STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675890	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care at Medical Center	3935 Medical Dr San Antonio, TX 78229

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observations, interviews, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by an interdisciplinary team for one (Resident #1) of one resident reviewed for revised Care Plan. The facility failed to ensure Resident #1's care plan was revised to reflect discontinued foley catheter. This failure could place the resident at risk of current needs not being met. Findings included: Review of Resident #1's Face Sheet dated 04/19/2024 reflected that the resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included altered mental status (a change in mental function), muscle wasting and atrophy (decline in muscle strength and energy), obstructive and reflux uropathy (when urine is unable to drain through the urinary tract and causes urine to back up into the kidneys), and chronic kidney disease (a condition where the kidneys lose their ability to filter blood and remove wastes). Review of Resident #1's Comprehensive MDS assessment dated [DATE] and signed as completed 04/12/2024 reflected the resident was able to complete the interview to determine the BIMS score, with a BIMS score of 15 indicating cognitively intact. The Comprehensive MDS Assessment also indicated resident was always incontinent of urine and bowel but did not have any appliances. Appliances would include indwelling catheter, external catheter, ostomy, and intermittent catheterization. Review of Resident #1's Comprehensive Care Plan Description dated as started 04/02/2024 and accessed for review 04/18/2024, reflected Resident #1 had a foley catheter in place. Review of Resident #1's Physician Orders on 04/18/2024 reflected no order for discontinued foley catheter or indwelling catheter. Interview on 04/18/2024 at 02:58 p.m. with MDS Nurse D and MDS Nurse E revealed they were responsible for updating Resident #1's care plan, including care planning on resident interventions. They revealed that a new care plan meeting would be scheduled within two (2) weeks of a significant change. (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/18/2024 at 03:10 p.m. of Resident #1 receiving incontinent care by CNA A and CNA B revealed Resident #1 did not have a foley catheter or indwelling catheter. Interview on 04/18/2024 at 05:06 p.m. with CNA A revealed Resident #1 did not have a foley catheter when she returned from the hospital (04/02/2024). Interview on 04/19/2024 at 11:08 a.m. with CNA C revealed Resident #1 did not return from the hospital with a foley catheter, she did not have a foley catheter prior to being discharged to the hospital, and had not had a foley catheter for a while. CNA C stated she was unable to provide an exact date of when Resident #1 last had a foley catheter. CNA C revealed the care plan mentioning a foley catheter would not impact resident care. CNA C stated that incontinent care checks, regardless of a resident having a foley catheter would be on the CNA task list for two-hour incontinent checks, and the nurse would verbally notify the CNA if a resident had a foley. Interview on 04/19/2024 at 11:37 a.m. with MDS Nurse D and MDS Nurse E revealed they did not recall Resident #1 having had a foley catheter right now and were not able to recall when the foley catheter was removed. They stated Resident #1 had not had a foley catheter during her last admission and had not had one this month. They revealed that Resident #1 had had a foley catheter around 2022 but per Resident#1's MDS of 06/15/2023, she was not coded for a catheter. They stated she would have been coded under Appliances for indwelling catheter if she had one. MDS Nurse E stated there would have been no impact in the resident's care with the care plan having stated foley catheter in place because the facility staff would not have been providing foley catheter care. MDS Nurse E stated she removed foley catheter from the care plan on 04/19/2024 during the interview. Record review of facility policy, Care Planning- Interdisciplinary Team, undated, revealed 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS).

