

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 07/18/2024
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observation, interview and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #51) of 5 residents reviewed for dignity.</p> <p>The facility failed to ensure LVN A closed the door and provided privacy obtaining Resident #51's blood sugar.</p> <p>This failure could place the residents at risk of not having their right to a dignified existence maintained.</p> <p>Findings included:</p> <p>Review of Resident #51's Face Sheet, dated 07/17/2024, reflected resident was a [AGE] year-old female admitted on [DATE]. Resident #51 was diagnosed with Type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar) without complication.</p> <p>Review of Resident #51's Quarterly MDS Assessment, dated 07/05/2024, reflected resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated diabetes mellitus as one of resident #51's active diagnosis.</p> <p>Review of resident #51's Care Plan, dated 07/05/2024, reflected resident had potential for hyperglycemia (high blood sugar)/hypoglycemia (low blood sugar) secondary to diabetes mellitus and one of the interventions was obtain blood sugar as ordered.</p> <p>Review of Resident #51's Physician Order, dated 07/01/2024, reflected Humalog Kwik Pen (U-100) insulin 100 unit/ml subcutaneous. Inject 7 unit(s) subcutaneously 6:30 A, 11:30 A, 4:30 P every day. Document blood sugar. Document how many units administered . inject 7 units subcutaneously before meals if glucose is greater than 200.</p> <p>Observation and interview with LVN A on 07/16/2024 at 11:29 AM revealed Resident #51 was sitting in the dining area waiting for lunch. LVN A stated she needed to get Resident #51's blood sugar before lunch. LVN A said she would go to the dining area because the resident was already in the dining area. LVN A then pushed her nurse's cart towards the dining area.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/16/2024 at 11:33 revealed LVN C approached LVN A and said she should not get the blood sugar at the dining area. LVN C told LVN A that she should move the resident from the dining area to get her blood sugar.</p> <p>Observation on 07/16/2024 at 11:37, LVN C approached LVN A again and said she needed to get Resident #51's blood sugar inside the resident's room. LVN A pushed Resident #51 to her room and then pushed her cart in front of the resident's room. LVN A prepared the things needed to obtain the blood sugar. LVN A then went inside the resident's room and proceeded to check the Resident #51's blood sugar. LVN A did not close the door when she was checking Resident #51's blood sugar.</p> <p>In an interview with LVN A on 07/16/2024 at 12:16 PM, LVN A stated she would sometimes get the blood sugar in the dining area if the resident was already in the dining area. She said, next time, she would get the resident from the dining area if the resident was already in the dining area. She said she would also instruct the CNAs next time that she would get the blood sugar and administer insulin before they take the residents to the dining room before meals. She said getting the blood sugar in the dining area would be a dignity issue. She said the resident could be embarrassed or their self-esteem could be affected. She also said that the resident's door should be closed everytime she was checking the blood sugar or administering insulin.</p> <p>In an interview with LVN C on 07/16/2024 at 12:37 PM, LVN C stated he did approach LVN A when he saw she was about to go to the dining area with her cart. He said the blood sugar, or the insulin administration should be done inside the resident's room with the door closed to provide privacy to the resident. The door should be closed every time a staff was providing care to the residents. He said some resident could not communicate and even though they were feeling embarrassed, they could not verbalize it.</p> <p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated a nurse could not get the blood sugar of a resident in the dining area. The DON said the staff should get it from the resident's room. The DON said the door should also be closed when the insulin was being administered to provide privacy to the resident and to avoid embarrassment. The DON said all the staff, including him, were responsible in providing dignity to the residents. The DON said the expectation was for the staff to make sure all care provided would be in the resident's room with the door closed. He concluded that he would continually remind the staff the importance of providing dignity and privacy through an in-service.</p> <p>In an interview with the ADON on 07/18/2024 at 8:51 AM, the ADON stated what she learned from school was to provide care in the privacy of the residents' room. She said the blood sugar should never be taken from the dining area. She said the blood sugar should be taken before the resident was taken to the dining area or get the resident from the dining area and take her to her room and get the blood sugar. Getting the blood sugar in-front of other residents, staff, and visitors might cause embarrassment to the resident. She said it was important that the residents will be safe and would not be embarrassed. She said she would coordinate with the DON to do an in-service about dignity.