STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flannery Oaks Guest House	1642 N. Flannery Road Baton Rouge, LA 70815

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident's call light was within reach for 2 of 2 (#201 and #401) residents reviewed for accommodation of needs. Findings: Review of the facility's policy, Resident Call Light System, dated 09/14/2022, revealed the following, in part: Purpose: To provide a communication system with audible or visual signals to allow residents to call for staff assistance . Procedure 6. When providing care to residents, be sure to positon the call light conveniently within reach for the resident to use. Resident #201 Review of Resident #201's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included, Transient Ischemic Attack and chronic pain. Review of Resident #201's admission MDS with an ARD of 06/17/2025, revealed a BIMS score of 15, which indicated she was cognitively intact. Review of Resident #201's current care plan revealed the call light was to remain within reach as an established intervention for bowel/bladder incontinence. On 06/29/2025 at 10:00 a.m., an observation was made of Resident #201 in her room. She was sitting upright in a Geri chair with the call light not within her reach. An interview was conducted with Resident #201 at this time and she confirmed the call light was not within her reach. On 06/29/2025 at 10:45 a.m., an interview and observation was conducted with S22CNA. S22CNA confirmed Resident #201 utilizes the call light to request staff assistance. S22CNA observed Resident #201 sitting in a Geri chair in her room and she confirmed the call light was not within Resident #201's reach. Resident #401 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #401's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included, Senile Degeneration of the brain and pain in leg. Review of Resident #401's current care plan revealed she required assistance from staff for ADLs. On 06/30/2025 at 8:47 a.m., an observation was made of Resident #401 in her room. She was sitting upright in a Geri chair with the call light in the center of the bed, not within her reach. An interview was conducted with Resident #401 at this time and she confirmed the call light was not within her reach. On 06/30/2025 at 8:56 a.m., an interview and observation was conducted with S7CNA. S7CNA confirmed Resident #401 utilizes the call light to request staff assistance. S7CNA observed Resident #401 sitting in a Geri chair in her room with the call light in the center of the bed. She confirmed the call light was not within Resident #401's reach. On 06/30/2025 at 1:45 p.m., an interview was conducted with S2DON. S2DON was made aware of the above findings. She confirmed call lights should be within a resident's reach at all times.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure all medical records regarding the resident's code status reflected the resident's wishes for 1 (#201) of 32 residents reviewed in the initial screening for advance directives. This deficient practice had the potential to affect the100 residents that resided in the facility. Findings: Resident #201 Review of Resident #201's clinical record revealed she was admitted to the facility on [DATE]. Review of Resident #201's Admit Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed, the resident had a Brief Interview for Mental Status (BIMS) of 15 indicating she was cognitively intact. Review of Resident #201's physical chart revealed no indication of Resident #201's code status. Review of Resident #201's [DATE] Physician Orders revealed: [DATE] CPR (Cardiopulmonary Resuscitation) Review of Resident #201's Electronic Health Record on [DATE] revealed a Full Code Status. On [DATE] at 10:10 a.m., an interview was conducted with S19LPN. She stated in the situation a code would arise, she would follow Resident #201's code status on the physical chart. S19LPN reviewed Resident #201's physical chart and confirmed there was no indication of Resident #201's code status. On [DATE] at 1:51 p.m., an interview was conducted with S2DON. She confirmed the code status should be found in the physical chart and the electronic chart.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interviews and record review, the facility failed to ensure resident assessments accurately reflected the resident's status. The facility failed to ensure staff accurately coded the correct discharge location for 1 (#99) of 3 (#98, #99, #100) residents reviewed for closed records. Findings: Review of Resident #99's Discharge Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/03/2025 revealed Resident #99 was discharged to a Short-Term General Hospital. Review of Resident #99's Nurse's Notes revealed the following, in part: 04/03/2025 at 2:19 p.m. Resident #99 discharged home with wife via personal transportation. On 07/01/2025 at 1:45 p.m., an interview was conducted with S2DON. She stated she expected MDS nurses to complete all assessments to accurately reflect each residents' discharge status. On 07/01/2025 at 2:03 p.m., an interview was conducted with S6LPN. She reviewed Resident #99's Nurse's notes and confirmed he discharged to home/community. She reviewed Resident #99's Discharge MDS with an ARD of 04/03/2025 and confirmed it indicated he discharged to a Short-Term General Hospital. She confirmed Resident #99's discharge status was not coded correctly and should have been coded as discharged to home/community.