

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Permian Residential Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 NE Mustang Andrews, TX 79714	
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 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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services.1. The facility failed to ensure cleaning supplies were stored in a separate area from food items.2. The facility failed to ensure the microwave was cleaned.3. The facility failed to ensure no expired food items were in the kitchen. 4. The facility failed to ensure all food items in the freezer were properly labeled or stored in airtight containers. These failures could place residents at risk for food contamination and foodborne illness. The findings include: Observations during the initial tour on 12/10/25 at 11:15 AM revealed dried food on the inside top of microwave, 6 cartons of Glucerna with carb steady 8 Fluid ounces with an expiration date of August 2025, 1 container of SuperSaniCloth germicidal wipes in the same cabinet as 2 pitchers used for drinking and 1 large silver food container. During an interview on 12/10/25 at 11:25 AM, the RD stated the dietary manager was currently out of the facility and was not available. The RD stated she did not know why the expired Glucerna cartons were in the kitchen, she stated I told them not to use these, but I should have removed them. The RD stated the microwave was cleaned daily and she did not know why there was dried food on the top. Observation of the dining room freezer on 12/10/25 at 11:55 AM revealed 1 small Styrofoam container of white solid frozen substance, unlabeled, 1 small Styrofoam container of brown solid frozen substance unlabeled and the lid was partially removed, and 1 medium sized Styrofoam container of what appears to be chocolate chips uncovered and unlabeled. During an interview on 12/10/25 at 12:04 PM, the RD stated the ambassadors refilled the refrigerators and freezers in the dining room, but she did not think they put unlabeled items in the freezer. During an interview on 12/12/25 at 9:32 AM, the RD stated the dietary staff went over training often regarding storage of food items and cleanliness, but she was unable to provide an exact date. The RD stated she expected all food items in the freezer to be labeled and covered. The RD stated several ice cream cups were prepared for meals and sometimes a resident may not want it and it could be covered and put in the freezer for later. The RD stated she thought that was why the items were not labeled or covered properly. The RD stated she was not sure how the SuperSaniCloth germicidal wipes got put in the cabinet with food items. The RD stated the cabinets were not used often and someone may have grabbed the wipes off the counter and just put in the cabinet, but the chemicals were usually stored under the sink. The RD stated a potential negative outcome with dried food on the top of the microwave was cross contamination. The RD stated potential negative outcomes to food items not being covered or labeled in the freezer were the food quality not being as good or a resident could get a supplement in the food if it was not labeled properly. The RD stated a potential negative outcome to expired Glucerna in the kitchen was it could make someone sick. The RD stated a potential negative outcome to the residents with chemicals being stored with food items was the food could be dangerous if ingested. During an interview on 12/12/25 at 10:05 AM, the ADM stated she expected the sanitation and food storage to be monitored daily for food compliance. The ADM stated she did not know why the SuperSaniCloth germicidal wipes were in the same cabinet as food equipment because they were usually kept under the sink. The ADM stated the expired Glucerna may (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676175 If continuation sheet Page 1 of 7

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been overlooked because none of the residents used it at this time. The ADM stated she did not know why food items were not labeled in the freezer and stated they should have been labeled. The ADM stated the kitchen staff were trained on food storage and sanitation, but it was unknown exactly when. The ADM stated there was the potential for cross contamination with improper food storage. Record review of the facility policy titled, Cleaning and Sanitizing Equipment, with a revised date of 11/3/23 reflected the following: Policy Statement/Purpose - There will be standards to ensure proper cleaning and sanitizing of equipment to prevent bacterial growth and contamination of food. Responsibility: All F&N[Food and Nutrition] personnel are responsible for proper usage, cleaning and disinfecting of kitchen tools and equipment. Procedure: 1. Equipment and utensils are direct food contact surfaces; it is important that they be cleaned thoroughly and sanitized regularly. Record review of the facility's policy titled, Food Storage, with a revised date of 12/20 reflected the following: Purpose: To establish guidelines for storing, thawing, and preparing food. Policy: Food items will be stored, thawed, and prepared in accordance with good sanitary practice. Procedure: .II. Frozen Meat/Poultry and Food Guidelines.C. Storage: Store items promptly at 0 degrees Fahrenheit or below. Foods should be stored in their original containers if designed for freezing. Foods to be frozen should be stored in airtight containers or wrapped in heavy-duty aluminum foil or special laminated papers.i. Label and date all food items.XIII. Dry Storage Guidelines:.K. Cleaning supplies must be stored in a separate area away from food.