many bottles of refrigerated narcotics were present. The DON stated all nursing staff were responsible for counting PRN narcotics when they worked a floor shift, and there was no excuse for them not doing so. The DON stated it was his expectation that all count sheets were completed at each shift change and any time the medication keys were exchanged. The DON stated he planned to check the count sheets daily and planned to complete audits on all narcotics twice a week going forward. The DON stated if all narcotics were not counted properly, a resident could go without a needed medication if it became missing. During an interview on 03/31/2026 at 5:38 PM the ADM stated it was the responsibility of all floor shift nurses to ensure PRN narcotics were counted any time their medication keys were exchanged. The ADM stated he did not feel this was being done on each shift previously. The ADM stated the new process was for the oncoming and exiting nurse to document their count on count sheets that would be verified daily by the ADM and/or DON. The ADM stated the new count sheets included the narcotic refrigerator and how many specific bottles of narcotics were in the refrigerator, as well as any other narcotics in the refrigerator or on the medication carts. The ADM stated these counts were supposed to be documented previously, but the count sheets were not as specific. The ADM stated he did not know if where the count sheets were form 03/18/2026 - 03/24/2026 or if they were being completed. The ADM stated it was his expectation that these count sheets were completed at each shift going forward. The ADM stated he was not aware the narcotic medication refrigerator was not being counted at each shift prior to Resident #1's PRN Lorazepam Oral Concentrate 2 MG/ML becoming missing. The ADM stated all nursing staff were trained on medication administration/reconciliation and counting narcotics prior to the medication being missing, and they have since received an in-service training to ensure all nursing staff were re-educated on counting medications. The ADM stated it was important to ensure all narcotics were counted at each shift to prevent medications from being taken which could lead to a resident missing a scheduled or needed dose of medication. Record Review of the facility document titled, Narcotic Book/EMAR. Verification Sheet, undated, revealed the following: Record Review of the facility policy titled, Controlled Substances, dated April 2019 revealed the following: Policy Statement:The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Policy Interpretation and Implementation:4. Access to controlled medications remains locked at all times and access is recorded.8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift.12. At the End of Each Shift:a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together.b. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately.c. The director of nursing services investigates all discrepancies in controlled medication reconciliation to determine the cause and identify any responsible parties and reports the findings to the administrator. Record Review of the facility document titled, Narcotic Book/EMAR. Verification Sheet, undated, revealed the following: AT SHIFT CHANGE, BOTH NURSES WILL VERIFY THAT ALL SCHEDULED AND PRN NARCOTICS ARE RECORDED IN THE EMAR AS WELL AS THE NARCOTIC COUNT SHEET DOCUMENT THE ACTUAL NUMBER OF CARDS, BOTTLES AND PATCHES THIS FORM AND ANY EMPTY CARDS I BOTTLES WILL BE TURNED IN TO THE DIRECTOR OF NURSING***EVERY SHIFT CHANGE WITHOUT EXCEPTIONS***(Failure to do so will result in automatic disciplinary action)Date:Time:Number of Narcotics Charted in Narcotic Book during shiftNumber of Narcotics Charted in EMAR during shift CART: Cards Bottles Patches FRIDGE: BottlesOncoming Nurse Outgoing Nurse

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident's bedside, toilet, and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff area for 1 of 5 residents (Resident #2) reviewed for resident call system.The facility failed to ensure Resident #2's call light was within reach while he was positioned in his bed.This failure could place residents at risk of not being able to call for assistance in emergency situations, a delay in care and services, and increased risk of falls and/or injuries. Findings include: Record Review of Resident #2's face sheet, dated 3/30/2026, revealed an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses that included: Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of cognitive functioning, thinking, remembering, and reasoning), and Parkinson's disease with dyskinesia without mention of fluctuations (progressive neurological disorder that primarily affects movement).Record review of Resident #2's Annual MDS assessment, dated 04/30/2025, revealed under Section C, Cognitive Patterns, a BIMS score of 14 indicating the resident was cognitively intact. Record Review of Resident #2's Care Plan dated 01/16/2026, revealed the following focus areas: (Resident #2) has an ADL self-care performance deficit d/t muscle weakness r/t Parkinsons. The intervention area revealed the following: TRANSFER: (Resident #2) requires assistance by 1-2 staff for transfers . Focus area: (Resident #2) is High risk for falls r/t Gait/balance problems, Psychoactive drug use. The intervention area revealed the following: Be sure (Resident #2's) call light is within reach and encourage (Resident #2) to use it for assistance as needed. (Resident #2) needs prompt response to all requests for assistance. Record Review of Resident #2s's physician orders dated 03/30/2026 revealed the following diagnoses: Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and Parkinson's disease with dyskinesia without mention of fluctuations.During an observation and interviews on 03/30/2026 at 1:55 PM Resident #2 was lying in bed upon entering the room. While interviewing Resident #2, he stated he had never had a call light in his room. An observation of Resident #2's room confirmed there was no call light within reach of Resident #2's bed. The call light was found with the cord wrapped and placed behind resident #2's roommate's nightstand, approximately 3 feet from Resident #2's bed. Resident #2 stated he did not know the call light was behind the roommate's nightstand. Resident #2's roommate stated Resident #2 never had a call light, and if Resident #2 needed staff, he would press his call light so staff would