

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Regent Care Center of the Woodlands		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469</p> <p>Based on observation, interview and record review, the facility failed to ensure for 1 of 3 residents (Resident #1) who needed respiratory care was provided care consistent with professional standards of practice reviewed for respiratory care, in that:</p> <ul style="list-style-type: none"> - Resident #1 was observed to be administered oxygen PRN, but nurses did not document the times PRN oxygen was given . - LVN D reported Resident #1's oxygen dipping low at times but did not document change of conditions and times in which PRN oxygen was needed. <p>This failure placed Resident #1 at risk of not receiving adequate respiratory care.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet revealed a [AGE] year-old female who was admitted into the facility on [DATE] and was diagnosed with cerebral palsy, shortness of breath, epilepsy, dementia and muscle wasting atrophy.</p> <p>Observations on 04/09/2024 at 10:34AM, revealed Resident #1 lying in bed with her nasal cannula on receiving oxygen from her oxygen concentrator set on 2L/min. The humidifier attached was labeled with date 04/07/24. Resident was observed have unlabored breathing.</p> <p>Record review of Resident #1's comprehensive MDS, dated [DATE], revealed the resident was not noted to have oxygen therapy while a resident.</p> <p>Record review of Resident #1's care plan, not dated, revealed the resident was at risk for shortness of breath and coughing up yellow phlegm due to acute diagnosis of acute bronchitis, resolved 05/05/2021 status post COVID and intervention listed included to administer oxygen as ordered.</p> <p>Record review of Resident #1's vital signs revealed from 03/29/2024 - 04/10/2024, the resident was documented to have O2 sat% of at least 95% or above.</p> <p>Record review of Resident #1's physician's orders revealed the resident had an order to:</p> <ul style="list-style-type: none"> - Check humidifier and change PRN when water level is low, starting 10/13/2022. <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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Administer Oxygen at 2-4L/minute via nasal cannula or mask PRN for SOB/Cyanosis, starting 10/13/2022.</p> <p>- Check humidifier and change PRN when water level is low, starting 10/19/2022.</p> <p>Record review of Resident #1's Nurse MAR from March - April 2024 revealed the resident was not documented to have received any PRN oxygen.</p> <p>In an interview with MDS Nurse on 04/11/24 at 03:09 PM, she stated Resident used the oxygen PRN in the past but referred to recent documentation in MAR/TAR or notes to see if the oxygen was administered. She said it was sometimes missed by the nurses to document when the oxygen therapy was used, and she likely did not mark the resident's MDS for oxygen therapy use because of that reason. She stated her recent observations of Resident #1 revealed the resident was not receiving oxygen.</p> <p>In an interview with LVN A on 04/11/24 at 03:27PM, she stated since she had been working with Resident #1 for the past 2-3 months and she had been administering oxygen to the resident as needed while she was in bed. She stated the oxygen was not needed by the resident at all times, but periodically, when checking her oxygen saturation levels, and she found her oxygen was low she put the resident on oxygen, so it was important for staff to know the necessity of oxygen therapy for the resident. LVN A refused to specify how low her oxygen got. When asked what the risk of not documenting use of oxygen was, she did not answer the question, but instead stated she knew it was important to document oxygen-use, but she just forgot to do so.</p> <p>In an interview with the DON on 04/11/24 at 04:00PM, she stated it was important for nurses document use of oxygen in the nurses notes to show continuity of care and for accuracy of assessments related to necessity of oxygen therapy. She stated if the nurse noticed the resident was having any shortness of breath, dip in oxygen saturation or a change of condition, details should have been noted in the nurses' notes. She stated she also did not believe the MAR was the best place to document oxygen administration use because of lack of ability to distinguish at what times that oxygen was in use.</p> <p>In an interview with the DON on 04/11/2024 at 4:45PM, she stated she had to retrain LVN A today on documenting a change of condition and reporting to the physician, because after interview with surveyor, she learned from LVN that Resident #1's oxygen dipped below 90% but did not yet document it because LVN A was swamped with other issues involving other residents.</p> <p>The facility's policy on 04/11/2024 at 3:48PM, was requested by the surveyor to the Administrator per email but was not provided prior to exit.</p>