STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	05/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Killeen	5000 Thayer Dr Killeen, TX 76549

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 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** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 3 of 8 residents (Resident #1, Resident #2, and Resident #3) reviewed for ADL care. The facility failed to ensure Resident #1 was provided with ADL care and repositioned timely per Resident #1's care plan The facility failed to ensure Resident #2 was assisted with ADLs timely. The facility failed to ensure that Resident #3 was assisted with incontinent care timely. This failure could place residents at an increased risk of not receiving services or care, diminishing quality of life, and decreased self-esteem. Findings included: 1.Record review of Resident #1's face sheet, dated 05/09/2026, reflected a [AGE] year-old-female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included myoneural disorder (conditions that impair the communication between nerves and muscles, causing muscle weakness, fatigue, and potential respiratory issues), bacterial pneumonia (a serious lung infection that causes inflammation in the air sacs, filling them with fluid or pus), end stage renal disease on hemodialysis (permanent kidney failure requires dialysis or a transplant to sustain life), and vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen and nutrients). Record review of Resident #1's admission MDS Assessment, dated 02/01/2026, reflected Resident #1's BIMS 11, moderate cognitive impairment and triggered care areas reflected: urinary incontinence and pressure ulcer. Record review of Resident #1's Comprehensive Care Plan, dated 04/30/2026, reflected focus: The resident has pressure ulcer Right heel, Left heel or potential for pressure ulcer development related to immobility. Bladder and bowl incontinence: personal hygiene - requires substantial/maximal assistance. Record review of NP B wound care notes, dated 02/11/2026 at 7:04 p.m., revealed Resident #1 is incontinent of urine and stool and is at an increased risk of skin breakdown. Recommend continuing ongoing interventions and protocol for incontinence management. Recommend preventive barrier cream. The patient was noted to have dry skin generalized to entire body. Record review of nursing notes for Resident #1, dated 02/17/2026, revealed skin issue: Right ischium (the lower and back part of the hip bone): Moisture associated skin damage. Wound acquired in-house. It is unknown how. Record review of order summary report for Resident #1, dated 05/10/2026, revealed an order for excoriation right buttock: clean with normal saline, pat dry, apply zinc barrier cream twice every shift ordered on 03/24/2026. Record review of Resident #1's nursing progress notes, dated 04/03/2026, reflected Resident is one person assist with ADL's and brief changes. Resident is incontinent of bowel and bladder. Record review of Resident #1's TN's notes, dated 04/28/2026, revealed new skin issue: location - buttocks - generalized. Laterally/orientation. Right. Issue type: excoriation (scrape, scratch, or wearing away skin, resulting in an abrasion, raw lesion, or sore) wound. Painful: yes. Record review of Resident #1's hospital records with Emergency Department admission wound care scans, dated 05/04/2026, revealed pressure injury of right heel, unstageable with surrounding deep tissue pressure injury, pressure injury left heel with characteristics of deep tissue pressure injury, pressure injury sacrum (a large triangular bone situated at the base of the spine) characteristics of DTPI, Pressure injury right buttock. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	05/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Killeen	5000 Thayer Dr Killeen, TX 76549

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Characteristics of DTPI. Bilateral (both) feet pressure ulcers stage III (a severe, full-thickness skin loss extending into the subcutaneous fat tissue) extensive nonhealing, poor candidate for surgical intervention at her age and continue on wound care. She had multiple pressure injuries, including unstageable and deep tissue injuries on the heels, toes, sacrum, buttocks, and elbows, managed with wound care protocols.She demonstrated severe muscular deconditioning and required maximum assistance for all ADLs and functional mobility. Resident #1 was sent to the hospital due to the fever and change of condition. Observation and interview on 05/09/2026 at 7:00 p.m. revealed Resident #1 was lying in bed at the hospital with nursing staff charting in Resident #1's room. Resident # 1 was observed with wound dressings to her bilateral heels Resident #1 was unable to comprehensively answer questions regarding her care at the facility. Observation of call light responses on 05/09/2026 between 4:30 p.m. - 7:00 p.m. for Resident #2 and Resident #3 and 05/10/2026 between 8 a.m. and 2 p.m. for Resident #2 and Resident #3 revealed multiple call lights were answered between 30 mins and 1.5 hours' time period for multiple residents on 500, 600, 400 and 800 halls. During an interview on 05/10/2026 at 10:20 am, the RP of Resident #1 stated she did not trust the facility and felt that they did not provide good care to Resident #1. She stated that every time she came to see Resident #1 she had to wait for at least 45 minutes to an hour.to get help to Resident #1. She stated that Resident #1 was not repositioned every two hours while she was visiting at the facility on multiple occasions and that was why she got those pressure sores. She thought the facility did not have sufficient staffing to assist with ADL care to Resident #1. During an interview on 05/11/2026 at 12:05 p.m., LPN A stated she worked the 500 and 600 halls during day shift for (6 a.m. to 6 p.m.) for the last 3 years and took care of Resident #1. She stated that skin check assessments popped up on