</p> <p>In an interview with the Administrator on 07/18/2024 at 9:21 AM, the Administrator stated the staff must make sure that the residents were provided privacy when providing care to prevent embarrassment. She said the expectation was for the staff to get the blood sugar inside the room and give the insulin with the door closed. Said she would do an in-service about privacy and dignity.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's policy for Dignity requested on 07/18/2024 at 8:04 AM but was not provided prior to exit.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #9, Resident #40, and Resident #43) of nineteen residents reviewed for reasonable accommodation of needs.</p> <p>The facility failed to ensure the call light system in Resident #9, Resident #40, and Resident #43's rooms were in a position that was accessible to the residents.</p> <p>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.</p> <p>Findings included:</p> <p>Resident #9</p> <p>Review of Resident #9's Face Sheet, dated 07/16/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Resident #9 was diagnosed with Parkinson's disease (a chronic and progressive movement disorder) without dyskinesia (uncontrolled, involuntary movements of the face, arms, or legs).</p> <p>Review of Resident #9's Quarterly MDS Assessment, dated 05/01/2024, reflected that Resident #9 was cognitively intact with a BIMS score of 15. Resident #9 required supervision for eating, oral hygiene, toileting, and dressing.</p> <p>Review of Resident #9's Comprehensive Care Plan, dated 06/15/2024, reflected that Resident #9 was at risk for falls and one of the interventions was to keep the call light in reach.</p> <p>Observation and interview with Resident #9 on 07/16/2024 at 10:34 AM revealed Resident was on her bed, awake. Resident #9's call light was on the floor behind her side table. Resident #9 stated she did not usually use the call light because she could do everything by herself. She said but to be sure, she wanted her call light near her especially at night in case she cannot stand up or move around. Resident #9 checked the side of her bed and said the call light was not clipped on her pillow. Resident #9 did not notice her call light was behind her side table.</p> <p>Resident #40</p> <p>Review of Resident #40's Face Sheet, dated 07/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included cerebral infarction (blockage in the blood vessels of the brain), epilepsy (a brain condition that causes recurrent seizures), and age related debility (a state of general weakness).</p> <p>Review of Resident #40's Quarterly MDS Assessment, dated 04/13/2024, reflected Resident #40 had a severe cognitive impairment with a BIMS score of 04. Resident #40 needed supervision when ambulating 10 feet or more.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #40's Comprehensive Care Plan, dated 06/18/2024, reflected Resident #40 was at risk for falls and one of the interventions was to keep call light in reach.</p> <p>Observation and interview with Resident #40 on 07/16/2024 at 8:46 AM revealed resident #40 was sitting on his bed eating breakfast. It was observed that his call light was on the floor at the back of his bed's headboard. The resident stated he was just finishing his breakfast. When he was done with his breakfast, Resident #40 looked for his call light and said he wanted to call somebody to take his tray. Resident #40 found the cord of his call light and tried to pull it. Resident #40 said the call light was stuck. He said the staff who made his bed did not notice his call light was not clipped on the bed. Resident #40 stood up, put his tray on his walker, started to push his walker outside his room, and said he would just take his tray to the dining area. Resident #40 started walking towards the dining area.</p> <p>Resident # 43</p> <p>Review of Resident #43's Face Sheet, dated 07/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included muscle weakness and epilepsy.</p> <p>Review of Resident #43's Quarterly MDS Assessment, dated 04/30/2024, reflected Resident #43 had a severe cognitive impairment with a BIMS score of 03. Resident #43 was dependent on staff for oral hygiene, shower, dressing, and bed mobility.</p> <p>Review of Resident #43's Comprehensive Care Plan, dated 06/18/2024, reflected Resident #43 was at risk for falls and one of the interventions was to keep call light in reach.</p> <p>Observation on 07/16/2024 at 8:51 AM revealed that Resident #43 was on his bed, awake. It was observed that his call light was on the floor, under his roommate's bed. Resident #43 did not reply when asked about his call light.</p> <p>Observation and interview with CNA E on 07/16/2024 at 10:56 AM, CNA E stated it was important that the call lights were placed near the residents. CNA E said the call lights should always be with the residents because the residents used them to call the staff if they needed something. CNA E said if the call lights were not with the residents, the residents would not be able to communicate their needs and wants. CNA E said the residents might be frustrated, mad, or might fall if the call light was far from them. CNA E went to Resident #40 and Resident #43's room. She confirmed that the call lights were on the floor. CNA E picked up Resident #43's call light from beneath his roommate's bed and placed it near the resident. CNA E then proceeded to pull Resident #40's call light from behind the headboard and said it was stuck on something. CNA E pushed Resident #40's bed, pulled the call light, and placed it near Resident #40. She said she was assigned to Resident #9. She said she did not notice the call light was on the floor when she did her initial round because she was in a hurry.