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care, were provided such care, consistent with professional standards of practice for 1 (Resident #39) of 5 residents reviewed for respiratory care. The facility failed to ensure Resident #39 had a physician order for oxygen therapy. This failure could place residents at risk for oxygen toxicity and respiratory compromise. Findings included: Record review of the admission record for Resident #39 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: unspecified dementia (decline in mental ability severe enough to interfere with daily life), pneumonia (lung infection), and hypoxemia (low oxygen in the blood). Record review of the comprehensive MDS assessment for Resident #39, dated 11/10/25, revealed Resident #39 received oxygen therapy while being a resident at the facility. The MDS further revealed Resident #39 had a BIMS score of 09, indicating moderately impaired cognition. Record review of the comprehensive care plan for Resident #39, undated, revealed Focus - The resident has PRN oxygen therapy r/t SOB. Interventions - Oxygen settings: O2 at 2L/min via NC as indicated with an initiation date of 11/21/25. Record review of the order summary report for Resident #39, dated 12/11/25, revealed no active orders for oxygen therapy. Observation on 12/10/25 at 1:45 PM revealed Resident #39 sitting in a recliner chair in her room with oxygen on via NC at 2LPM via NC. Interview on 12/10/25 at 1:47 PM, Resident #39 stated she used oxygen therapy at all times due to a recent respiratory infection. Observation on 12/11/25 at 3:58 PM revealed Resident #39 sitting in a recliner in her room with oxygen therapy on via NC at 2LPM. During an interview on 12/11/25 at 4:01 AM, LVN A stated Resident #39 was admitted to the facility on oxygen. LVN A stated she did not know why Resident #39 did not have a physician order for oxygen and stated she assumed one was in the chart. LVN A stated those orders were usually put in the chart when the resident was admitted to the facility. LVN A stated a potential negative outcome to the resident with not having a physician order for oxygen was the resident could not need the oxygen and she could get too much oxygen. During an interview on 12/12/25 at 10:00 AM, the DON stated residents should have orders in place for oxygen therapy. The DON stated the admitting nurse looked over the oxygen orders for Resident #39 and that was why it was missed. The DON stated she was responsible for ensuring residents who received oxygen therapy had physician orders. The DON stated the nurses were trained on admission orders and usually 2 nurses signed off on the orders. The DON stated a potential negative outcome to the resident with using oxygen with no physician order was the residents could have adverse effects. The DON also stated it could be a medication error if oxygen was given to the resident with no physician order. During an interview on 12/12/25 at 10:05 AM, the ADM stated she expected oxygen orders to be input in PCC as the prescribing physician details. The ADM stated the admitting nurse was responsible for ensuring Resident #39 had an order for oxygen therapy. The ADM stated the admitting nurse did not put in the order for oxygen due to oversight. The ADM stated a potential negative outcome to the residents was it could cause them harm. During a phone interview on 12/12/25 at 10:13 AM, RN C stated she was the admitting nurse for Resident #39. RN C stated as the admitting nurse, it was her or the DON's responsibility to ensure the orders for oxygen were put in. RN C stated it was her oversight and that was why the oxygen order for Resident #39 was missing. RN C stated the nurses were trained constantly by word of mouth. RN C stated a potential negative outcome to the resident was another nurse could remove the oxygen from Resident #39 because there was not a physician order for it. Record review of the facility policy titled, Oxygen Administration, with a revised date of 10/10 reflected the following: Purpose - The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation - Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and maintained in accordance with currently accepted professional standards for 1 of 2 medication carts (Medication Cart 1) reviewed. 1. The facility failed to ensure three boxes of Ipratropium Bromide/Albuterol Sulfate (a combination bronchodilator medication used to treat bronchospasm) were not expired in Medication Cart 1. 