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for one (Resident #1) of one resident reviewed for hospice services. The facility failed to maintain required hospice forms and documentation to ensure Resident #1 received adequate end-of-life care. This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. The findings were: Record review of Resident #1's Face Sheet dated [DATE] reflected that the resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included altered mental status (a change in mental function), muscle wasting and atrophy (decline in muscle strength and energy), obstructive and reflux uropathy (when urine is unable to drain through the urinary tract and causes urine to back up into the kidneys), and chronic kidney disease (a condition where the kidneys lose their ability to filter blood and remove wastes). Record review of Resident #1's Physician's Telephone Orders dated [DATE] at 07:00 p.m. and signed by Physician F, revealed the following order, Admit patent to [Hospice G] hospice services. Interview on [DATE] at 12:57 p.m. with Resident #1's representative revealed Resident #1 was admitted on to [Hospice G] upon discharge from the hospital and re-admission to the nursing facility, [DATE]. Resident #1 representative stated that he took Resident #1 off hospice on [DATE]. Interview on [DATE] at 05:00 p.m. with LVN H, LVN H stated Resident #1 did not have a hospice binder because she was only on hospice for about four (4) days. Interview on [DATE] at 08:11 a.m. with Hospice Clinical Director I revealed she was the clinical director for Hospice G. She revealed that the hospice would have provided the facility with a hospice binder within the first couple of days. She revealed Resident#1's case manager stated that he had provided the documentation to one of the facility's charge nurses, LVN J. Interview on [DATE] at 10:30 a.m. with CNA C and the DON, surveyor requested Hospice G binder for Resident #1. CNA C revealed the binder was requested the prior day by the surveyor and that she had not been able to locate the hospice binder or any hospice documentation for Resident #1 from Hospice G. Resident #1's paper medical documentation binder was requested to be reviewed by the DON for hospice documentation, but hospice records were not found. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:08 a.m. with CNA C revealed the facility nurses and the DON were responsible for coordinating care with the hospices. CNA C stated Hospice G never brought a book or any documentation that she was aware of or had possibly given it to Resident #1's representative. CNA C stated that upon receipt of a hospice binder she would have reviewed it for signatures, made sure the documents were in order, and would have uploaded them to the facility's EMR. CNA C stated that this was the first time they had had a problem with not having the hospice documentation. CNA C stated she did not believe that not having the hospice documentation would impact Resident #1's care because the nursing staff would still provide the care the resident needed. Interview on [DATE] at 11:37 a.m. with MDS Nurse D and MDS Nurse E revealed they do not handle the hospice documentation. They revealed that medical records staff member would be responsible for verifying the facility had the hospice binder and the DON and the ADON would be responsible for ensuring the resident received the visits and services the resident required. MDS Nurse E revealed that she felt the facility not having Resident #1's Hospice G documentation would have had a low impact on the Resident #1's care. MDS Nurse E stated that the major thing was that the facility was fulfilling the resident's orders and meeting the resident's needs. MDS Nurse E stated that the facility was taking care of the resident regardless and the hospice's services were supplemental. Interview on [DATE] at 12:52 p.m. with LVN J revealed he did recall a Hospice G staff member stating that they were going to bring a binder for Resident #1 but that he never saw one. LVN J stated that it would be the responsibility of all of the facility staff to check that the hospice binder was at the facility but that the staff would also expect the binder to be brought the next time the hospice visited if they did not locate it. Interview on [DATE] at 02:44 p.m. with the DON revealed the hospice documentation would be uploaded to the resident's EMR by medical records once the resident on hospice had expired. The DON revealed the ADON would be responsible on the next business day to ensure the hospice documentation contained all the proper signatures and that the discharge summary was don't. The DON revealed that if the nursing staff identify a pattern of the hospice not fulfilling their expected services, he would contact the hospice. The DON stated that he checks to see if the hospice binders were present and on a monthly basis, requests a list of all the residents on hospice so that he can maintain a personal resident status sheet for his own monitoring. Interview on [DATE] at 03:52 p.m. with the ADMIN revealed that the ADMIN believed that there had been a hospice binder for Resident #1 but that when the hospice was discontinued the hospice nurse might have taken the binder with them. The ADMIN stated that she was not aware of the hospice leaving the facility with any copies of the hospice documentation. Record review of emailed response on [DATE] at 04:33 p.m. from the ADMIN revealed the Skilled Nursing Facility Hospice Patient Services Agreement dated effective [DATE] between the nursing facility and Hospice G was current. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Skilled Nursing Facility Hospice Patient Services Agreement dated effective [DATE] between the nursing facility and Hospice G revealed under 4. Records, 4.1 Compilation of Records, (a) Preparation. CENTER [nursing facility] and HOSPICE shall each prepare and maintain complete and detailed clinical records concerning each Hospice Patient receiving services under this Agreement in accordance with prudent record keeping procedures, their own policies and procedures, and applicable federal and state laws and regulations. Records include all documents that are necessary to certify the nature and extent of the costs of services provided. CENTER shall cause each entry made for services provided under this Agreement to be signed and dated by the person providing services (b) Retention. CENTER and HOSPICE shall each retain such records for ten (10) years from the date of discharge of each Hospice Patient or such longer time period as required by applicable federal and state laws and regulations. Under 4.4 Destruction of Records, CENTER shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure. Under 13. Verification of Regulatory Requirements, (e) Responsible CENTER Representative, The Responsible CENTER Representative is the Director of Nursing at the CENTER. Record review of facility policy, Hospice Program, undated, revealed 1. Our facility has entered into a contractual arrangement for hospice services to ensure that residents who wish to participate in a hospice program may do so .5. All hospice services are provided under contractual arrangement. Complete details outlining the responsibilities of the facility and the hospice agency are contained in this agreement. A copy of this agreement is on file in the business office and hospice agency.