</p> <p>In an interview with CNA D on 07/16/2024 at 11:04 AM, CNA D stated he was assigned to Residents #40 and #43. CNA D said he did not notice the call lights were not with the residents. He said it was important for the call light to be within reach, so the residents could be helped when they needed assistance or help. CNA D said if the call lights were not with the residents, the residents might fall or the staff would not know the residents were having an emergency. He said he was responsible in ensuring the call lights were within reach for his assigned residents.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with LVN A on 07/17/2024 at 9:21 AM, LVN A stated the call lights should always be with the residents because the call lights were their form of communication. For some residents, the call lights were their sense of security that if they needed help, they could call the staff to help them. If the call lights were not with the residents, the residents might fall while trying to do things by themselves. Some of the residents would be mad and frustrated because they could not call the staff. She said all the staff were responsible in making sure the call lights were within reach of the residents.</p> <p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated call lights were very essential for the residents. The DON said, for some residents, the call lights were the only way of communication between the residents and the staff. The DON said the call lights were used by the resident if they needed something, like pain medication, refill of water, or to turn the lights off. The DON said without the call lights, the needs of the residents would not be known and would not be met. He added, without the call lights the needed care would not be provided. The DON said the expectation was for the staff would be mindful that every time they leave the resident's room, the call lights were with the residents. The DON said he would conduct an in-service about the call lights because the call lights were everybody's responsibility. He said the in-service would be for the nurses, CNAs, housekeeping, therapists, and management. He said he would personally monitor that all the residents' call lights were within reach.</p> <p>In an interview with the ADON on 07/18/2024 at 8:51 AM, the ADON stated the call lights should not be on the floor or in a place where the residents could not reach them. The ADON said the call light must be within reach of the residents at all times because they use the call light to let the staff know they needed something. The ADON said if the call lights were far from the residents, the residents would not be able to call the staff and their needs would not be addressed. The ADON said the resident might even have a fall if they try to go to the bathroom by themselves because they could not call the staff. The ADON said the expectation was for all the staff to make sure the call lights were within the reach of all the residents. The ADON said they would do an in-service about call lights being accessible to the residents.</p> <p>In an interview with the Administrator on 07/18/2024 at 9:21 AM, the Administrator stated the call lights should not be far from the residents. The Administrator said the call lights were used by the residents to call the attention of the staff if they needed something. The Administrator said the residents might be having an emergency and staff would not know. The Administrator said the staff should be sensible about call light placement. The Administrator said they would re-educate the staff regarding call lights and would constantly remind them that before leaving the room, make sure the call lights were with the resident.</p> <p>Record review of facility's policy Answering The Call Light revealed Purpose: The purpose of this procedure is to respond to the resident's request and needs . general Guidelines . 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for areas in the facility for 8 (room [ROOM NUMBER], #103, #104, #106, #110, #113, #116, and facility shower room) of 12 rooms observed for environment.</p> <p>The facility failed to ensure Resident rooms #102, #103, #104, #106, #110, #113, #116, and facility shower room were clean and sanitized.</p> <p>The facility failed to ensure Resident room [ROOM NUMBER]'s floor was repaired of cracks to prevent accidents.</p> <p>These deficient practices could place residents at risk of living in an unclean, unsafe and unsanitary environment which could lead to a decreased quality of life.</p> <p>Findings included:</p> <p>An observation on 07/16/24 at 10:06 AM of Resident room [ROOM NUMBER] reflected the entry way into the resident's bathroom had a large crack in the floor and a piece of tile was broken off. On the floor, behind the toilet was a large brown stain. The floor along the resident room wall, had a long crack going down the length of the room. The air conditioning in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thin layer of dust on them.