2. The facility failed to ensure 1 loose pill in Medication Cart 1 was properly labeled or stored. These failures could place residents at risk for medication errors and adverse drug reactions. The findings include: During an observation on 12/11/2025 at 11:43AM with RN B on Medication Cart 1, 1 loose white pill was found in the second drawer, unlabeled. Subsequently, 3 boxes of Ipratropium Bromide/Albuterol Sulfate were found in the middle right drawer of Medication Cart 1. Box 1 had an expiration date of June 2025. Box 2 had an expiration date of April 2025. Box 3 had an expiration date of 10/31/2025. During an interview and observation with the DON on 12/11/2025 at 11:55AM, she stated the white loose pill was Spironolactone (used to treat a variety of conditions, including heart failure, high blood pressure, fluid retention). A total of 35 expired vials of Ipratropium Bromide/Albuterol Sulfate were identified between all three boxes. During an interview with RN B on 12/11/2025 3:35pm, she stated she had been trained upon hire on how to check the medications carts. She stated she was trained to check the carts at the beginning and end of each shift. She stated she checked the carts for expired medications, organization, cleanliness and any loose pills. She stated she had not noticed the expiration on the boxes as she was looking at the pharmacy's do not use by date which was different than the expiration date. She stated she would check the medication box for the manufacturer's expiration date in the future. She stated the potential negative outcome of expired medication being in the cart could be causing an adverse reaction to the resident. She stated the potential negative outcome of loose pills in the cart could be a medication error or possible drug diversion. She stated it would be everyone's responsibility to ensure the carts were being looked through and kept up to date. During an interview with the DON on 12/12/2025 at 9:38AM, she stated training on the medication carts had been weekly. She stated the last training was approximately a year ago. She stated the training included checking medication dates for expiration and open dates, cleanliness of the cart, and keeping the carts up to date. She stated she monitored compliance by observation and being on the floor addressing concerns as they arose. She stated there were monthly checks done on the carts to order medication and restock as needed. She stated the potential negative outcome of having expired medication in the cart could be residents having an adverse effect if the medication were to be administered. She stated the potential negative outcome of loose pills in the cart could be medication errors. She stated her expectations of staff are to count the narcotic medications, keep the carts clean, and ensure all medication are accounted for. She stated the DON was responsible for the overall care of the medication carts. During an interview with the ADM on 12/12/2025 at 9:51 AM, she stated staff were trained weekly on the medication carts. She stated staff were trained to check expiration dates, and discharged resident's medications. She stated she was unsure when the last in-service or training for the medication carts had been conducted. She stated a potential negative outcome of giving residents expired medication could be not providing the residents with the intended effects. She stated the potential negative outcome of having loose pills in the cart could be the resident's medication being off on the quantity. She stated the DON was responsible for ensuring the checks on the medication carts were being completed. Record review of the facility's policy titled Storage Medications last revised on April 2007 revealed; The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received.2. The nursing staff (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.		

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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 24 residents (Resident #10) reviewed for resident call system. The facility failed to ensure Resident #10's call light was within reach while she was positioned in her recliner. 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 #10's face sheet, dated 12/11/2025, revealed an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included: Cerebral Infarction unspecified (blood flow to the brain is disrupted due to issues with the arteries that supply it), Confusion Arousals (when some parts of the brain stay asleep while others wake up due to interrupted sleep), Unqualified Vision Loss (both Eyes) (inability to see clearly without any specific reason or underlying cause), Chronic Pain, Dysphagia following Cerebral Infarction (swallowing disorder that may occur after a stroke), and Weakness. Record review of Resident #10's Annual MDS assessment, dated 02/12/2025, revealed under Section C, Cognitive Patterns, a BIMS score of 00 indicating the resident's cognition was severely impaired. The MDS assessment indicated under Section GG Functional abilities GG0170, Resident #10 was dependent in the following areas: roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer. Record Review of Resident #10's Care Plan dated 02/26/2025, revealed the following focus areas: The resident has an ADL self-care performance deficit r/t Limited Mobility, Cerebral Infarction. The intervention area revealed the following: TRANSFER: Total Dependence with Hoyer lift X 2 staff members; Encourage the resident to use bell to call for assistance and within reach. Focus area: The resident is at risk for falls r/t weakness, Unaware of safety needs. The intervention area revealed the following: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance Record Review of Resident #10's physician orders dated 12/11/2025 revealed the following diagnoses: CEREBRAL INFARCTION, UNSPECIFIED, WEAKNESS, DYSPHAGIA FOLLOWING CEREBRAL INFARCTION, UNQUALIFIED VISUAL