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	06/23/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to ensure each resident had the right to personal privacy for 2 of 4 residents (Resident #2 and Resident #4) reviewed for dignity. 1. Resident #2's privacy curtain was not closed completely during wound care on 6/21/24. 2. Resident #4's privacy curtain was not closed completely during wound care on 6/22/24. These failures could affect residents by contributing to poor self-esteem and decreased self-worth and quality of life. Findings included: 1. Record review of Resident #2's Facesheet, dated 6/21/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Seizure (burst of uncontrolled electrical activity between brain cells causing temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness), GERD (digestive disease in which stomach acid or bile irritates the food pipe lining) , Muscle Weakness, Glaucoma (condition that can cause blindness by damaging the optic nerve) , and Dysphagia (difficulty swallowing). Record review of Resident #2's quarterly MDS assessment, dated 4/30/24, revealed the resident's cognitive skills for daily decision making was severely impaired-never/rarely made decisions. Record review of Resident #2's Physician Order, dated 6/7/24, revealed an order for wound care as follows: SACRAL ULCER STAGE 4: CLEANSE WITH WOUND CLEANSER, PAT DRY WITH GAUZE, APPLY CALCIUM ALGINATE TO WOUND BED COVER WITH SILICONE BORDERED GAUZE QD AND PRN . Observation of wound care for Resident #2, on 6/21/24 beginning at 1:40 pm, revealed LVN A left the resident's room to retrieve more gloves after cleaning Resident #2's wound, leaving the resident exposed and the privacy curtain open. During an interview on 6/21/24 at 2:35 pm, LVN A said privacy curtains were closed to provide the residents privacy. LVN A further stated this was done because they were human, and it was a dignity issue. LVN A added she thought the CNA covered the resident. (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

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 06/23/2024

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #4's Facesheet, dated 1/11/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Atherosclerosis (The build-up of fats, cholesterol, and other substances in and on the artery walls , Schizoaffective Disorder (mental health condition including schizophrenia and mood disorder symptoms) , Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood) , and Type 2 diabetes (chronic condition that affects the way the body processes blood sugar). Record review of Resident #4's quarterly MDS assessment, dated 4/19/24, revealed the resident had a BIMS score of 8, suggesting moderate cognitive impairment. Record review of Resident #4's Physician Order, dated 6/21/24, revealed an order for wound care as follows: Stage 4 to right ischium [curved bone forming the base of the pelvis]: Cleanse area with wound cleanser, pat dry with gauze, pack with lodoform 1/4, apply skin prep spray to outside of the wound bed and cover with superabsorbent dressing QD/PRN . Observation of wound care for Resident #4, on 6/23/24 beginning at 11:06 am, revealed RN A did not completely draw the privacy curtain prior to removing the resident's brief for wound care. During an interview on 6/23/24/24 at 11:35 am, RN A said he was expected to provide the residents with total privacy by closing the door and the curtain. RN A further stated this was for resident dignity and to avoid exposure to passersby and the resident's roommate. During an interview on 6/23/24 at 1:18 pm, the DON said providing privacy during care was the residents' right. The DON further stated privacy was to be always maintained. The DON said it was the responsibility of all staff providing care and the supervisors such as, ADONs, DON, Lead CNAs or charge nurses to ensure residents privacy is maintained. The DON further stated not maintaining privacy could affect the residents' dignity. During an interview on 6/23/24 at 2:07 pm, the Administrator said staff should ensure blinds and curtains were closed when staff provided care, ensuring resident privacy. The Administrator further stated the staff that provided the care was responsible for ensuring privacy and dignity, otherwise there was a potential for the resident to feel embarrassed.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44906 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 8 medication carts (the 100-hallway medication cart) reviewed for medication storage, The facility failed to ensure the 100-hallway medication cart was locked when it was left unattended in the common area in front of the nurses' station. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings were: In an observation on 6/19/2024 at 6:30 PM, the 100-hallway cart was observed unlocked and unattended in the common area near the nurse's station. The surveyor was able to open the drawers without staff intervening. The 100-hallway cart contained over-the-counter medications, prescription medications and glucose monitoring paraphernalia. Non-ambulatory residents were in the area. In an interview on 6/19/2024 at 6:35 PM, the DON stated the surveyor was the only visitor in the immediate vicinity. The DON stated the cart should have been locked when unattended. The DON stated he was not sure where the nurse responsible for the 100-hallway cart was at the moment. The DON stated he had made rounds within the last five minutes and did not believe that the medication cart had been left unlocked and unattended for more than three minutes. The DON stated there was a risk to residents if an unauthorized person had access to the contents of the medication cart. Review of the undated Storage of Medications policy reflected under the section entitled Policy Interpretation and Implementation: 2. The Nursing staff shall be responsible for maintaining medication storage; 7. Compartments (including .carts .) .shall be locked when not in use .; 10. Only persons authorized to prepare and administer medications shall have access. Review of the undated Security of Medication Cart policy reflected under the section entitled Policy Interpretation and Implementation: 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39251 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 staff (RN A) reviewed for infection control. During Resident wound care, RN A failed to perform hand hygiene appropriately. This failure could affect residents and place them at risk for infection. Findings included: Observation of wound care on 6/23/24 at beginning at 11:06 am, revealed RN A entered the resident's bathroom and washed his hands for 4 seconds prior to gathering wound care supplies. RN A then placed wound care supplies on the resident's bedside table and returned to the bathroom, RN A washed his hands for 3 seconds. Once RN A complete wound care, he entered the bathroom and washed his hands for 2 seconds. During an interview on 6/23/24/24 at 11:35 am, RN A said he was expected to wash his hands for 15-20 seconds. RN A further stated hand hygiene was to be performed after touching a wound, when going from a dirty area to a clean one, when hands were visibly soiled, before and after treatments, before and after passing meal trays, and in between gloves if you had touched something contaminated. RN A said hand hygiene was important to avoid the spread of infection. During an interview on 6/23/24 at 1:18 pm, the DON said he expected staff to perform hand hygiene before and after providing direct resident care, by washing or sanitizer. The DON further stated facility procedure was for hands to be washed for a minimum of 15-20 seconds and 20 seconds for the gel or allowing to dry completely. The DON said it was everybody's responsibility for ensuring proper hand hygiene was performed when direct resident care was provided. The DON further stated the Super CNAs, ADON, and the DON performed random hand hygiene observations on a monthly basis. The DON further stated hand hygiene was important to prevent the spread of infections and pathogens. Record review of the facility's policy, titled, Handwashing/Hand Hygiene, dated 2/2022, read: .All staff in the facility are responsible for following hand hygiene policies and procedures .Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers .