

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER Regent Care at Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents maintained the right to receive visitors of his or her choosing at the time of his or her choosing for 1 of 1 facility reviewed for resident rights.</p> <p>The facility failed to ensure all residents had the right to receive visitors between 7:00 PM and 7:00 AM.</p> <p>This deficient practice placed residents at risk of isolation, decreased emotional well-being, and diminished quality of life.</p> <p>The findings included:</p> <p>Observation on 05/22/2024 at 11:10 AM revealed a sign on the front door entrance that read visiting hours are from 7:00 AM to 7:00 PM.</p> <p>Record review of Resident #11's assessment, dated 03/09/2024 reflected an [AGE] year-old female, admitted on [DATE] with a primary diagnosis of chronic respiratory failure with hypoxia (a long-term condition that occurs when the airways to the lungs become damaged and narrow, limiting the movement of air and oxygen into the body).</p> <p>Interview on 05/22/2024 at 4:07 PM, Receptionist V stated she was a receptionist Monday through Friday from 1:00 to 7:00 PM, and Saturday from 1:00 PM to 6:00 PM. Receptionist V stated at 6:45 PM she locked the front doors, puts the phone to forward to the nurse's station, and makes the announcement on the intercom that visiting hours are over in both English and Spanish. Receptionist V stated visitors would start to leave at 7:00 PM when she makes the announcement. Receptionist V stated no administrative staff had ever asked her about the facility visiting hours. Receptionist V stated the sign had been in place at the facility for a while but unknown on the precise time.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675890	Facility ID: 675890 If continuation sheet Page 1 of 25

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/22/2024 at 4:39 PM, Resident #11's family member stated he visited the facility every single day from 2:30 PM to about 7:00 PM for the last year that Resident #11 had been in the facility. Resident #11's family member stated he saw the front door sign depicting the visiting hours and had heard the evening receptionist who made the announcements regarding the ending of visiting hours. Resident #11's family member stated he would see visitors leave at 7:00 PM when the announcements were made but stated he would normally remain for few minutes longer. Resident #11's family member stated he was not aware that restricting visiting hours was prohibited and that he could visit Resident #11 at any time on any day. Resident #11's family member stated he did not remember if the visiting hours limitation was described during Resident #11's admission process.</p> <p>Interview on 05/22/2024 at 5:15 PM, the ADM stated she was aware of the visiting hours posting at the facility entrance. The ADM stated she was not aware of Receptionist V's daily announcement of the end of visiting hours at 7:00 PM. The ADM stated she had never received concerns from visitors regarding visiting hours, and stated she understood the potential concern of the posting and announcement regarding visting hours. The ADM stated her primary motivation in allowing the posting of visitor's hours was that she was attempting to restrict vagrants and unauthorized visitors to the facility in addition to notifying visitors after 7:00 PM that there was no receptionist and that the front door would be locked and would require visitors to call the nursing staff to come unlock the door. The ADM stated the potential risk associated with the visitation sign and announcement regarding the end of visitor's hours would be that visitors would not have perpetual access to their family members.</p> <p>Record review of the facility's policy, titled Visitation,, dated revised December 2006, reflected The facility provides 24-hour access to all individuals visiting with the consent of the resident.</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307</p> <p>Based on interview and record review the facility failed to immediately consult with Resident #2's primary care physician when an incident involving the resident which results in injury and has the potential for requiring physician intervention for 1 of 11 residents (Resident #2) reviewed for resident rights.</p> <p>The facility failed to notify Resident #2's responsible party and ensure the MD was notified of an incident when Resident #2 fell on [DATE] at 1:30 AM which resulted in bruising to the left hand, slight discoloration began to form on the left thumb and a change in skin condition.</p> <p>An IJ was identified on 05/26/2024 at 12:52 PM. The IJ template was provided to the facility on [DATE] at 2:00 PM. While the IJ was removed on 05/28/2024 at 2:05 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on fall prevention.</p> <p>This deficient practice could place residents at risk for not having their change of condition addressed appropriately by their attending physician which could cause serious harm.</p> <p>The findings included:</p> <p>Record review of Resident #2's Comprehensive MDS assessment, dated 03/18/2024, reflected an [AGE] year-old female with an admitted [DATE], was assessed to have moderate cognitive impairment, with a primary diagnosis of Encounter for other orthopedic aftercare (receiving orthopedic services after a treatment). Additionally it reflected Resident #2 was assessed to be dependent on staff for both toilet transfers and toilet hygiene.</p> <p>Record review of Resident #2's Comprehensive MDS, dated [DATE], reflected Resident #2 was assessed to be independent for toilet transfers and toilet hygiene.</p> <p>Record review of Resident #2's face sheet, dated 03/25/2024 reflected Family Member A was Resident #2's RP.</p> <p>Record review of Resident #2's Comprehensive Person-Centered Care Plan on fall prevention, reflected an intervention dated 03/11/2024 that upon return from acute care to enact fall prevention policy minimize risk.</p> <p>Record review of the EMS run report, dated 03/08/2024, reflected EMS was contacted at 7:00 AM, Resident #2 was picked up by EMS at 7:44 AM, and arrived at the ER at 7:56 AM.</p> <p>Record review of Resident #2's progress notes, dated 03/08/2024 at 11:36 PM as a late entry for 1:30 AM, by LVN C, reflected: Called to resident's room by CNA. Found resident sitting on floor with her back against the closet. Crying, anxious calling for help. Assessed for injury. With assist of CNA resident lifted off floor to a standing position. Gait unsteady but did walk to bed. Placed in Bed .</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Pain Evaluation, dated 03/08/2024 at 11:55 PM as a late entry for 1:30 AM, by LVN C, and revealed to be the first assessment completed for Resident #2, in reference to the fall on 03/08/2024 at 1:30 AM, reflected Resident #2 denied pain and did not receive pain medication, and that Resident #2 had discoloration on left thumb with good dexterity.</p> <p>Record review of Skin/Wound Observation, dated 03/08/2024 at 11:59 PM as a late entry for 1:30 AM, authored by LVN C, in reference to fall on 03/08/2024 at 1:30 AM, reflected Resident #2 had bruising on her left hand and that there was a change in skin condition, and there was a slight discoloration forming on left thumb.</p> <p>Record review of SBAR, dated 03/09/2024 at 12:12 AM as a late entry for 1:30 AM, authored by LVN C, reflected [Resident #2] found on floor sitting in room sitting up with back against the wall next to closet and feet stretched out toward bed. Crying and calling for help. And further reflected under Provider Notification Comments At 0635 [AM] [Resident #2] fell again while attempting to ambulate to bathroom without assistance, when lifted off floor and assisted back to bed, noted dislocation of left hip. Nurse notified physician and MD okayed transfer to [ER] to eval and treat.</p> <p>Record review of Resident #2's progress notes, dated 03/09/2024 at 2:56 AM as a late entry for 03/08/2024 at 6:30 AM, authored by LVN F, reflected .nurse note bruising to the left hand, c/o pain to left leg after getting in bed the resident could no longer move her leg out of pain, [notified] md who gave order to send to [local] hospital to eval and treat, notified rp and management assist x2 (two person assistance) to Transferring</p> <p>Record review of Resident #2's hospital records, dated 03/11/2024 from 3:19 PM, reflected Resident #2 sustained a left femoral fracture and intra-articular impaction fracture with mild articular diastases.