the MAR every week with different dates depending on the residents' admission dates. She stated she was not sure what day of the week the skin assessment was for Resident #1, but she did her skin assessments on regular basis, weekly. She stated that she initially saw pressure sores on Resident #1's bilateral heels about 3 weeks ago. She stated that Resident #1 normally wore soft boots while in bed for wound prevention, but she did not want to wear heel protecting boots due to pain or discomfort and did not wear them for two days when she noticed DTPI. She stated that Resident #1 developed those pressure sores due to staying in bed too long even nursing staff repositioned her every two hours per order. LPN A stated that they had an order for moister protective cream application to Resident #1's bottom, but Resident #1 did not have any skin openings on her bottom, elbows and heels. She stated that Resident #1 had some blanchable redness (a reddened area of the skin that temporarily turns pale or white when you press your finger on it and then quickly returns to red when the pressure is released) with some skin excoriation (red or irritated patches with visible linear marks or scabs) on her bottom and purplish DTPI on both heels. She stated that she communicated the finding to the doctor, sending her a picture and the wound care nurse was providing wound care for the resident. LPN A stated that Resident #1 had dialysis 3 times a week and did not want to get up on other days because she was tired. She stated that Resident #1 was totally dependent on staff to reposition her and assist with ADL activities like feeding and perineal care. She stated that she rounded on all 25 residents every 2 hours. She stated that recently they had 4-5 CNAs per 4 hallways which was enough staff to answer call lights promptly and attend to residents' needs in the timely manner. She stated that it could be difficult sometimes with acute residents that required a lot of attention, but she felt like she could handle that load. She stated sometimes they did not get medication aides and nurses had to pass medications to residents which put extra pressure on charge nurses. She stated that answering call lights was everybody's responsibility and she did not feel that Resident #1 was neglected. She stated that wound care nurse was notified, wound care NP and family nurse practitioner were notified immediately and wound care treatment ordered and provided by facility. She stated that Resident #1 was not eating well over weekend and started feeling worse on Monday morning and she contacted NP A immediately to get new orders and received an order to send Resident #1 to the hospital. During an interview on 05/10/2026 at 2:26 p.m., the TN stated that charge nurses were responsible for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	05/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Killeen	5000 Thayer Dr Killeen, TX 76549

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weekly skin assessments and reporting to her any issues. She stated that Resident #1 did not have any issues before 04/28/2026 and when it was reported to her on 04/28/2026, she assessed her and got an order from NP B for wound care treatment. She stated that she could not tell if the DTPIs were related to not being repositioned or due to trauma. She stated that she was not aware of any redness on Resident #1's bottom. She stated that everybody was responsible for answering call lights and she was not aware of any issues with attending to residents in the facility. During an interview on 05/09/2026 at 05:26 p.m., NP B stated she assesses residents in this facility weekly when received a wound referral and Resident #1 was referred for wound care as soon as unopened and unknown nature DTPI was identified on her both heels. She did not see this resident before her hospitalization due to Resident #1 was out of facility in dialysis. She stated that every 2 months she performed skin assessment for every resident in this facility and Resident #1 did not have any issues in March 2026 when she saw her last time. 2.Record review of Resident #2's face sheet, dated 05/10/2026, reflected a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included hypertensive heart disease (structural and functional heart damage caused by chronically high blood pressure), non-pressure chronic ulcer (wound) of buttock limited to breakdown of skin, depression, and pain. Record review of Resident #2's MDS Assessment, dated 03/15/2026, reflected Resident #2's BIMS score of 15 which indicated intact cognition and frequently incontinent of bladder and always incontinent of bowel required substantial/maximal assistance when helper does more than half the effort for toileting hygiene and shower/bath. Record review of Resident #2's Comprehensive Care Plan, revised 03/31/2026, reflected focus: ADL self-care performance deficit related to limited mobility. Incontinent of bowel and bladder required x2 max assistance with ADLs and transfers with Hoyer lift (a mechanical device used by caregivers to transfer individuals with limited mobility between surfaces) x2 assistance. Resident #2 is totally dependent on x2 staff for incontinent care. Does not use toilet. Encourage the resident to use bell to call for assistance. Problematic manner in which resident acts characterized by ineffective coping. Agitation related to refuses care from staff and states the aides don't do her care the way she wants them to do her care. Record review of order summary report Resident #2, dated 05/10/2026, revealed an order for Bacitracin external ointment 500 unit/GM/Apply to Right buttock topically one time a day related to non-pressure chronic ulcer of buttock limited to breakdown of skin with the start date 04/15/2026. Abscess right buttocks: clen with normal saline, pat dry, apply bacitracin ointment daily and as needed and leave open to air one time a day.Record review of progress notes signed by NP