LOSS, BOTH EYES, CONFUSIONAL AROUSALS, and OTHER CHRONIC PAIN. During an observation and interview on 12/10/2025 at 10:00 AM, revealed Resident #10 was lying in her recliner in her room, alone without staff, approximately 6 feet away from her call light. The call light was observed clipped to her privacy curtain, next to her bed. The call light was out of reach from the resident's bed as well as the resident's recliner. Resident #10 stated she was in pain and wanted the surveyor to obtain assistance for her from staff. Resident #10 stated she was unable to stand on her own for fear of falling. Resident #10 stated she was supposed to call for staff assistance for all of her needs, as the worst thing that could happen to her, would be to fall. Resident #10 was not aware of where her call light was. CNA B responded after the surveyor pressed the call light for assistance. CNA B stated the call light should have been within the resident's reach, and she repositioned the call light within Resident #10's reach. CNA B stated she was uncertain why Resident #10's call light would have been clipped to her privacy curtain and not within reach. CNA B stated Resident #10 was unable to stand or transfer herself. During an interview on 12/12/2025 at 10:20 AM, CNA A stated she worked with Resident #10 frequently. CNA A stated she was not in the facility on 12/10/2025, and she did not know why Resident #10 did not have her call light within reach that morning. CNA A stated Resident #10 depended on staff for all transfers and most activities of daily living. CNA A stated Resident #10 would not have been able to reach her call light if it was clipped to her privacy curtain and she was lying in her recliner. CNA A stated Resident #10's call light should have always been within reach while she was in her bedroom, but she stated Resident #10 would (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequently call out for help when she needed assistance. CNA A stated Resident #10 was able to use her call light, but she became confused at times also and would call out for help if needed instead of using the call light. CNA A stated she received frequent training regarding call lights at their monthly meetings and upon hire. CNA A stated the expectation was for all residents to have their call light accessible to ensure they could call for assistance when needed. CNA A stated if a resident did not have access to their call light, the resident may have been at risk of not receiving assistance when needed. During an interview on 12/12/2025 at 10:41 AM, the ADM stated all nursing staff were responsible for ensuring residents' call lights were within reach of the resident while in bed or in other positions in their bedrooms. The ADM stated she was not aware Resident #10's call light was not within her reach while she was in her recliner on the morning of 12/10/2025. The ADM stated Resident #10 depended on staff for all transfers and most activities of daily living. The ADM stated Resident #10 became confused at times and had trouble using her call light, but she stated the call light should still have been within reach. The ADM stated it was her expectation that nursing staff made frequent rounds to check on Resident #10. The ADM stated it was her expectation that all residents had access to their call light, and it should be within their reach at all times when they were in their bedrooms. The ADM stated staff were trained frequently on call lights, upon hire and at least annually. The ADM stated the last training staff received was in October 2025. The ADM stated there was a risk to Resident #10 not being able to notify staff if she needed assistance if her call light was not within reach. During an interview on 12/12/2025 at 11:05 AM, the DON stated she was not aware Resident #10's call light was not within her reach on the morning of 12/10/2025. The DON stated Resident #10 was dependent on staff for most of her activities of daily living. The DON stated Resident #10's cognition was better some days, but she could become confused often. The DON stated staff received training often regarding call lights, and she recalled the last in-service was in October 2025. The DON stated all nursing staff received training upon hire regarding call lights as well as annually, but they also completed in-service training as needed throughout the year. The DON stated it was her expectation that all residents had access to their call lights if they were in bed or sitting in another area of their room, so they would have access to contact staff if they needed assistance. The DON stated whoever assisted with transferring the resident to her recliner, should have placed Resident #10's call light within reach. The DON was unsure which staff transferred Resident #10 to her recliner that morning (12/10/2025). The DON stated there was a risk to residents if their call light was not within their reach, as they may not be able to call for help if they needed assistance. Record review of the facility's document, In-Service Training Report, Dated 10/08/2025, revealed the following: Call Bell Policy: Residents rely on staff to respond to call bells promptly. Timely responses: Reassure residents that they are in a safe and attentive environment Ensure needs are met without unnecessary delay Demonstrate respect and professionalism in caregiving		