</p> <p>Record review of Provider's Investigation Report, dated 03/25/2024, reflected the incident involving Resident #2 occurred on 03/08/2024 at 1:30 AM, and reported to the state on 03/18/2024 based on Resident #2's family member expressing concerns and allegations of neglect, that LVN C failed to notify MD and RP of fall. Additionally reflected, after the fall occurred at 6:35 AM an assessment of Resident #2 was completed and transferred to the ER at 7:00 AM, followed by completing an in-service on fall prevention, ANE, charting and documentation and terminating LVN C.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Phone interview on 05/23/2024 at 11:10 AM, Resident #2's family member A stated the morning of the incident, at about 6:50 AM someone called her to tell her that her Resident #2 was sent to the ER, to which the caller denied it being about seizures and specified it being about a fall that morning. Resident #2's family member A stated the staff found her on the floor before she was sent to the ER. Resident #2's family member A stated the caller notified her Resident #2 possibly broke her leg or her hip, and it was later discovered she did break her left hip and left wrist. Resident #2's family member A stated Resident #2 had surgery the following day and received a rod in her femur. Resident #2's family member A stated the following morning (03/09/2024) she called the ADM and was informed that Resident #2 had experienced two falls and not one, to which Resident #2's family member A was confused about the occurrence of a second fall. Resident #2's family member A stated Resident #2 mobilized with a walker. Resident #2's family member A stated the ADM told her the bed was soiled, Resident #2 was placed back in the bed and was later found on the floor by LVN F and was sent to the ER. Resident #2's family member A stated Resident #2 asked for assistance from the staff but the staff will not always come promptly. Resident #2's family member A stated the conversation with both the ADM and DON regarding whether the incident appeared to be neglectful was on the following Monday (03/18/2024).</p> <p>Phone interview on 05/23/2024 at 11:58 AM, CNA D stated she remembered the first fall on 03/08/2024 at 1:30 AM involving Resident #2 yelling for help very faintly against the wall when CNA D told LVN C to which they both laid Resident #2 in the bed. CNA D stated Resident #2 expressed a lot of pain, but Resident #2 kept asking for a restroom break repeatedly, but CNA D declined so as to not cause more pain. CNA D stated she felt uncomfortable with how LVN C declined to take action on the fall at 1:30 AM but did not express this as she felt it was out of her scope of practice.</p> <p>Interview on 05/26/2024 at 11:50 AM, LVN F stated during shift change on 03/08/2024 he and LVN C heard Resident #2 yelling, observed Resident #2 to be wrapped up in the sheets, without a brief or any clothing whatsoever and observed a wet substance on the floor, unsure if it was urine. LVN F stated after he assisted Resident #2 back into the bed, he observed one leg to be shorter than the other and believed it to be consistent with a potential fracture. LVN F stated Resident #2 expressed pain, and she described her pain expression to be on her leg. LVN F stated Resident #2 stated she fell in the shower room, but due to the Resident #2 being a 2PM to 10PM shower he concluded Resident #2 was confused.</p> <p>Interview on 05/23/2024 at 11:55 AM, the DON stated he was contacted on 03/08/2024 regarding Resident #2's 2nd fall and discussed with LVN F whether the MD was contacted. The DON stated LVN F confirmed the MD was contacted after the 2nd fall but was uncertain on the first fall earlier that morning.</p> <p>Interview on 05/23/2024 at 12:10 PM, the ADM confirmed she was the ANE coordinator. The ADM stated she had the responsibility of reporting and investigating abuse and neglect. The ADM stated she was first informed on 03/08/2024 of Resident #2's fall by the family and not by any staff member. The ADM stated all major injuries were to be reported to her. The ADM stated during the termination conference LVN C was apathetic and did not seem to care about her termination. The ADM stated the expectation was for LVN C to report the fall to the MD and to the DON or ADM. The ADM stated Resident #2 was independent at the time and would not ask for help, during which she felt Resident #2 slipped on her way to the restroom and was assessed to go out. The ADM stated during the in-person meeting with Resident #2's family member, the determination of neglect was made.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/23/2024 at 1:33 PM, the MD confirmed he was informed of this incident afterwards with no known particular time, but confirmed he was never informed by the charge nurse during the first fall regarding the details of the fall and that if he had been contacted, an assessment and review could have taken place but he was never given the opportunity. The MD stated he was uncertain of what action he would have taken at that time as he would have questioned LVN C of what observations and assessments she made of Resident #2 to determine if discharge to the ER was necessary.</p> <p>Attempted a phone interview with LVN C on 05/23/2024 at 11:09 AM and 2:51 PM, and on 05/24/2024 at 12:27 PM, there was no answer, left voicemail.</p> <p>Record review of LVN C's skills checkoff, dated 12/21/2023, titled LVN/LPN --- Job Functions, reflected a hire date of 11/21/2023, and further reflected the LVN C was determined to Performs Function Satisfactorily in the areas of Notify the resident's attending physician when the resident is involved in an accident or incident but no evaluation of notifying family of incidents.</p> <p>Record review of LVN C's termination notice, dated 03/11/2024, reflected LVN C signed confirming their termination and understanding for the incident.</p> <p>Record review of in-service, dated 03/19/2024, subjected documentation of incidents, notification to RP's and MD's, completing assessments, intended for Nursing reflected 17 nurses in-serviced.</p> <p>Record review of in-service, dated 03/19/2024, subjected ANE intended for All Staff, reflected 33 total staff in attendance.</p> <p>Record review of in-service, dated 03/22/2024, subjected ANE intended for All Staff, reflected 17 total staff in attendance.</p> <p>An Immediate Jeopardy (IJ) was identified on 05/26/2024 at 12:52 PM and presented to the Administrator at 2:00 PM. A Plan of Removal was requested.</p> <p>The following Plan of Removal submitted by the facility was accepted on 05/27/2024 at 02:11 PM.</p> <p>Immediate action:</p> <p>Facilities Plan to ensure compliance quickly</p> <p>Resident #2 head to toe assessment completed and resident with no injuries at this time, no complaints of pain.</p> <p>05/26/2024 04:44 PM</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Head to toe: scab to back of head from previous fall area is flat no swelling scab is intact. No drainage signs of infection. No other areas of concern to head. Right eye is around, even and brisk with light stimulation at 33MM, left eye with blindness, presents with corneal opacity, orbital mucosal membranes are pale and color, no conjunctivitis, or drainage. Nasal and oral membranes are appropriate and color, no aeration or areas of concern. Upper range of motion assessed move appropriately. Hand grasps And even. Multiple areas are see now per are seen to bilateral upper extremities. Chest, abdomen and back are intact with no areas of concern. Left lower presents with 0.5 inch skin tear. No signs of infection. Skin is presented with no skin loss. [NAME] skin was retracted and is healing well. Range of motion, assess and move appropriately. Abdomen, genital, and [NAME] crest are all intact with no skin concerns. Left upper leg presents with surgical incision scar, which is flushed to skin no redness or irritation, signs or symptoms of infection and intact. Areas of concern to lower leg heels, feet or toes, Resident denies any pain discomfort, or any other concerns at this time.</p> <p>Role: N, Category: Nurses Note</p> <p>Signed by: [Staff]</p> <p>Nurse, LVN C failed to notify MD and RP was immediately suspended and terminated on 03/11/2024. Termination is part of the self-report submitted.</p> <p>Second fall noted at 0635 hrs. LVN F notified MD and RP of fall and MD ordered resident sent to the hospital. Per preliminary findings indicating LVC C instead of LVN F.</p> <p>At 0635 [Resident #2] fell again while attempting to ambulate to bathroom without assistance, when lifted off floor and assisted back to bed, [LVN C] noted dislocation of left hip. [LVN C] notified [MD] and [MD] okayed transfer to [ER] to eval and treat.