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident with a mental disorder had an accurate Pre-admission Screening and Resident Review (PASARR) for 1 (#16) of 1 (#16) resident reviewed for PASARR. Findings: Review of Resident #16's Medical Record revealed she was admitted to the facility on [DATE] with a diagnosis, which included Delusional Disorder. Review of Resident #16's Level 1 Pre-admission Screening PASARR completed by a social worker at a local hospital dated 06/20/2024 revealed in part, the following: Section III: Mental Illness - Yes An interview was conducted on 06/30/2025 at 10:00 a.m. with S17SW. S17SW confirmed Resident #16's Pre-admission Level I PASSAR PASARR Screening dated 06/20/2024 did not contain a diagnosis of Delusional Disorder. She reviewed facility records and could not produce documentation of Level II PASARR review was requested, and confirmed it should have been. An interview was conducted on 07/01/2025 at 2:00 p.m. with S2DON. S2DON reviewed Resident #16's Pre-admission Level I PASSAR PASARR Screening dated 06/20/2024. S2DON confirmed it did not contain her diagnosis Delusional Disorder. She confirmed the facility did not resubmit a new resident review, and should have.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to develop a Comprehensive Person Centered Care Plan, which met the needs of 2 (#29 and #56) of 20 residents Care Plans reviewed in the final sample. The facility failed to ensure the Comprehensive Care Plan included the following: 1. Resident #29's discharge goals; and 2. Resident #56's physical need for a Mechanical Lift for transfers. 1. Review of Resident #29's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis, which included Rheumatoid Arthritis. Review of Resident #29's most recent Care Plan revealed no documented evidence of discharge plans. 2. Review of Resident #56's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Hemiplegia, Hemiparesis, Muscle Wasting to Multiple Sites, and Lack of Coordination. Review of Resident #56's most recent Care Plan revealed no documented evidence the resident required use of Mechanical Lift for safe transfers. An interview was conducted on 07/01/2025 at 11:21 a.m. with S3ADON. She confirmed Resident #56 required two person assist with a mechanical lift for transfers. An interview was conducted on 07/01/2025 at 11:59 a.m. with S8LPN. She confirmed Resident #56 required two person assist with a mechanical lift for transfers. She further confirmed she was responsible for the Care Plan and Resident #56's transfer status should be documented in the Care Plan, but was not. An interview was conducted on 07/02/2025 at 8:58 a.m. with S2DON. She confirmed all Care Plans should be developed to each resident's individualized needs. She further confirmed discharge plans should be documented in the Care Plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure services provided by the facility met professional standards of quality. The facility failed to ensure: 1. Nursing staff adequately conducted full body skin assessments for 1 (#202) of 2 (#75 and #202) residents reviewed for skin injury and; 2. Nursing staff communicated changes in resident status to oncoming nursing staff for 1 (#202) of 2 (#51 and #202) residents reviewed for pain. Findings: Review of the Louisiana Administrative Code, Title 46, Professional and Occupational Standard, Part. XLVII, Nurses: Practical Nurses and Registered Nurses (As amended through December, 2024) Subpart, I. Practical Nurse, under subchapter E. Curriculum Requirements revealed in part: 3. Development of those qualities and personal characteristics needed to practice practical nursing safely, effectively and with compassion, including increased and ongoing development of self-awareness, sound judgement, [NAME], ethical thing and behaviors, problem solving and critical thinking abilities. 7. Principles and Practice of Nursing-presenting the application of concepts which will provide basic principles of nursing care and correlated experiences to develop competency in medical-surgical nursing, geriatric nursing, and mental health. Clinical experience shall include, but not be limited to, the performance of basic and advanced nursing skills, general health and physical assessment, critical thinking and critical problem solving, medication administration, patient education, health screening, health promotion, health restoration and maintenance, supervision and management, safety and infection control, communication and documentation, and writing as member of the interdisciplinary health care team. Review of Resident #202's clinical record revealed the resident was admitted to the facility on [DATE] with the following medical diagnoses: Pain, Unspecified and Long Term (Current) Use of Anticoagulants. Review of Resident #202's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/14/2025 revealed a Brief Interview for Mental Status (BIMS) of 13, indicating resident was cognitively intact. Review of Resident #202's current Physician Orders revealed the following, in part: 06/10/2025 weekly body audit completed on 06/22/2025 and 06/29/2025 by S21LPN. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 07/01/2025 at 10:35 a.m., an observation was conducted with S20LPN. Resident # 202 was noted lying in her bed with red gripper socks noted on her feet. S20LPN removed the sock and noted the upper right foot with red bruising, the second toe noted to be dark purple, purple bruising extended to the big toe and 3rd toe, and swelling noted to the right ankle. Resident # 202 reported pain to touch of her right foot. Resident #202 stated the second toe was better because over the weekend it was black. On 07/01/2025 at 11:27 a.m., an interview was conducted with S21LPN. She stated Resident # 202 had weekly skin audits conducted weekly, every Sunday. She stated she completed Resident #202's weekly skin audit on 06/29/2025 and observed no skin issues. She confirmed when conducting the skin audit she did not remove Resident #202's socks and should have. 2. On 07/01/2025 at 11:27 a.m., an interview was conducted with S21LPN. She confirmed she did not report to oncoming staff Resident #202 complained of right foot pain and swelling on 06/29/2025. On 07/02/2025 at 8:45 a.m., an interview was conducted with S24LPN. She stated she received report from the night shift, and was not informed of Resident # 202's right foot pain, swelling, or pending x-ray results and should have been. On 07/02/2025 at 10:06 a.m., an interview was conducted with S25LPN. She stated she provided care to Resident # 202 on the night shift of 07/01/2025. She stated she received report Resident #202 complained of foot pain and had an x-ray completed on 07/01/2025 with results pending. She confirmed she did not report the above information to the oncoming day shift staff on 07/02/2025 and should have. On 07/02/2025 at 10:31 a.m., an interview was conducted with the S2DON. She stated skin audits were conducted weekly on an assigned day. She confirmed Resident #202's body audit was conducted on Sundays. She further confirmed weekly body audits should include visual observation of all the skin including removing the socks to observe the toes. She confirmed nursing staff should report any pending x-ray results or new bruising identified to the oncoming nursing staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews, observations, and record review, the facility failed to ensure that a resident was provided services to restore as much normal bladder and bowel function as possible for 1 (#351) of 2 (#45, and #351) residents reviewed for Bladder and Bowel Incontinence. Findings: Review of the facility's policy titled Bowel and Bladder Program Policy and Procedure with an effective date of 09/11/2014, revealed the following, in part: Purpose: To potentially improve resident's bladder and/or bowel functional control and promote dignity and wellbeing through a scheduled toileting program. Policy: To implement an individual, organized toileting program after voiding patterns have been established and a potential benefit for scheduled toileting has been identified and deemed medically appropriate. Review of Resident #351's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Neuromuscular Dysfunction of Bladder, Constipation, and Acute Cystitis. Review of Resident #351's current Care Plan revealed the following, in part: Resident requires staff assistance for Activities of Daily Living care. Interventions included: assist resident with toilet transfers. Review of Resident #351's Progress Notes revealed the following, in part: Brief Interview for Mental Status on 06/25/2025 revealed Resident #351 had a BIMS of 12-indicating moderately impaired cognition. Further review of notes revealed Resident #351 was admitted on [DATE] with an indwelling, Urinary Catheter, but it was removed on 06/27/2025. An interview and observation was conducted on 06/30/2025 at 9:59 a.m. with Resident #351. Resident #351 reported she had her urinary catheter removed last week due to frequent urinary infections and staff had not been assisting her with maintaining her continence. She stated staff refused to assist her to the toilet. Observation of resident revealed she was wearing a urine soaked brief. An interview and observation was conducted on 07/01/2025 at 10:02 a.m. with Resident #351. Resident #351 was wearing an adult brief which was soiled with urine and reported she would prefer to use the toilet but required physical assistance from staff, and stated staff did not assist her with toilet transfers. She further confirmed since admission she has not been assisted to the toilet by staff or been placed on a bowel/ bladder training program. An interview was conducted on 07/01/2025 at 10:36 a.m. with S23LPN. She confirmed Resident #351 was incontinent. She further confirmed Resident #351 was a one person assist to transfer and if she was transferred to bathroom she could use the toilet, but she had never assisted Resident #351 to the toilet. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 07/01/2025 at 11:05 a.m. with S3ADON. S3ADON confirmed Resident #351 has not been on a bowel or bladder incontinence training program and that Resident #351 called staff for assistance when she is soiled. She confirmed resident was aware when she was soiled and further confirmed Resident #351 can stand to transfer to toilet with staff assistance. An interview was conducted on 07/01/2025 at 3:30 p.m. with S13LPN. S13LPN confirmed Resident #351 has had foul smelling urine. She further confirmed Resident #351 requires staff assistance to transfer to toilet but has not been placed on a bowel/ bladder training program, instead she was placed in a brief. An interview was conducted on 07/02/2025 at 8:54 a.m. with S5 LPN. S5LPN confirmed she was responsible for assessing bowel and bladder continence of Resident #351 upon admission. She reported Resident #351 told her she was soiling in her brief but would like to go on the toilet. S5LPN further confirmed Resident #351 could transfer to toilet with staff assistance, but was never placed on a bowel/ bladder training program, and should have been. An interview was conducted on 07/02/2025 at 8:58 a.m. with S2DON. She confirmed the facility's goal was to provide services to restore as much normal bowel and bladder function as possible for each resident and that the new suggestions for Resident #351 as of 07/01/2025 was for her to use a bed pan despite resident being a one person assist to transfer. She further confirmed resident was never placed on a bowel or bladder training program to restore as much normal function as possible.