B, dated 04/29/2025, revealed Resident #2 was at high risk for pressure ulcer formation related to decreased mobility, comorbidities, history of a previous pressure injury, incontinence of urine and stool. Patient has a moderate to severe risk of significant complications related to wound healing, morbidity, and overall mortality due to comorbidities. Use appropriate moisture barrier creams per approved list to provide thorough skin care.Keep patient off bottom as resident will allow; turn patient side to side as tolerated. Continue with turning and repositioning schedule per protocol for pressure prevention. Record review of toileting hygiene documentation for Resident #2, dated 04/11/2026 - 05/10/2026, revealed the documentation of assisting Resident #2 with toileting (dependent - helper does all of the efforts or partial (helper does less than half the efforts) only once a day: 4/12/20264/14/2026, 4/21/2026, 4/25/2026, and 4/28/2026. During interview on 05/10/2026 at 9:25 a.m., Resident #2 stated she had issues with the call light answering time, often 45minutes to 2 hours wait time. She stated that she has a cell phone she can monitor her wait time on. She stated that she wanted to be up in her wheelchair by now and she had been waiting for nursing staff to assist her with getting up She stated that she notified staff about wanting to get up and they told her they will come, but it was 2 hours and they did not come. She stated that she required a Hoyer lift for transferring from bed to wheelchair. She stated that she wanted to be back in bed by 4:00 p.m. and get assistance with the bed pan and cleaning but she had to wait for somebody to get her back to bed for a while. The resident stated one time the Hoyer lift batteries were all dead in the whole facility, and they could not get her back to bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	05/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Killeen	5000 Thayer Dr Killeen, TX 76549

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated nursing staff told her to wait, but she had pain 10/10 in her bottom and could not wait any longer. She called 911 and local firefighters came and assisted her back to bed. She stated that it made her feel sad and she could not stand the pain sitting in chair and waiting for too long. During an interview on 05/10/2026 at 10:20 am, CNA C stated she worked with Resident #1, Resident #2 and Resident #3. She stated that she was able to round on all residents that required incontinent care task. She stated she did not recall these residents complaining of not being changed or having skin issues. She stated that she was taking care of 15-18 residents on different halls if nobody called in and felt like she was able to provide good care for those residents. She stated that she did not recall the Hoyer lift not working to get Resident #2 to bed. CNA C stated that not rounding on residents every two hours and not assisting them with incontinent care or showers could lead to neglect and skin problems. During an interview on 04/10/2026 at 10:40 am, LPN E stated she worked as a charge nurse on day shift (6 a.m. -6 p.m.) on 400 hall. She stated she worked with Resident #2 and provided her with care she required. She stated that CNAs were responsible for providing residents' incontinent care and showers but charge nurses assisted them as needed. She stated if a can observed any problems with a resident's skin during peri care or showers, they were to report it to charge nurse using shower sheets for documentation. She stated she had been in-serviced on incontinent care and rounding time, every 2 hours. She stated that sometimes it was hard to attend to every resident timely due to volume of work and acuity of residents. 3.Record review of Resident #3's face sheet, dated 05/10/2026, reflected 78 years-old-female initially admitted on [DATE] and readmitted on [DATE] with diagnoses which included gastro-esophageal reflux disease (a chronic digestive condition where stomach acid repeatedly flows back into the esophagus), cellulitis of left upper and lower limbs (a common, potentially serious bacterial infection of the deep layers of the skin and underlying tissues), depression, and type 2 diabetes mellitus (a chronic condition where the body resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 13 indicating her cognition was intact and always incontinent for bowel and bladder. Record review of Resident #3's care plan, dated 03/31/2026, reflected that he had an ADL self-care performance deficit related to activity intolerance, fatigue and impaired balance. The relevant intervention was one staff assistance with personal hygiene and oral care. Record review of Resident #3's progress notes, dated 05/10/2026 and signed by RN B, revealed Resident #3 had a new skin issue. Location: buttocks - generalized. Laterality/Orientation: inferior. Issue type: Moisture associated skin damage. Incontinent associated dermatitis (skin inflammation). Wound acquired in-house. Length: 10 centimeters - Width: 10 centimeters. Resident has non-opened redness to the inferior (lower) buttock bilaterally (both buttocks). Affected area is being cleaned and dried throughout shift. No signs of opening or drainage present. Resident has no other skin related concerns at this time. Resident is incontinent of urine. Resident uses adult briefs. Observation of call light for Resident #3's room for 48 minutes from 9:11 a.m. - 9: 59 a.m. revealed nursing staff passing by and not attending to Resident #3's call light. Resident #3 was observed lying in bed with a breakfast tray in front of her. During an interview on 05/10/2026 at 10:10 a.m., Resident #3 stated that nobody checked on her last night and she had a wet incontinent brief part of the night. She stated the CNA came this morning to change her and the only brief they had available was too small for her, so she waited for a few hours to get the right size brief. She stated that she