</p> <p>05/26/2024 All nursing licensed staff immediately in-serviced on facility policy Fall - Clinical Protocol and facility policy Assessing Falls and Their causes.</p> <p>05/27/2024 Fall - Clinical Protocol policy and Assessing Falls and Their causes will be part of orientation packet to be reviewed with new hires and part of orientation for agency staff.</p> <p>05/26/2024 Fall Risk Assessment to be completed on all residents to ensure fall risk are up to date.</p> <p>05/27/2024 DON/Designee to spot check each shift by contacting nurses.</p> <p>Monitoring of the POR was as follows:</p> <p>Interview on 05/27/2024 at 3:01 PM, RN J stated she worked the 2-10 shift and confirmed she received an in-service on falls and felt confident on the content. RN J stated the in-service was completed by LVN F and felt affirmed on the appropriate protocol.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/27/2024 at 3:19 PM, LVN G stated she works the 2-10 shift and confirmed she received an in-service on falls. She confirmed the falls training included protocol during and after a fall, to assess the resident, and to report to the physician. She stated when residents will be on the floor and even if they can explain it, those are falls.</p> <p>Phone interview on 05/27/2024 at 4:12 PM, RN I stated she works the 2-10 and 6-2 shift confirmed she received an in-service related to falls, when she had a phone in-service, what to do when there was a fall and how to identify when there is a fall. RN I stated if the resident was on the floor to presume there was a fall. She stated she understood the content perfectly well and had even conducted the in-services herself.</p> <p>Phone interview on 05/27/2024 at 4:19 PM, LVN M stated she worked the 10-6 shift and confirmed she received the in-service on falls, such as doing paperwork and assessments, notifying the MD after an incident. She stated she understood the content, and affirmed confidence in the protocol.</p> <p>Interview on 05/28/2024 at 9:31 AM, LVN F stated he normally worked the 6-2 shift but would also work the 2-10 shift and on the weekends. LVN F stated he received an in-service on falls and confirmed he felt confident on the content of the in-service. LVN F stated the in-service discussed prevention measures in falls as well as discussing</p> <p>Interview on 05/28/2024 at 10:18 AM, LVN S stated she was the case manager for the special-contracted residents and confirmed she did receive the in-service regarding falls. LVN S stated she normally only works from 8-5 M-F but stated she will assist on the floor and will conduct trainings herself. LVN F stated she received the in-service along with other staff and that it was delivered by the ADON. LVN S stated she felt confident on the course content and felt comfortable with how the in-service was conducted.</p> <p>Interview on 05/28/2024 at 10:21 AM, LVN T stated she normally worked the 6-2 and 2-10 every weekend but has recently started working the 6-2 shift on the weekdays as well. LVN T stated she received the training on falls and felt confident on the content of the in-service. LVN T stated the ADON provided the in-service.</p> <p>Interview on 05/28/2024 at 10:41 AM, RN V stated he was primarily the weekend RN supervisor and stated he will also work the 6-2 on occasion as he was there day. RN V stated he received the in-service on falls. RN V stated he was also in-serviced on fall prevention measures to take such as increased monitoring and supervision.</p> <p>Record review of in-service, dated 05/26/2024, titled Falls - Clinical Protocol Policy, addressed to [Facility] Nursing Staff, reflected a total of 25 signatures of licensed nursing staff.</p> <p>Record review of [NAME] Fall Risk Assessments completed, dated assessments all on 05/26/2024 from 4:56 PM through 7:14 PM reflected a total of 76 residents reviewed for fall risk.</p> <p>Record review of Resident #3's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #3 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #4's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #4 was determined to be low a fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #5's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #5 was determined to be low a fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #6's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #6 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #7's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #7 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #8's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #8 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #9's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #9 was determined to not be a fall risk.</p> <p>Record review of Resident #10's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #10 was determined to be low a fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of DON's spot check list for nurses document, titled Monitoring: DON/ Designee will spot check each shift by contacting nurses and verify if there is no incidents or accidents with in the current shift. Reflected a layout of five instances asking Any incident or accident during the shift? If YES, is complete incident and accident protocol completed by nurse. With date, details box, and whether the care plan was initiated. Further reflected were indications of spot checks completed on 05/27/2024 on the 2-10 shift with a single unwitnessed fall, to add note and initiate protocol. An additional indication was reflected on 05/27/2024 - 05/28/2024 on the 10-6 shift with a reported resident expiration taken place.</p> <p>Record review of an email, dated 05/27/2024 at 12:03 PM, reflected the ADM enacted a new policy to the Human Resources Director to amend the new hire orientation for all staff and agency to also review and sign the policies: Elopements, Falls - Clinical Protocol, and Falls P&P Assessing Falls and Their Cause.</p> <p>The Administrator was informed on 05/28/2024 at 2:00 PM that the IJ was removed, however the facility remained out of compliance at a scope of Isolated and a severity level of No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy because all staff had not been trained on fall prevention.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER Regent Care at Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3935 Medical Dr San Antonio, TX 78229	
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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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 11 resident (Resident #2) reviewed for quality of care.</p> <p>The facility failed to ensure Resident #2 was not left without care after her initial fall on 03/08/24 at 1:30 AM until after a second fall on 03/08/24 at 6:30 AM which resulted in a left hip and left distal radius fracture.</p> <p>An IJ was identified on 05/26/2024 at 12:52 PM. The IJ template was provided to the facility on [DATE] at 2:00 PM. While the IJ was removed on 05/28/2024 at 2:05 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on fall prevention.</p> <p>This deficient practice placed residents at risk of experiencing a delay in treatment that could result in harm or potentially death.</p> <p>The findings included:</p> <p>Record review of Resident #2's Comprehensive MDS assessment, dated 03/18/2024, reflected an [AGE] year-old female with an admitted [DATE], was assessed to have moderate cognitive impairment, with a primary diagnosis of Encounter for other orthopedic aftercare (receiving orthopedic services after a treatment). Additionally it reflected Resident #2 was assessed to be dependent on staff of both toilet transfers and toilet hygiene.</p> <p>Record review of Resident #2's Comprehensive MDS, dated [DATE], reflected Resident #2 was assessed to be independent for toilet transfers and toilet hygiene.</p> <p>Record review of Resident #2's Comprehensive Person-Centered Care Plan on fall prevention, reflected an intervention dated 03/11/2024 that upon return from acute care to enact fall prevention policy minimize risk.</p> <p>Record review of Resident #2's face sheet, dated 03/25/2024, reflected Family Member A was Resident #2's RP. Additionally reflected was Resident #2 was diagnosed with but not limited to: Dementia, unspecified lack of coordination, other specified disorders of muscle, muscle weakness, adult failure to thrive, and displaced intertrochanteric fracture of left femur.</p> <p>Record review of the EMS run report, dated 03/08/2024, reflected EMS was contacted at 7:00 AM, Resident #2 was picked up by EMS at 7:44 AM, and arrived at the ER at 7:56 AM.