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review and interviews, the facility failed to post nurse staffing data on a daily basis which included the total resident census. This deficient practice had the potential to affect the 100 residents residing in the facility. Findings: On 06/29/2025 at 9:08 a.m., an observation was made of the Daily Staffing Reporting Form dated 06/27/2025 with no resident census listed. On 06/29/2025 at 9:43 a.m., an interview was conducted with S16UC. She stated she was responsible for posting the Daily Staffing Reporting Form on the weekends. She stated she turned in the Daily Staffing Reporting Forms to S2DON. On 06/29/2025 at 9:50 a.m., a record review was conducted of the Daily Staffing Reporting Forms dated 06/27/2025 through 06/29/2025 and revealed no resident census was listed on any of the forms provided. On 06/30/2025 at 8:26 a.m., an interview was conducted with S9UC. She stated she worked Monday through Friday and was responsible for posting the Daily Staffing Reporting Forms in the mornings. She stated S11HR collected the Daily Staffing Reporting Forms at the end of the day. She reviewed the Daily Staffing Reporting Forms dated 06/27/2025 through 06/29/2025 and confirmed the resident census was not completed daily and should have been. On 07/01/2025 at 9:24 a.m., an interview was conducted with S2DON. She stated the Unit Clerks were responsible for completing the Daily Staffing Reporting Forms and posting it in the main lobby. She stated the Daily Staffing Reporting Form should be completed with the resident census, date, facility name and staffing information. She stated S11HR was responsible for collecting those sheets. She reviewed the Daily Staffing Reporting Forms dated 06/27/2025 through 06/29/2025 and confirmed the resident census was not completed daily and should have been. On 07/01/2025 at 1:41 p.m., an interview was conducted with S11HR. She stated the Unit Clerks were responsible for completing and posting the Daily Staffing Reporting Form. She stated the Daily Staffing Reporting Form should be complete and accurate. She reviewed the Daily Staffing Reporting Forms dated 06/27/2025 through 06/29/2025 and confirmed the resident census was not completed daily and should have been.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store food in accordance with professional standards for food service safety. The facility failed to ensure food was properly sealed, stored, and dated in the refrigerator and dry storage area of the facility's kitchen. This had the potential to affect 100 residents who were served from the kitchen. Findings: Review of the facility's policy, titled, Food Storage Labeling, with a revised date of 10/2018, revealed, in part: The facility will store and label all foods to ensure safety and quality. 7. Food is stored in containers that are sealable, leak proof, durable and undamaged. Review of the facility's policy titled, Food Service Operation Standards for Purchasing, Cooking and Storage, with a revised date of 10/2018, revealed, in part: 3. Storage a. Store food only in designated storage areas 8. Cooling and storing g. Label and store foods with the date and time they were prepared to indicate when to discard An initial tour of the kitchen was conducted on 06/29/2025 at 9:15 a.m. with S18CO. Observations were made of the following items: Dry Storage: 1-gallon, ¾ full of soy sauce, opened, with no opened date and refrigerate after opening on the product label. Refrigerator 1-packet, 1/2 full of sliced deli ham, unsealed. On 06/29/25 at 9:26 a.m., an interview was conducted with S18CO. She confirmed the aforementioned findings, which were observed in the kitchen. She stated all food should be sealed, dated, and stored properly and was not. On 06/30/25 at 8:26 a.m., an interview was conducted with S15DM. She confirmed all food in the dry pantry and refrigerator should be dated, stored, and sealed appropriately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure medication administration was accurately documented for 1 (#202) of 2 (#51 and #202) residents reviewed for pain. Findings: Review of Resident #202's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses, which included Pain. Review of Resident #202's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/14/2025 revealed a Brief Interview for Mental Status (BIMS) of 13, indicating the resident was cognitively intact. Review of the facilities standing orders revealed an order for Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 4 hours as needed for general discomfort. Review of Resident #202's June Medication Administration Record (MAR), printed and reviewed on 06/30/2025 at 3:40 p.m., revealed no documentation of an order for Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 4 hours as needed for general discomfort. On 06/29/2025 at 10:11 a.m., an interview was conducted with Resident #202. She stated she had right foot pain and requested Acetaminophen from her nurse for the pain. On 06/29/2025 at 10:11 a.m., an interview was conducted with S21LPN. She confirmed Resident #202 complained of right foot pain and administered Acetaminophen for Resident#202's discomfort. On 06/30/2025 at 3:30 p.m., an interview was conducted with S20LPN. She reviewed Resident #202's physician orders and confirmed she did not have an order for Acetaminophen. She stated the Acetaminophen was a standard order. She confirmed if Acetaminophen was administered the order should have been entered in the computer in order to document the medication administration. On 07/01/2025 at 10:27 a.m., an interview was conducted with S21LPN. She stated on the weekend of 06/21/2025-06/22/2025 and on 06/29/2025, Resident #202 complained of right foot pain and she administered Acetaminophen for discomfort. She stated the Acetaminophen was a standard order. She stated when a standing order was administered, the medication should be added to the orders and placed on the MAR so staff could document the date and time the medication was administered. She confirmed she administered 2 doses of Acetaminophen to Resident #202 and did not documented it. On 07/01/2025 at 1:53 p.m., an interview was conducted with S2DON. She stated medication standing orders were not entered in the computer unless the medication was administered. She confirmed if staff administered Acetaminophen, the medication should have been entered and placed on the MAR, so staff could document the date and time the medication was administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195477	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flannery Oaks Guest House	1642 N. Flannery Road Baton Rouge, LA 70815

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interviews and record review, the facility failed to maintain documentation and demonstrate evidence of its ongoing Quality Assurance and Performance Improvement (QAPI) program demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. This deficient practice had the potential to affect a census of 100 residents. Findings: Review of the facility's policy, Quality Meeting Policy and Procedure, dated 04/28/2025 revealed, in part, the following: Purpose: To identify, respond, track and trend, and monitor for improvement of facility potential quality deficiencies. The overall goal is to improve the quality of care for the residents of the facility. Policy: II. Facility will monitor performance by previous performance, established benchmarks, and/or determined by the QAA committee. IV. The quality assessment and assurance committee will meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program; such as, identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program are necessary. Review of the facility's Quality Improvement Corrective Action Plan revealed in part, the following: Identified Date: 05/20/2025 1. Corrective actions taken by: a. The Nursing Facility Administrator and/or designee have initiated a quality review to determine average call light response times. 2. Identification of at-risk population: All residents have the potential to be affected by delayed call light responses and are considered potentially impacted by the deficient practice. 3. Measures and System Changes to Prevent Recurrence: c. CNAs must ensure that call lights remain within resident's reach at all times, especially after care is completed or following transfers or repositioning. 4. Monitoring and Quality Assurance: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. All direct care staff will be re-in serviced on proper call light placement and the expectation for immediate response. b. The NFA or designee will audit call light weekly to evaluate response times and identify trends requiring corrective action. e. Negative outcomes or recurrent delays in call light response will be reviewed during the Interdisciplinary Team (IDT) meetings for case-based problem-solving. Review of the facility's in-service log revealed in part, the following: Date completed: 06/07/2025 Topics discussed: After care call lights should be placed within reach of the resident whether the resident is in bed or in their wheelchair. If you roll a resident to their room do not forget to clip call light to resident or attach to resident's chair or blanket. Review of the facility's monitoring forms revealed documentation for 06/07/2025 and 06/09/2025. No further documented evidence of monitoring was provided for review upon request. Review of the facility's follow-up documentation revealed in part, the following: Date completed: 06/26/2025 Several residents noted sleeping in chairs without call light. Expectations set and will continue with QA until no further issues noted. No further documented evidence of monitoring was provided for review upon request. On 07/02/2025 at 11:18 a.m., an interview was conducted with S1ADM. He stated that he was responsible for the facility's QAPI program. He stated a QAPI pertaining to call light response time and placement was initiated on 05/20/2025. He stated S4CNAS was responsible for ongoing monitoring of call light response times and call light placement. He stated any identified issues were discussed in the weekly IDT meeting. He confirmed there was no documentation of monitoring after 06/09/2025, no changes were made to the corrective action plan, and he observed call lights not within several residents' reach on 06/26/2025. On 07/02/2025 at 11:35 a.m., an interview was conducted with S4CNAS. She stated she was responsible for completing daily monitoring for call light response times and placement. She stated she had not filled out a monitoring form since 06/09/2025. She stated all issues found during her monitoring rounds were discussed in the weekly IDT meetings. She confirmed she continued to find call lights not within reach and no new changes have been made to the corrective action plan.