

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2025
NAME OF PROVIDER OR SUPPLIER Regent Care Center of Laredo		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 McPherson Rd Laredo, TX 78041	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47371</p> <p>Based on interviews and record review, the facility failed to ensure that all alleged violations involving the reasonable suspicion of a crime were reported immediately to a law enforcement entity for its political subdivision, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 (Resident #1) of 5 residents reviewed for abuse/neglect.</p> <p>The facility failed to report to the local law enforcement agency within the allotted time frame of 24 hours on 01/14/2025 around 6:30 PM when housekeeper A notified the administrator and DON of her suspicion of abuse regarding Resident #1.</p> <p>This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse.</p> <p>The findings included:</p> <p>Record review of Resident #1 face sheet dated 04/19/2025 revealed Resident #1 was an [AGE] year-old-male who was initially admitted on [DATE] and readmitted on [DATE]. Resident #1 was admitted with diagnoses of Alzheimer's disease (cognitive impairment) and dementia (cognitive impairment).</p> <p>Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 5 which meant severely cognitively impaired and was dependent on staff for ADLs.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Care Plan date implemented 09/18/2024 I may be at risk for: self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress. Goal: Resident's condition will be stable, and his/her needs will be anticipated and met as indicated. Interventions: Resident's emotional needs will be supported, and resident will adjust to placement without any sign of emotional distress noted. Resident will not experience a health decline, will tolerate medication/treatment and progress towards goals established until the comprehensive plan of care can be developed. Therapy services as ordered by the physician. Social Services as indicated. Mental health providers as ordered. Coordinate all essential medical and/or mental health provider visits or telehealth visits as indicated. Provide care and safety checks throughout shift. Nutrition/hydration (food/foods) within prescribed diet. Provide care and services as indicated. Provide teaching regarding medications, treatment, care, and health status as needed. Activities as tolerate. Administer medication, care & treatments as per MD recommendation. Provide ADL care as indicated. Monitor psycho-social status or monitor behaviors to establish targeted behaviors. Monitor vital signs & health condition as indicated. Notify PCP & RP of any change in condition as clinically indicated. See nurse for any care related questions or concerns.</p> <p>Record review of the facility's Provider Investigation Report regarding Resident #1 dated 01/17/2025 revealed Description of the allegation: staff reported a concern regarding the attitude of a nurse toward a resident. The housekeeper stated that she observed [Resident #1] calling for assistant and felt the nurse responded with a rough attitude. Was the incident reported to the police yes case number 2025-001298.</p> <p>Record review of Resident #1's local law enforcement police report printed timestamped 04/22/2025 at 8:21AM revealed case number 2025-00011298, report detailed that event occurred from 01/14/2025 at 12:00AM to 01/14/2025 at 8:00PM. Additionally, facility reported date and time: 01/21/2025 at 11:29PM which revealed the facility reported the allegation of abuse 7 days after the allegation was made. Narrative on January 21, 2025, police responded to [facility] to incident report.</p> <p>During an interview on 04/19/2025 at 10:28AM dispatcher for the local law enforcement agency stated case number 2025-001298 was not a case number and stated 2025-00011298 was called in by the facility administrator on 1/21/2025 around 11:29AM, which was 7 days after the allegation was made on 01/14/2025.</p> <p>During a phone interview on 04/19/2025 at 11:28AM the local law enforcement officer who responded to the 01/21/2025 call regarding Resident #1 stated when he initiated his onsite investigation on 01/21/2025, he was notified by the administrator that the incident regarding Resident #1 had transpired several days before the administrator called in the allegation of abuse. The local law enforcement officer stated he interviewed Resident #1 and other staff members but did not find any definitive evidence that the allegation of abuse occurred. The local law enforcement officer stated he filled out a report shortly after he completed his facility on-site visit on 01/21/2025 and the report he completed would accurately depict the timeframe of when the facility called in the allegation of abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/19/2025 at 2:19PM the Administrator and DON stated their protocol was to suspend LVN A pending investigation results. Both stated they gathered information from the housekeeper on 01/14/2025 and commenced a head-to-toe assessment for Resident #1 and notified Resident #1's [family member]. Both stated they called the police department within 24 hours when the allegation was made on 01/14/2025. Both stated they never found any definitive evidence of abuse as Resident #1 never verbalized any allegation of abuse or mistreatment nor did they find any skin irregularities or behavioral abnormalities. Both stated the investigation took roughly 5 days to complete. Both stated they commenced their investigation with residents on 01/14/2025 thru 01/15/2025, followed by staff members. Both stated they treated the allegation as abuse and notified the proper entities including state agencies and local law enforcement. Both did not verbalize a definitive answer of what potentially could occur if the local law enforcement agency is not called within 24 hours. Both reiterated the facility notified the local law enforcement within 24 hours after the allegation of abuse was made. The Administrator said it was his responsibility for reporting any allegation of abuse to the state agency and local authority.</p> <p>Record review of the facility's Abuse and Neglect in-service dated 01/15/2025 revealed Reviewed the process of reporting all allegations of abuse and neglect. Understanding the process of preventing, identifying, and reporting all allegations/suspicious. [facility] policy for preventing, identifying, and timely reporting all suspicions and/or allegations of abuse and neglect, the [state agency] guidance/provider letter and adhering to the timely reporting per regulation. Community has a 2-hour reporting window on certain abuse and neglect allegations.</p> <p>Record review of the facility's Abuse Guidance: Preventing, Identifying and Reporting policy and procedures date/revised January 2024 documented,</p> <p>Report alleged or suspicions of abuse to HHSC by email reporting or via TULIP reporting within the designated time frames in accordance with HHSC's 19-17 are reported immediately,</p> <p>Not later than 24hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury,</p> <p>State authorities should be notified of reports of abuse described above which alleges that: 4. A resident has been a victim of any act or attempted act of abuse or neglect.</p>		