</p> <p>Record review of Resident #2's progress notes, dated 03/08/2024 at 11:36 PM as a late entry for 1:30 AM, by LVN C, reflected: Called to resident's room by CNA. Found resident sitting on floor with her back against the closet. Crying, anxious calling for help. Assessed for injury. With assist of CNA resident lifted off floor to a standing position. Gait unsteady but did walk to bed. Placed in Bed .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Pain Evaluation, dated 03/08/2024 at 11:55 PM as a late entry for 1:30 AM, by LVN C, and revealed to be the first assessment completed for Resident #2, in reference to the fall on 03/08/2024 at 1:30 AM, reflected Resident #2 denied pain and did not receive pain medication, and that Resident #2 had discoloration on left thumb with good dexterity.</p> <p>Record review of Skin/Wound Observation, dated 03/08/2024 at 11:59 PM as a late entry for 1:30 AM, authored by LVN C, in reference to fall on 03/08/2024 at 1:30 AM, reflected Resident #2 had bruising on her left hand and that there was a change in skin condition, and there was a slight discoloration forming on left thumb.</p> <p>Record review of SBAR, dated 03/09/2024 at 12:12 AM as a late entry for 1:30 AM, authored by LVN C, reflected [Resident #2] found on floor sitting in room sitting up with back against the wall next to closet and feet stretched out toward bed. Crying and calling for help. And further reflected under Provider Notification Comments At 0635 [AM] [Resident #2] fell again while attempting to ambulate to bathroom without assistance, when lifted off floor and assisted back to bed, noted dislocation of left hip. Nurse notified physician and MD okayed transfer to [ER] to eval and treat.</p> <p>Record review of Resident #2's progress notes, dated 03/09/2024 at 2:56 AM as a late entry for 03/08/2024 at 6:30 AM, authored by LVN F, reflected .nurse note bruising to the left hand, c/o pain to left leg after getting in bed the resident could no longer move her leg out of pain, [notified] md who gave order to send to [local] hospital to eval and treat, notified rp and management assist x2 (two person assistance) to Transferring</p> <p>Record review of Resident #2's hospital records, dated 03/11/2024 from 3:19 PM, reflected the following related to a CT scan of Resident #2's left hip: 1. Comminuted, displaced and angulated fracture of the left proximal femur. This involves the basicervical portion of the femoral neck, and intertrochanteric regions with displaced fractures of the greater and lesser trochanters. 2. Osteopenia. No discrete underlying bone lesion is identified. 3. Posttraumatic soft tissue edema about the lateral aspect of the left proximal thigh and the hip. Referring to a CT scan of both hips reflected: Comminuted, laterally angulated subtrochanteric/intertrochanteric left femoral fracture. 2. Osteopenia and degenerative bony changes. I, [NAME] F [NAME], have personally interpreted the image(s) and dictated this examination or I have reviewed the image(s) as well as the residents interpretation and agree with the interpretation. Referring to an x-ray of the left hand, left wrist, left forearm, and left elbow: Left distal radius intra-articular impaction fracture with mild articular diastases. 2. Age-indeterminate scapholunate diastases. 3. Chronic ulnar styloid ossified body. 4. No acute fracture or dislocation of the left elbow or hand. 5. Osteopenia and osteoarthritis.</p> <p>Record review of Provider's Investigation Report, dated 03/25/2024, reflected the incident involving Resident #2 occurred on 03/08/2024 at 1:30 AM, and reported to the state on 03/18/2024 based on Resident #2's family member expressing concerns and allegations of neglect, that LVN C failed to notify MD and RP of fall. Additionally reflected, after the fall occurred at 6:35 AM an assessment of Resident #2 was completed and transferred to the ER at 7:00 AM, followed by completing an in-service on fall prevention, ANE, charting and documentation and terminating LVN C.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on 05/22/2024 at 3:32 PM, Resident #2 was revealed to be sitting in a wheelchair in her room with a bandage on her right arm. Resident #2 stated she has had the bandage for an unknown time and stated she showers herself on her own and fell recently which caused her arm injury needing the bandage. Resident #2 stated she did not remember her fall from 03/08/2024 and denied memory of anything related.</p> <p>Phone interview on 05/23/2024 at 11:10 AM, Resident #2's Family Member A stated the morning of the incident, at about 6:50 AM someone called her to tell her that Resident #2 was sent to the ER, to which the caller denied it being about seizures and specified it being about a fall that morning. Resident #2's family member stated the staff found her on the floor before she was sent to the ER. Resident #2's family member stated the caller notified her Resident #2 possibly broke her leg or her hip, and it was later discovered she did break her left hip and left wrist. Resident #2's Family Member A stated Resident #2 had surgery the following day and received a rod in her femur. Resident #2's Family Member A stated the following morning (03/09/2024) she called the ADM and was informed that Resident #2 had experienced two falls and not one, to which Resident #2's family member was confused about the occurrence of a second fall. Resident #2's family member stated Resident #2 mobilized with a walker. Resident #2's family member stated the ADM told her the bed was soiled, Resident #2 was placed back in the bed and was later found on the floor by LVN F and was sent to the ER. Resident #2's family member stated Resident #2 asked for assistance from the staff but the staff will not always come promptly. Resident #2's family member stated the conversation with both the ADM and DON regarding whether the incident appeared to be neglectful was on the following Monday (03/18/2024).</p> <p>Phone interview on 05/23/2024 at 11:58 AM, CNA D stated she remembered the first fall on 03/08/2024 at 1:30 AM involving Resident #2 yelling for help very faintly against the wall when CNA D told LVN C to which they both laid Resident #2 in the bed. CNA D stated Resident #2 expressed a lot of pain, but Resident #2 kept asking for a restroom break repeatedly, but CNA D declined so as to not cause more pain. CNA D stated she felt uncomfortable with how LVN C declined to take action on the fall at 1:30 AM but did not express this as she felt it was out of her scope of practice.</p> <p>Interview on 05/26/2024 at 11:50 AM, LVN F stated during shift change on 03/08/2024 he and LVN C heard Resident #2 yelling, observed Resident #2 to be wrapped up in the sheets, without a brief or any clothing whatsoever and observed a wet substance on the floor, unsure if it was urine. LVN F stated after he assisted Resident #2 back into the bed, he observed one leg to be shorter than the other and believed it to be consistent with a potential fracture. LVN F stated Resident #2 expressed pain, and she described her pain expression to be on her leg. LVN F stated Resident #2 stated she fell in the shower room, but due to the Resident #2 being a 2PM to 10PM shower he concluded Resident #2 was confused.</p> <p>Interview on 05/23/2024 at 11:55 AM, the DON stated he was contacted on 03/08/2024 regarding Resident #2's 2nd fall and discussed with LVN F whether the MD was contacted. The DON stated LVN F confirmed the MD was contacted after the 2nd fall but was uncertain on the first fall earlier that morning.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/23/2024 at 12:10 PM, the ADM confirmed she was the ANE coordinator. The ADM stated she had the responsibility of reporting and investigating abuse and neglect. The ADM stated she was first informed on 03/08/2024 of Resident #2's fall by the family and not by any staff member. The ADM stated all major injuries were to be reported to her. The ADM stated during the termination conference LVN C was apathetic and did not seem to care about her termination. The ADM stated the expectation was for LVN C to report the fall to the MD and to the DON or ADM. The ADM stated Resident #2 was independent at the time and would not ask for help, during which she felt Resident #2 slipped on her way to the restroom and was assessed to go out. The ADM stated during the in-person meeting with Resident #2's family member, the determination of neglect was made.