respond. Resident #2's roommate then pressed his call light to alert staff they were needed. LVN E entered Resident #2's room in response to the call light. LVN E stated she did not know why Resident #2 did not have a call light within reach. LVN E located Resident #2's call light and unwrapped the cord. LVN E placed the call light within Resident #2's reach. LVN E tested the call light for Resident #2, and it worked. LVN E stated Resident #2's call light should have been within reach while he was in his bed. During an interview on 03/31/2026 at 10:35 AM the DOR stated Resident #2 did not have many physical limitations, but Resident #2 used a wheelchair. DOR stated Resident # 2 was able to transfer to and from the wheelchair on his own. The DOR stated he should have assistance with one staff to prevent falls from occurring. The DOR stated Resident #2 had the cognitive ability to use his call light. The DOR stated Resident #2 did not usually use his call light to request assistance, but he usually looked outside of his room for staff when he needed assistance. The DOR stated Resident #2's call light should always be within reach while he was in his room to prevent falls and to allow the resident to call for assistance if needed. The DOR stated all staff were responsible for ensuring call lights were within reach, and any staff could ensure a resident's call light was placed within their reach. During an interview on 03/31/2026 at 2:00 PM LVN A stated Resident #2 was capable of using his call light on (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	most days, if needed. LVN A stated Resident #2 did not usually use his call light because he did not like to use it. LVN A stated Resident #2 usually came out of his room to get staff if he needed assistance. LVN A stated she could not remember a time Resident #2 used his call light on the previous day, 03/30/2026. LVN A stated Resident #2's call light should always be within reach when he was in his room to give the resident the opportunity to use the call light if necessary. LVN A stated she was not aware Resident #2's call light was wrapped and stored behind a nightstand. LVN A stated she never saw the call light or where it was placed, that she could remember. LVN A stated all staff were responsible for ensuring call lights were within a resident's reach to prevent falls. LVN A stated she received regular in-service training in regard to call lights. During an interview on 03/31/2026 at 3:10 PM LVN D stated Resident #2 was independent and was able to get in and out of his wheelchair on his own. LVN D stated Resident #2 did not press his call light often LVN D stated Resident #2 was capable of using his call light, but he was forgetful often. LVN D stated it was important for Resident #2 to have a call light within reach while positioned in bed, even if he did not use it, so he had the opportunity to use it, if needed. LVN D stated she had never seen Resident #2's call light wrapped behind a nightstand in his room. LVN D stated all facility staff were responsible for ensuring residents' call lights were within reach, and any staff could have placed Resident #2's call light within his reach for his safety. LVN D stated she received regular in-service training in regard to call lights. During an interview on 03/31/2026 at 3:30 PM LVN E stated Resident #2 was capable of using his call light when needed. LVN E stated she was not aware Resident #2's call light was not within his reach prior to her being notified on 03/30/2026. LVN E stated Resident #2's call light should have been within his reach for his safety and to prevent falls. LVN E stated she has received regular in-service training pertaining to call lights and ensuring all call lights were within a resident's reach while they were in their room. During an interview on 03/31/2026 at 5:38 PM the DON stated Resident #2 was capable of using his call light. The DON stated resident #2's call light should always be within reach when he was in his room. The DON stated he was not aware Resident #2's call light was wrapped and placed behind his roommate's nightstand. The DON stated it was important for all call lights to be within a resident's reach when they were in their room to prevent falls and for resident safety, even if the resident did not use the call light frequently. The DON stated it was the responsibility of all facility staff to ensure residents' call lights were within reach. The DON stated call lights should have been checked during all nursing rounds, every two hours, and anytime any staff entered a resident's room. The DON stated all staff received regular in-service training regarding call lights, and it was his expectation that all facility staff check resident's call lights throughout their shifts. During an interview on 03/31/2026 at 6:00 PM the ADM stated he was not aware that Resident #2's call light was not within his reach and was wrapped and placed behind his roommate's nightstand. The ADM stated all call lights should be within the residents' reach while they were in their rooms to allow the residents to use them when necessary. The ADM stated staff should check call lights within nursing rounds or when any staff enters or exits the resident's room. The ADM stated it was also his expectation that staff glanced into rooms as they walk down the hallways to ensure call lights were within the resident's reach. The ADM stated all facility staff were responsible for ensuring call lights were within reach. The ADM stated any staff member could place a call light within reach for the resident. The ADM stated all facility staff received regular in-service training pertaining to call lights. The ADM stated the administrative staff was responsible for overseeing staff and ensuring call lights were within reach. The ADM stated if a resident's call light were not within reach, the resident could miss out on getting care in emergency situations. Record review of the facility's document, Call System, Residents, dated September 2022, revealed the following: Policy Statement:Residents are provided with a means to call staff for assistance through a communication system that directly calls a s member or a centralized work station. Policy Interpretation and Implementation:Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/ bathing facilities and from the floor.The resident call system is routinely maintained and tested by the maintenance department.