asked her RP to bring incontinent briefs for her that fit her as incontinent briefs at the facility are too small. She stated that it bothered her that she waited too long to be assisted with changing her wet brief on different shifts. She stated that it happened over different shifts: night and days. She stated that no specific nursing staff that she could name don't attend to her. Attempted to contact Resident #3's RP on 05/10/2026 at 10:34 a.m. to confirm Resident #3 statement regarding incontinent brief supply was unsuccessful. Observation of Resident #3's brief on 05/10/2026 at 10:21 a.m. revealed a moderately wet incontinent brief without signs of being too small and uncomfortable to Resident #3. During an interview on 05/10/2026 at 10:51 p.m., CNA F stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	05/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Killeen	5000 Thayer Dr Killeen, TX 76549

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that she started a month ago working the day shift on 700 and 800 halls. She stated that she rounded on residents every two hours and was assisting Resident #3 with incontinent care and she could not find the right size brief this morning, but RN B brought incontinent briefs and now she had it. She stated that she had in-service on answering call lights as soon as possible. She stated that she did not see the call light for Resident #3 being on for that long. She stated that not assisting resident who need incontinent care or answering call lights could lead to falls and residents being upset. During an interview on 04/10/2026 at 11:10 a.m., RN B stated that he worked as a charge nurse during day shift on 700 and 800 halls. He stated that CNAs and charge nurses were responsible for rounding on residents every 2 hours and assisting them with incontinent care as needed. He stated that he rounded on Resident #3 today several times. He stated he was able to provide high quality care to residents, but it was challenging sometimes if only 3 CNAs were scheduled for 4 hallways During an interview on 05/10/26 at 2:15 p.m., the DON stated that CNAs were responsible for providing incontinent care to residents promptly and checking on residents every two hours. She stated that Resident #1 was assessed for skin issues on the weekly basis by charge nurses and wound care nurse was providing her with wound care treatment daily. She stated that she assessed Resident #1 herself on the day she was sent to the hospital when she was informed about Resident #1 not eating and increased fever. She explained that Resident #2 was particular about how the tasks were performed and that she often refused being assisted by certain staff and requested only one particular nursing staff to assist her with incontinent care or transfers which was care planned in Resident #2's care plan. She stated that they have manual Hoyer lift and Resident #3 did not want to use it. She stated that answering call lights was everybody's responsibility and if residents who required assistance left unattended could affect their skin integrity. She stated that they had enough nursing staff attend to residents and provide them with good care. The DON stated that she did not think Residents #1, 2 and 3 were neglected. During an interview and observation on 05/10/2026 at 2:21 p.m., the ADM stated she worked at this facility as administrator for 3 years. She stated the facility was fully staffed and they did not have any issues with short nursing staff including CNAs and nurses to provide the care to residents. She stated that answering call lights depended on the situation and potentially answering call lights within 1 hour was reasonable if nursing staff was busy addressing an emergency situation. She stated that there was no set rounding time on residents but residents should be assessed and checked by staff on regular basis. She stated that residents who complained about not being checked and assisted on the timely matter were lying to get the facility in trouble. The ADM stated that residents were supposed to be repositioned according to physician's orders within 2 hours by CNAs or nurses. She stated that Resident #2 wanted special treatment from the staff, refusing to be transferred by certain staff and they could not provide her special treatment. She stated that they had two batteries charged on nursing station 1 and two Hoyer battery charged on nursing station 2. The ADM stated, If there is ever an instance where the battery-operated Hoyer lifts were not working, we have 2 manual Hoyers that can be utilized. The internal batteries for the Hoyers get replaced as needed. She stated that all residents at the facility were fitted for right size of incontinent briefs and they had invoices confirming ordering and receiving enough supplies for residents at the facility. She demonstrated the supply closet with briefs on the shelves which was observed by surveyor. Record review of grievances for 3 months (February -April 2026), revealed multiple concerns on not answered call lights and Waiting to get changed. Record review of the facility policy Activities of daily living (ADL), supporting, revised in March 2018 and updated February 2025, reflected: Residents will be provided with care, treatment and services as appropriated to maintain or improve their ability to care out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	05/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Killeen	5000 Thayer Dr Killeen, TX 76549

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hygiene (bathing, dressing, grooming, and oral care);Mobility (transfer and ambulation, including walking);Elimination (toileting); If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. Record review of facility policy Call System, Residents, revised in September 2022 and updated in January 2025, reflected Residents provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. 6. Calls for assistance are answered timely.