</p> <p>Interview on 05/23/2024 at 1:33 PM, the MD confirmed he was informed of this incident afterwards with no known particular time, but confirmed he was never informed by the charge nurse during the first fall regarding the details of the fall and that if he had been contacted, an assessment and review could have taken place but he was never given the opportunity. The MD stated he was uncertain of what action he would have taken at that time as he would have questioned LVN C of what observations and assessments she made of Resident #2 to determine if discharge to the ER was necessary.</p> <p>Attempted a phone interview with LVN C on 05/23/2024 at 11:09 AM and 2:51 PM, and on 05/24/2024 at 12:27 PM, there was no answer, left voicemail.</p> <p>Record review of LVN C's skills checkoff, dated 12/21/2023, titled LVN/LPN --- Job Functions, reflected a hire date of 11/21/2023, and further reflected the LVN C was determined to Performs Function Satisfactorily in the areas of Notify the resident's attending physician when the resident is involved in an accident or incident but no evaluation of notifying family of incidents.</p> <p>Record review of LVN C's termination notice, dated 03/11/2024, reflected LVN C signed confirming their termination and understanding for the incident.</p> <p>Record review of in-service, dated 03/19/2024, subjected documentation of incidents, notification to RP's and MD's, completing assessments, intended for Nursing reflected 17 nurses in-serviced.</p> <p>Record review of in-service, dated 03/19/2024, subjected ANE intended for All Staff, reflected 33 total staff in attendance.</p> <p>Record review of in-service, dated 03/22/2024, subjected ANE intended for All Staff, reflected 17 total staff in attendance.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of facility fall prevention policy, titled Falls, undated, reflected The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications associated with increased falling risk) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant). a. Falls often have medical causes; they are not just a nursing issue. And The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. And Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. And The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. And The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.</p> <p>An Immediate Jeopardy (IJ) was identified on 05/26/2024 at 12:52 PM. The IJ template was presented to the Administrator at 2:00 PM. A Plan of Removal was requested.</p> <p>The following Plan of Removal submitted by the facility was accepted on 05/27/2024 at 02:11 PM.</p> <p>Immediate action:</p> <p>Facilities Plan to ensure compliance quickly</p> <p>Resident #2 head to toe assessment completed and resident with no injuries at this time, no complaints of pain.</p> <p>05/26/2024 04:44 PM</p> <p>Head to toe: scab to back of head from previous fall area is flat no swelling scab is intact. No drainage signs of infection. No other areas of concern to head. Right people is around, even and brisk with light stimulation at 33MM, left eye with blindness, presents with corneal opacity, orbital mucosal membranes are pale and color, no conjunctivitis, or drainage. Nasal and oral membranes are appropriate and color, no aeration or areas of concern. Upper range of motion assessed move appropriately. Hand grasps And even. Multiple areas are see now per are seen to bilateral upper extremities. Chest, abdomen and back are intact with no areas of concern. Left lower presents with 0.5 inch skin tear. No signs of infection. Skin is presented with no skin loss. [NAME] skin was retracted and is healing well. Range of motion, assess and move appropriately. Abdomen, genital, and [NAME] crest are all intact with no skin concerns. Left upper leg presents with surgical incision scar, which is flushed to skin no redness or irritation, signs or symptoms of infection and intact. Areas of concern to lower leg heels, feet or toes, Resident denies any pain discomfort, or any other concerns at this time.</p> <p>Role: N, Category: Nurses Note</p> <p>Signed by: [Staff]</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Nurse, LVN C failed to notify MD and RP was immediately suspended and terminated on 03/11/2024. Termination is part of the self-report submitted.</p> <p>Second fall noted at 0635 hrs. LVN F notified MD and RP of fall and MD ordered resident sent to the hospital. Per preliminary findings indicating LVC C instead of LVN F.</p> <p>At 0635 [Resident #2] fell again while attempting to ambulate to bathroom without assistance, when lifted off floor and assisted back to bed, [LVN C] noted dislocation of left hip. [LVN C] notified [MD] and [MD] okayed transfer to [ER] to eval and treat.</p> <p>05/26/2024 All nursing licensed staff immediately in-serviced on facility policy Fall - Clinical Protocol and facility policy Assessing Falls and Their causes.</p> <p>05/27/2024 Fall - Clinical Protocol policy and Assessing Falls and Their causes will be part of orientation packet to be reviewed with new hires and part of orientation for agency staff.</p> <p>05/26/2024 Fall Risk Assessment to be completed on all residents to ensure fall risk are up to date.</p> <p>05/27/2024 DON/Designee to spot check each shift by contacting nurses.</p> <p>Monitoring of the POR was as follows:</p> <p>Interview on 05/27/2024 at 3:01 PM, RN J stated she worked the 2-10 shift and confirmed she received an in-service on falls and felt confident on the content. RN J stated the in-service was completed by LVN F and felt affirmed on the appropriate protocol.</p> <p>Interview on 05/27/2024 at 3:19 PM, LVN G stated she works the 2-10 shift and confirmed she received an in-service on falls. She confirmed the falls training included protocol during and after a fall, to assess the resident, and to report to the physician. She stated when residents will be on the floor and even if they can explain it, those are falls.</p> <p>Phone interview on 05/27/2024 at 4:12 PM, RN I stated she works the 2-10 and 6-2 shift confirmed she received an in-service related to falls, when she had a phone in-service, what to do when there was a fall and how to identify when there is a fall. RN I stated if the resident was on the floor to presume there was a fall. She stated she understood the content perfectly well and had even conducted the in-services herself.</p> <p>Phone interview on 05/27/2024 at 4:19 PM, LVN M stated she worked the 10-6 shift and confirmed she received the in-service on falls, such as doing paperwork and assessments, notifying the MD after an incident. She stated she understood the content, and affirmed confidence in the protocol.</p> <p>Interview on 05/28/2024 at 9:31 AM, LVN F stated he normally worked the 6-2 shift but would also work the 2-10 shift and on the weekends. LVN F stated he received an in-service on falls and confirmed he felt confident on the content of the in-service. LVN F stated the in-service discussed prevention measures in falls.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/28/2024 at 10:18 AM, LVN S stated she was the case manager for the special-contracted residents and confirmed she did receive the in-service regarding falls. LVN S stated she normally only works from 8-5 M-F but stated she will assist on the floor and will conduct trainings herself. LVN F stated she received the in-service along with other staff and that it was delivered by the ADON. LVN S stated she felt confident on the course content and felt comfortable with how the in-service was conducted.</p> <p>Interview on 05/28/2024 at 10:21 AM, LVN T stated she normally worked the 6-2 and 2-10 every weekend but has recently started working the 6-2 shift on the weekdays as well. LVN T stated she received the training on falls and felt confident on the content of the in-service. LVN T stated the ADON provided the in-service.</p> <p>Interview on 05/28/2024 at 10:41 AM, RN V stated he was primarily the weekend RN supervisor and stated he will also work the 6-2 on occasion as he was there day. RN V stated he received the in-service on falls. RN V stated he was also in-serviced on fall prevention measures to take such as increased monitoring and supervision.</p> <p>Record review of in-service, dated 05/26/2024, titled Falls - Clinical Protocol Policy, addressed to [Facility] Nursing Staff, reflected a total of 25 signatures of licensed nursing staff.</p> <p>Record review of [NAME] Fall Risk Assessments completed, dated assessments all on 05/26/2024 from 4:56 PM through 7:14 PM reflected a total of 76 residents reviewed for fall risk.