STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44915 Based on interview, record review, and observation, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 6 resident (Resident #1) reviewed for accidents. The facility did not provide supervision to prevent Resident #1 from having a witnessed fall, when CNA A failed to ensure the resident was secured and placed appropriately in her bed prior to plugging in her bed. As a result the resident sustained a fracture. This failure could place residents at risk for inadequate supervision resulting in injuries. The findings included: Record review of Resident #1's admission record dated, 03/28/2024, revealed she was an [AGE] year old female, with an initial date of 06/26/2014, and her diagnosis included: Other bacterial infections of unspecified site, Acute cough, Dysphagia, oropharyngeal phase(swallowing problems occurring in the mouth and/or throat), Cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with blood vessels that supply it), Wedge compression fracture of unspecified lumbar vertebra , subsequent encounter for fracture with routine healing . Record review of Resident #1's significant change MDS assessment dated [DATE], revealed Resident #1 had a BIMS (Brief Interview for Mental Status) score of 0 which indicated her cognition was not intact and she was unable to speak. She required 1 person assistance for all ADLs (Activities of Daily Living), with extensive assistance for dressing, toilet use and personal hygiene. She required limited assistance with bed mobility and supervision for transfers, walking in room, walking in corridor, locomotion on the unit, locomotion off the unit, and for eating. Record review of Resident #1's Comprehensive Care Plan initiated 03/07/2024 revealed: Focus: Resident #1 had a history of falling and a history of CVA (Cerebrovascular accident) with right sides weakness He had gait/balance problems. Poor cognition with [NAME] safety awareness noted. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions included: Keep bed in lowest position. Keep call light in reach and encourage to use. Assure that are is adequately lit and free from clutter. Monitor for changes in condition that may warrant increased supervision/assistance and notify the physician. Assist with one staff member for all ambulation. Goal: Will minimize risk for falls daily and ongoing over the next 90 days. Record review of Resident #1's fall incident dated 03/07/2024 at 09:52AM completed by DON Incident date: 03/02/2024 Incident Type: Fracture Location: Resident Room Incident Level: Non-witnessed Description: Approximately @ about 7:00PM nurse was alerted to room by CNA A. Resident noted to be on the floor lying on her left side near the bed. Resident alert nonverbal responding to touch stimulation; no obvious distress, resp. even and unlabored, skin pink, bruise to left knee, small cut to the lip. No swelling, pain 5/10, Tylenol PO given and ordered. Vital signs taken and staff assist x3 resident back to bed with wedges in place. transfer to hospital. Immediate Actions Taken: Assessed; assisted off of the floor, V/S skin, neuro check, assist x2, Notifications made to family, Administrator/ DON; Doctor who gave orders to transfer resident to hospital for further evaluation. Record review of Resident #1's fall incident follow-up dated 03/07/2024 at 9:53AM completed by DON 24-Hour Follow-up Resident condition after 24 hours: hospitalized 24-Hour condition and injury appearance: Bruise to left knee, small superficial cut to lip. Per hospital resident noted with hip fracture and knee fracture, Tylenol administered for pain 5/10. Additional Follow-ups: 03/04/2024: IDT Meeting held; resident was noted to roll out of bed and was transferred to the hospital for further evaluation. Resident had just received peri-care. CNA A was attempting to lower residents' bed, but bed was noted unplugged. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	03/04/2024: Therapy notified of residents fall out of bed. Bed re-assessed; resident would benefit from a scoop mattress for positioning/comfort; CNA A re-educated to ensure bed is close to outlet to prevent bed from becoming unplugged; re-education on fall prevention. Record review of Radiology Results dated 03/04/2024 revealed: Patient laboratory studies in the ED show creatinine 1.21 with GFR 42. CT of the brain shows acute renal abnormality. CT of the cervical spine shows acute fracture. CT pelvis shows acute abnormality x-ray of the knee shows mild displaced impacted distal femoral fracture. X-ray femur shows distal supracondylar femur CT of the knee shows mildly comminuted distal impacted distal femoral fracture nondisplaced patella fracture demineralized bones. Observation on 03/28/2024 at 11:37AM. Resident #1 in bed awake, bed in low position and floor mats to both side of bed. Call light in reach to left side of bed. Room and restroom free of clutter. Resident did not respond to any of my questions. In an interview on 03/28/2024 at 12:05PM with CNA A, she stated she went in Resident #1's room to complete incontinent care and prior to starting she lifted the resident's bed. She stated she noticed that the bed was unplugged when she went to lower the bed, she stated she made sure the resident was secured and she tried to plug the bed back in, and the resident fell . She stated the resident was on her side when she reached to plug the bed back in. When asked why she did not lay the resident on her back prior to plugging the bed back in she stated, she did not know. She stated Resident #1 was a one person assist. She stated the risk of not having the bed plugged in was that the resident had a fall. She stated she was the only person that witnessed the incident. She stated she was providing incontinent care, so the residents curtain was closed. She stated the she now checks the plug prior to giving care to residents. She stated there was an in-service after the incident occurred. In an interview on 03/28/2024 at 12:41 PM with DON, she stated she was not working the day the incident occurred, but she completed the investigation of the incident. She stated CNA A was completing incontinent care with when the resident had a fall. She stated CNA- A had completed incontinent care and laid the resident flat and CNA A was done providing incontinent care. She stated CNA A noticed the bed was unplugged and reached to plug the bed back in and the resident fell . She stated CNA A never informed her that the resident was lying on her side, she stated she was under the impression that the resident was laid down flat and the staff member was done providing care. She stated the outlet in the residents' room was loose and it is what caused the bed to become unplugged. She stated maintenance replaced the outlet in the resident's room. The DON stated Resident #1 was immediately sent to the hospital when the incident occurred and stated the staff were in-serviced. She stated she did not think the incident should have been reported to state because it was a witnessed fall, but the facility decided to report it anyway. In an interview on 03/28/2024 at 1:15PM with CNA A and the DON, the DON informed the surveyor that she wanted to clear up the misunderstanding of what occurred the day of the incident. CNA A denied that she informed surveyor that Resident #1 was lying on her side when she had a fall. CNA A reported that Resident #1 was laying flat when she rolled out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 03/28/2024 at 1:30PM with the Maintenance Director, he stated on the day that the incident occurred, he received a notification from the DON on that there was something wrong with the outlet, in Resident #1's room; he stated the outlet had come loose. He stated he changed out the outlet and put a new panel on it. He stated the outlet looked as if it was a bit worn. He stated it was the first report received regarding the outlet in the resident's room. He stated he did a check of other outlets as well to ensure there was no issues with outlets in other rooms and he reported he did not find any issues with any other outlets. In an interview on 03/28/2024 at 2:50PM with Administrator, she stated CNA A was completing incontinent care with Resident #1 and when she went to lower the bed back down, she noticed the bed was unplugged. She stated when CNA A went to plug the bed back in, the resident rolled out of bed. She stated CNA A had already completed incontinent care with the resident. She stated it was an accident and reported the incident could have still occurred even if the bed was in a lower position. She stated the incident was a witnessed fall by the CNA A. Record Review of the facility's undated Falls and Fall Risk, Managing Policy reflected: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.