</p> <p>Record review of Resident #3's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #3 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #4's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #4 was determined to be low a fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #5's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #5 was determined to be low a fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #6's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #6 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #7's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #7 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of Resident #8's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #8 was determined to be a high fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #9's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #9 was determined to not be a fall risk.</p> <p>Record review of Resident #10's Morse Fall Risk Assessment, dated 05/26/2024, reflected Resident #10 was determined to be low a fall risk. Further review of the comprehensive person-centered care plan reflected interventions in place to prevent and respond to falls.</p> <p>Record review of DON's spot check list for nurses document, titled Monitoring: DON/ Designee will spot check each shift by contacting nurses and verify if there is no incidents or accidents with in the current shift. Reflected a layout of five instances asking Any incident or accident during the shift? If YES, is complete incident and accident protocol completed by nurse. With date, details box, and whether the care plan was initiated. Further reflected were indications of spot checks completed on 05/27/2024 on the 2-10 shift with a single unwitnessed fall, to add note and initiate protocol. An additional indication was reflected on 05/27/2024 - 05/28/2024 on the 10-6 shift with a reported resident expiration taken place.</p> <p>Record review of an email, dated 05/27/2024 at 12:03 PM, reflected the ADM enacted a new policy to the Human Resources Director to amend the new hire orientation for all staff and agency to also review and sign the policies: Elopements, Falls - Clinical Protocol, and Falls P&P Assessing Falls and Their Cause.</p> <p>The Administrator was informed on 05/28/2024 at 2:05 PM that the IJ was removed, however the facility remained out of compliance at a scope of Isolated and a severity level of No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy because all staff had not been trained on fall prevention.</p>		

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NAME OF PROVIDER OR SUPPLIER Regent Care at Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3935 Medical Dr San Antonio, TX 78229	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307</p> <p>Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 11 resident (Resident #1) reviewed for accidents and hazards supervision.</p> <p>The facility failed to provide adequate supervision to prevent the elopement of Resident #1 between 01/28/2024 at 10:30 PM and in Resident #1 being found outside of the facility on 01/29/2024 at 3:06 AM.</p> <p>An IJ was identified on 05/26/2024 at 12:52 PM. The IJ template was provided to the facility on [DATE] at 2:00 PM. While the IJ was removed on 05/28/2024 at 2:05 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on supervision and elopement.</p> <p>This deficient practice could result in a risk to the residents' health and safety and placed the resident at risk of heat or cold exposure, dehydration and/or other medical complications, or being struck by a motor vehicle.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet reflected a [AGE] year-old male admitted initially on 10/23/2023 and readmitted on [DATE] with a discharge date on 02/05/2024. Diagnoses included: PTSD (A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), MDD (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), mood disorder (a disorder in which you experience long periods of extreme happiness, extreme sadness or both), and other stimulant abuse (Excessive use of psychoactive drugs, such as alcohol, pain medications, or illegal drugs.)</p> <p>Record review of Resident #1's EHR and physician orders reflected five related orders for a wandeguard all dated on 01/30/2024. Further review of the EHR reflected no consents obtained from the RP.</p> <p>Record review of Resident #1's progress notes, dated 01/29/2024 at 12:32 AM, authored by LVN E, reflected a late entry from 01/27/2024 that Resident #1 was trying to elope when a late arrival of a CNA resulted in him being revealed to be outside of the facility on the corner of the street and coaxed back into the facility. The notes reflected Resident #1 was being supervised and observed while he was outside of the facility by staff, including but not limited to LVN E.</p> <p>Record review of Resident #1's progress notes, dated 01/29/2024 12:40 AM, authored by LVN E, reflected Late entry for 1/28/24 . resident continued to elope and exit seek all day, wandeguard placed to R wrist, resident set off alarm to front entrance . ammonia last checked 12/21/23, also received order for prn lorazepam 0.5 mg q 6 hrs, nurse called [in order] and went through process of requesting first dose through [emergency med kit], medication was effective, resident also ripped off wandeguard, it was found on his room floor by his bed .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's progress notes, dated 01/29/2024 4:51 AM, authored by LVN A, reflected at 10:30 PM Resident #1 was observed to be wandering around the nurse's station going toward the snack machines with walker and without his wanderguard. The note continues that at 1:40 AM the following morning on 01/29/2024 Resident #1 was unable to be located after searching his room and bathroom. The note continues that at 2:05 AM, the DON, ADON, and ADM were notified of the elopement. The note continues that at 3:06 AM, the DON located Resident #1 2.5 blocks away at a local fast food restaurant location with Resident #1 stating he was hungry and felt pain in his bilateral lower extremities. The note continues at 3:16 AM, LVN A assessed Resident #1 and Resident #1 stated he is always hurting and denied medication for pain and answered why he left the facility with Resident #1 responding that he was hungry and wanted to get something to eat.</p> <p>Record review of google maps reflected distance from [Resident #1's destination] to facility is 0.9 miles away, winding road, typically high traffic area.</p> <p>Record review of historic temperature records reflected on 01/29/2024 at 1:51 AM, the temperature was 44 degrees Fahrenheit.</p> <p>Record review of SBAR, dated 01/29/2024, authored by LVN A, reflected Resident #1 returned cooperatively, was provided PRN Ativan for agitation, and the incident was reported to the RN case manager, and RP.</p> <p>Record review of wanderguard placement Q 30 minute monitoring, dated 02/05/2024, reflected monitoring took place from 10:30 PM to 7:30 AM the following morning.</p> <p>Phone interview on 05/22/2024 at 1:53 PM, Resident #1's Family Member B stated Resident #1 was only recently revealed to be an elopement risk after a change in condition. Resident #1's Family Member B stated the staff discussed with him about having a wanderguard and being exit-seeking. Resident #1's Family Member B stated he felt concerned with the number of staff at the facility in the evening and overnight. Resident #1's Family Member B stated he was notified about the elopement on 01/29/2024 and that after, the facility stated they were going to look into accepting facilities for a transfer.</p> <p>Interview on 05/22/2024 at 3:11p.m., LVN R stated Resident #1 experienced a sudden change in condition, and that the elopement was very unexpected. LVN R stated Resident #1 would verbalize wanting to go home frequently since before the elopement. LVN R stated Resident #1 has attempted to elope from the facility since the successful elopement on 01/29/2024. LVN R stated after the elopement, Resident #1 was discharged from the facility within a couple days but before he was discharged, he was placed on a perpetual 1:1 supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Phone interview on 05/23/2024 at 9:57 AM, LVN A stated she did more frequent rounding as she knew Resident #1 was an elopement risk due to being confused, having liver disease, and being on hospice. LVN A stated constant watch was needed for Resident #1. LVN A stated each nurse had two halls to cover during the 10 PM to 6 AM shift, and on 01/29/2024, after midnight during rounds, she noticed Resident #1 was not in bed while assisting with another resident concern across the hall. She returned to search his bathroom to no avail, followed by telling the remaining staff to help in the search. LVN A stated after they swept the building, she contacted the ADM, DON, and ADON. LVN A stated the front door had an alarm, and that the alarm did not go off. LVN A stated CNA D was working that night. LVN A stated the staff might have turned off the front door alarm off as they went outside to smoke, get food, or get fresh air. LVN A stated there were normally three aides in the night, but sometimes four. LVN A stated any of the staff can turn on the front door alarm, but she will check the door herself. LVN A stated Resident #1 was aware of potential danger with leaving the facility, and when Resident #1 returned she asked him how he got out and stayed safe to which he replied he walked out the front door and was staying on the sidewalk. LVN A stated the primary danger with Resident #1 potentially eloping was Resident #1 would have moments of confusion and not know where he was and be in danger. LVN A stated Resident #1 would refuse medications frequently thus causing his ammonia levels to be toxic which would result in confusion. LVN A stated staff were doing the rounds and felt the primary reason she was not aware of Resident #1 being gone was because there were too many residents to staff. LVN A stated she had expressed concern with her administration to explain the need for more staff but stated she felt the facility was actually higher staffed than most other buildings she had worked at previously. LVN A stated CNA B was the last one to see him at midnight and noted his brief was dirty.</p> <p>Phone interview on 05/23/2024 at 10:16 AM, CNA B stated she was present for when Resident #1 was found and missing. CNA B stated she was not sure what time he was missing or when he returned. CNA B stated the facility front door was supposed to be kept locked after hours, but it isn't always locked due to pharmacy, family, or a food delivery service. CNA B stated the staff must lock the door manually by the keypad, and the door stays unlocked until it is locked back again manually. CNA B stated she does not remember if the front door was locked during the night of 01/28/2024.</p> <p>Interview on 05/23/2024 at 12:27 PM, the ADM stated the front door had a code and that the staff are required to lock the door. The ADM stated she interviewed the nursing staff regarding Resident #1's elopement but did not discover why the front door alarm did not go off. She stated the risk was that Resident #1 or someone else could be stuck by a motor vehicle.</p> <p>Interview on 05/24/2024 at 3:42 PM, the DON stated Resident #1 was assessed on 01/28/2024 to require a wanderguard, initially place on resident on 1/28/24, due to repeated attempts to elope, was placed on 1:1 but resumed to a regular state. The DON confirmed all staff had been trained on elopement prevention prior during regular in-services and annual training but could not identify the last date of a training that all staff took part in.</p> <p>Record review of the facility Provider's Investigation Report, dated 02/05/2024, reflected the incident occurred on 01/29/2024 at 3:06 AM when victim was found at a local restaurant, Resident #1 was noted by charge nurse in bed at 1:40 AM, Resident #1 had removed wanderguard and it was observed next to bed, after incident, in-service completed on elopement, routine checks, resident ID system, and ANE. Also completed referrals for d/c but were denied initially and was eventually sent out to VA per his request.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy, titled Protocol for WanderGuard Placement, undated, reflected WanderGuards were to ordered by the physician.</p> <p>Record review of policy for securing exits/entrances, grounds security, titled Exits or Means of Egress, dated revised June 2005, reflected did not provide any relevant information related to securing the facility's doors.</p> <p>Record review of schedule for 01/28/2024 reflected on the 10PM - 6AM shift had 2 nurses and 4 CNA's: CNA D, CNA D, CNA B, and Staff W.</p> <p>Record review of in-service, titled Communication between nurses and CNA's, nurses completing 24hr report, CNA's notifying of changes, dated 01/29/2024, intended for All nursing staff reflected 42 staff in-serviced.</p> <p>Record review of in-service, subjected Elopement, dated 01/29/2024, intended for All staff, reflected 42 staff in-serviced.</p> <p>Record review of in-service, subjected ANE, dated 01/29/2024, intended for All staff, reflected 56 staff in-serviced</p> <p>Record review of elopement prevention policy, titled Elopements, dated revised August 2006, reflected staff were to complete routine rounding, to immediately have begun a search if suspected missing resident with have notified other staff to assist in search, and one they were believed to have left the premises they were to notify ADM, DON, and MD/NP to continue/assist search off premises, followed by doing a full report and full assessment to confirm of injury, along with incident report.</p> <p>An Immediate Jeopardy (IJ) was identified on 05/26/2024 at 12:52 PM and presented to the Administrator at 2:00 PM. A Plan of Removal was requested.</p> <p>The following Plan of Removal submitted by the facility was accepted on 05/27/2024 at 02:11 PM.</p> <p>Date: 05/26/2024</p> <p>Immediate action:</p> <p>Facilities Plan to ensure compliance quickly</p> <p>Resident #1 was discharged from the facility on 02/05/2024. This resident had no injuries related to the elopement. Elopement occurred on 01/29/2024. See nurses note for resident assessment:</p> <p>01/29/2024 0316 Resident assisted to bed. Assessed head to toe. No obvious injuries noted. Denies falling. Verbalizes pain/discomfort to bilateral lower extremities. Noted with edema to bilateral feet/ankles. Resident again denies fall or hurting himself. Stated that he is always hurting. Able to move both feet and ankles with no issues. Full range of motion to all extremities without any complaints of acute pain. Denies wanting anything for pain. Asked resident why he left the building. Resident stated he was hungry and wanted something to eat. Reminded resident needed to call for assist and that it is not safe to be outside by himself. Resident then stated he was tired and wanted to go to sleep. No signs of acute distress. Will continue to monitor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Role: N, Category: Nurses Note, Significance: High</p> <p>Signed by: [LVN A]</p> <p>05/26/2027 The facility will perform an elopement risk assessment for all residents to ensure no current residents are at risk for elopement.</p> <p>As of 05/26/2027[sic 2024] - 0 residents triggered for elopement risk after 100% elopement risk assessment completed.</p> <p>05/26/2027 [sic 2024]No residents currently with a wander guard in the building at this time. If a resident removes a wander guard they will be placed on a 1:1 until wander guard can be replaced or resident is discharged .</p> <p>05/26/2027 [sic 2024]All nursing staff to be in-serviced on facility Elopement Policy.</p> <p>05/27/2024 Elopement policy to be part of all new hire orientation and orientation to agency staff.</p> <p>Per preliminary findings noted see below:</p> <p>Phone interview on 05/23/2024 at 10:16 AM, CNA B stated she was present for when Resident #1 was found and missing. She stated she was not sure what time he was missing or when he returned. She stated the facility front door is supposed to be kept locked after hours, but it isn't always locked due to pharmacy, family, or a food delivery service. She stated the staff must lock the door manually by the keypad, that the door stays unlocked until it is locked back again manually. She stated she does not remember if it was locked during the night of 01/18/2024.</p> <p>Incorrect date of elopement was not 01/18/2024 but 01/29/2024.</p> <p>05/27/2024 Door lock check to be completed and logged by 2-10 shift and 10-6 shift.</p> <p>05/27/2024 DON/Designee to monitor by spot checking each shift by contacting nurses.</p> <p>Monitoring of the POR was as follows:</p> <p>Interview on 05/27/2024 at 3:19 PM, LVN G stated she works the 2-10 shift and confirmed she received an in-service on elopement. She stated the appropriate protocol is to check on every resident every two hours. She stated the facility uses wanderguards and if the resident takes it off, to consider changing the position. She stated protocol when a resident is attempting to elope and removes the wanderguard, and can utilize 1:1. She confirmed front door locking is to take place once the receptionist leaves, even if there are visitors in the facility.</p> <p>Interview on 05/27/2024 at 3:25 PM, CNA H stated she normally works the 6-2 shift and confirmed she received an in-service on 05/26/2024 regarding elopement. CNA H confirmed she understood the policy as it was described and affirmed confidence on the protocol. CNA H stated she understood the expected protocol related to elopement prevention and the in-service affirmed her understanding of the policy.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/27/2024 3:39 PM, CNA I, stated she works the 2-10 shift and confirmed she received an in-service on elopements. CNA I confirmed she understood the policy as it was described and affirmed confidence on the protocol. CNA I stated she understood the expected protocol related to elopement prevention and the in-service affirmed her understanding of the policy.</p> <p>Phone interview on 05/27/2024 at 4:08 PM, LVN K, stated he works generally the 10-6 shift and confirmed he received an elopements in-service that included reviewing the residents during the shift. LVN K confirmed the in-service included front door locking and monitoring, ensuring it was locked. LVN K stated he understood the expected protocol related to elopement prevention and the in-service affirmed her understanding of the policy.</p> <p>Phone interview on 05/27/2024 at 4:12 PM, RN L stated she works the 2-10 and 6-2 shift and confirmed she received the in-service regarding elopement, and what to do when a resident attempts to elope. RN L stated she understood the expected protocol related to elopement prevention and the in-service affirmed her understanding of the policy.</p> <p>Phone interview on 05/27/2024 at 4:19 PM, LVN A stated she works the 6-2 shift and confirmed she received the in-service on elopement, and confirmed she understood the policy to a high degree and described the elopement protocol was to attempt wanderguards but even to attempt 1:1 supervision if the wanderguard is ineffective. LVN A stated she understood the expected protocol related to elopement prevention and the in-service affirmed her understanding of the policy.</p> <p>Interview on 05/28/2024 at 9:24 AM, CMA O stated she normally worked the 6-2 shift and confirmed she was in-serviced on elopement before the start of her shift. CMA O stated she in-service was conducted by the ADON and discussed elopement prevention measures including wanderguards, frequent monitoring, and observing the front door. CMA O stated she understood the expected protocol related to elopement prevention and the in-service affirmed her understanding of the policy.</p> <p>Interview on 05/28/2024 at 9:31 AM, LVN F stated he normally works the 6-2 shift but will also work the 2-10 shift and on weekends. LVN F stated he received an in-service on elopement and confirmed he felt confident on the content of the in-service. LVN F stated the in-service discussed prevention measures in elopement and denied any current residents being an elopement risk.</p> <p>Interview on 05/28/2024 at 9:42 AM, CNA P stated he was the staffing coordinator for the facility but will frequently work the floor as an aide during the 6-2, 2-10, and will often fill in shifts on the 10-6 shift. CNA P he confirmed he received an in-service on elopement and felt confident on the content. CNA P stated he was also in-serviced on the front door locking as to ensue the front door was locked during the evening times after the receptionist leaves.</p> <p>Interview on 05/28/2024 at 9:49 AM, RA Q stated she generally worked the 6-2 and 2-10 but will also sometimes work the 10-6 shift including weekends. RA Q stated the received an in-service on elopement and denied any current residents who were exit-seeking and elopement risks. RA Q stated she was in-serviced on the protocol regarding the front door locking and felt confident on the course content.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 05/28/2024 at 9:55 AM, CMA R stated she normally works the 6-2 and 2-10 shift in doubles, and confirmed she received an in-service before she started her shift yesterday. CMA R confirmed the ADON provided the in-service to her and felt confident on the in-service content. CMA R confirmed the elopement in-service included elopement prevention measures and protocol when residents might remove the wanderguard equipped.</p> <p>Interview on 05/28/2024 at 10:18 AM, LVN S stated she was the case manager for the special-contracted residents and confirmed she did receive the in-service regarding elopements and the front door locking. LVN S stated she normally only works from 8-5 M-F but stated she will assist on the floor and will conduct trainings herself. LVN S stated she received the in-service along with other staff and that it was delivered by the ADON. LVN S stated she felt confident on the course content and felt comfortable with how the in-service was conducted.</p> <p>Interview on 05/28/2024 at 10:21 AM, LVN T stated she normally worked the 6-2 and 2-10 every weekend but has recently started working the 6-2 shift on the weekdays as well. LVN T stated she received the training on elopement and felt confident on the content of the in-service. LVN T stated the ADON provided the in-service and denied any current residents were an elopement risk and stated she was also in-serviced on the front door locking protocol to ensure the front door remained locked after the receptionist left at 7 each day.</p> <p>Interview on 05/28/2024 at 10:36 AM, CNA U stated she normally worked the 6-2 shift exclusively and stated she received the in-service on elopement. CNA U stated the in-service described when an elopement resident is admitted or when someone has a change in condition that they would receive more frequent supervision and to communicate with the charge nurse if the resident is exit-seeking or if they remove their wanderguard.</p> <p>Interview on 05/28/2024 at 10:41 AM, RN V stated he was primarily the weekend RN supervisor and stated he will also work the 6-2 on occasion as he was today. RN V stated he received the in-service on elopement that discussed the front door remaining locked after hours. RN V stated he was also in-serviced on elopement prevention measures to take such as increased monitoring and supervision, in addition to having wanderguards to alert staff.</p> <p>Record review of Elopement Risk Tool assessments completed, dated assessments all on 05/26/2024 from 3:37 PM through 7:13 PM reflected a total of 76 total residents reviewed for elopement risk.</p> <p>Record review of Resident #3's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>Record review of Resident #4's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>Record review of Resident #5's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>Record review of Resident #6's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>(continued on next page)</p>		

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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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #7's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>Record review of Resident #8's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>Record review of Resident #9's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>Record review of Resident #10's Elopement Risk Tool Assessment, dated 05/26/2024, reflected Resident #3 was determined to not be an elopement risk.</p> <p>Record review of in-service, dated 05/26/2024, titled Policy and procedures; Risk of elopement - routine resident checks to help maintain resident safety and well-being, address to [Facility] Nursing Staff, reflected 56 of 63 total signatures.</p> <p>Record review of the DON's spot check list for nurses, titled Monitoring: DON/ Designee will spot check each shift by contacting nurses and verify if there is no incidents or accidents with in the current shift. It reflected a layout of five instances asking Any incident or accident during the shift? If YES, is complete incident and accident protocol completed by nurse. With date, details box, and whether the care plan was initiated. Further reflected were indications of spot checks completed on 05/27/2024 on the 2-10 shift with a single unwitnessed fall, to add note and initiate protocol. An additional indication was reflected on 05/27/2024 - 05/28/2024 on the 10-6 shift with a reported resident expiration taken place.</p> <p>Record review of an email, dated 05/27/2024 at 12:03 PM, reflected the ADM enacted a new policy to the Human Resources Director to amend the new hire orientation for all staff and agency to also review and sign the policies: Elopements, Falls - Clinical Protocol, and Falls P&P Assessing Falls and Their Cause.</p> <p>The Administrator was informed on 05/28/2024 at 2:05 PM that the IJ was removed, however the facility remained out of compliance at a scope of Isolated and a severity level of No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy because all staff had not been trained on supervision and elopement.</p>