</p> <p>An observation on 07/16/24 at 10:20 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thin layer of dust on them.</p> <p>An observation on 07/16/24 at 10:23 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thin layer of dust on them. The floor along the wall had built up black stains.</p> <p>An observation on 07/16/24 at 10:27 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thin layer of dust on them. The middle of the floor had brownish stains.</p> <p>An observation on 07/16/24 at 10:32 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filter had a thick layer of dust on it. The floor along the walls had built-up black stains. There was a broken tile located near a bedside table. There was a long crack in the floor near the middle of the room. The bathroom sink was scraped and damaged near the drain.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 07/16/24 at 10:36 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thin layer of dust on them. A white air vent along the wall was stained and dirty.</p> <p>An observation on 07/16/24 at 10:47 AM of Resident room [ROOM NUMBER] reflected the air conditioning located in the room had dirt particles and black dirt grime on the top and between the vents of the units. The air filters had a thin layer of dust on them. The floor along the front of the toilet had a black stain. The handrails in the bathroom had dark and reddish stains.</p> <p>An observation on 07/16/24 at 10:57 AM of the Residents' only shared shower room, reflected the shower room floor had blackish and reddish stains along the floor and shower walls. The handrails and shower heads had built-up soap scum on them. One of the shower stalls had a dead cockroach dead in the corner of the stall.</p> <p>In an interview on 07/18/24 at 10:45 AM Housekeeping G, stated she had been at the facility a month. She stated she was given a cleaning cart and was shown by a housekeeper who was at the facility longer on what to clean. She stated they had to clean restrooms, dressers, windows, air condition units, and dust. She stated she worked the 300- hall. She was shown pictures of the concerns observed in the resident rooms. She stated that they were supposed to clean the air conditioning units in the resident rooms and also clean the air filters. She stated they are supposed to wipe down the handrails in the rooms, bathrooms, and hallways. She stated she and another co-worker are responsible for cleaning the showers, which are supposed to be cleaned daily. She stated the risk of not ensuring the resident rooms are not thoroughly the residents could get sick, bacteria could spread, and the residents would not want to take a shower in a dirty shower.</p> <p>In an interview on 07/18/24 at 11:00 AM with Housekeeping M, she stated she had been at the facility for a year. She stated she had been doing this [housekeeping] for [AGE] years. She stated she was supposed to clean the 100 Hall rooms, wipe down the handrails daily, but she did not clean the shower room. She stated she had helped them when they are short staffed. She stated they [housekeeping] was supposed to empty the trash, dust, clean the air conditioning unit, including cleaning the air conditioning filter, clean the restrooms, and sweep and mop. She was shown pictures of the findings in the facility, and she stated she cleans everything. She stated the risk of not cleaning the resident room thoroughly is was not right and it should be clean.</p> <p>In an interview on 07/18/24 at 11:18 AM Maintenance/Housekeeping Director stated he had been at the facility for over 3 years. He stated staff was supposed to clean the entire rooms, including the bathrooms, sweep and mop floor, clean the air conditioning units, and wipe the furniture down. He was shown pictures of the damages to the floor, and he stated that there were foundational problems on the 100 Hall. He stated the resident rooms, handrails, and showers were to be cleaned daily. He stated there was no excuse why those areas were not clean. He stated he tried to inspect the rooms and other areas daily but sometimes he just checks with the housekeeping team to ensure that it was done. He stated he would get right on resolving the issues observed. He stated the risk of the issues not being resolved could result in residents getting sick.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observation, interviews and record review, the facility failed to ensure assessments accurately reflected the resident's status for two (Resident #40 and Resident #43) of eight residents reviewed for Accuracy of Assessments.</p> <p>The facility failed to ensure Resident #40's Quarterly MDS Assessment accurately reflected that Resident #40 still had his g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach).</p> <p>The facility failed to ensure Resident #43's Quarterly MDS Assessment accurately reflected that Resident #43 still had his g-tube.</p> <p>The facility failed to ensure Resident #'s 43's Quarterly MDS Assessment accurately reflected that Resident #43 had impairment to his right hand.</p> <p>These failures could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health.</p> <p>Findings included:</p> <p>Resident #40</p> <p>Review of Resident #40's Face Sheet, dated 07/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #40 was diagnosed with dysphagia (difficulty in swallowing).</p> <p>Review of Resident #40's Quarterly MDS Assessment, dated 04/13/2024, reflected Resident #40 had a severe cognitive impairment with a BIMS score of 04. Resident #40's Quarterly MDS Assessment did not indicate that the resident still had a feeding tube.</p> <p>Review of Resident #40's Comprehensive Care Plan, dated 06/18/2024, reflected Resident #40 required feeding tube for nutrition and interventions were check for placement of tube, check for residual (food from previous feeding left in the stomach), and flush feeding tube with water as ordered. Resident #40's Comprehensive Care Plan did not reflect that the resident's g-tube was not in use.</p> <p>Review of Resident #40's Physician Order, dated 07/13/2024, reflected G-tube Flush: 60 cc H2o Q shift.</p> <p>Review of Resident #40's Physician Order, dated 07/13/2024, reflected G-tube observation: site/drsg, assess for leakage or skin irritation at tube insertion site Q shift - Cleanse with normal saline q shift.</p> <p>Review of Resident #40's Physician Order, dated 07/13/2024, reflected G-tube placement check: via auscultation (listening to the sounds inside the body through the use of a stethoscope) AC H2O medications and formula Q shift.</p> <p>(continued on next page)</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 07/18/2024
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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #40 on 07/16/2024 at 8:46 AM revealed Resident #40 was sitting on his bed eating breakfast. After eating breakfast, Resident #40 stood up to fix his tray. It was observed that Resident #40 had a g-tube. Resident #40 stated he had a g-tube but he was not using it anymore. He said he was already eating through his mouth.</p> <p>Resident # 43</p> <p>Review of Resident #43's Face Sheet, dated 07/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #43 was diagnosed with dysphagia.</p> <p>Review of Resident #43's Quarterly MDS Assessment, dated 04/30/2024, reflected Resident #43 had a severe cognitive impairment with a BIMS score of 03. Resident #43's Quarterly MDS Assessment did not indicate that the resident still had a feeding tube and had an impairment on his right hand.</p> <p>Review of Resident #43's Comprehensive Care Plan, dated 06/01/2024, reflected Resident #43 required enhanced barrier precautions due to having an enteral feeding tube. Resident #43's Comprehensive Care Plan indicated that the resident was receiving restorative therapy PROM, splint to right hand.</p> <p>Review of Resident #43's Physician Order, dated 06/12/2024, reflected Restorative to provide: AROM and right hand splint.</p> <p>Observation on 07/16/2024 at 8:51 AM revealed that Resident #43 was on his bed, awake. It was observed that he was wearing a splint to his right hand. Resident did not reply when asked how long he had the splint. It was also observed that he had a g-tube to the right lower quadrant of his abdomen.</p> <p>In an interview with CNA D on 07/16/2024 at 10:46 AM, CNA D stated Resident #43 was dependent on staff for most of the ADLs. He said Resident #43's right hand was contracted and that was why he was wearing a splint. CNA D also said Resident #43 had a feeding tube but he was not aware if the resident was still using it.</p> <p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated if a resident still had his g-tube but was not using it, it should still be reflected in the MDS because it still needed to be care planned. There should still be an order on how to take of Resident #43's g-tube because the g-tube was still there for a reason. He said it should still be reflected on the medical diagnosis, physician orders, MDS, and care plan. He also said that if a resident had an impairment to the upper extremity, it should also be reflected in the MDS. He said the resident should be accurately assessed to provide the needed interventions. If the residents were not properly assessed, the proper care and needs would not be met. The DON said the expectation was the residents were properly assessed not only during admission but every day to see if there was a change in condition, any refusal of care, or resident acting different than usual. He said he would collaborate with the MDS Nurse and the ADON to audit MDS assessments and make appropriate changes.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the MDS Nurse on 07/18/2024 at 8:38 AM, the MDS Nurse stated if a resident had an impairment, it should be reflected on the MDS assessment or on the resident's profile. She said the medical diagnosis, physician order, MDS, and the care plan should be all in-line and should match to provide a clear overview of the resident's current condition. She said, by doing so, accurate goals and interventions would be provided. The MDS Nurse said she would check Resident #40 and Resident #43's profile and make the needed modifications. She said she was the one doing the assessment and must have overlooked it. She said if the resident had impairments, it should be reflected in the MDS. She added if the resident still had a g-tube, it should also be reflected in the MDS. She said an accurate MDS assessment was important because it would be the basis of the care needed by the resident. If the assessment was not accurate, the current status of the resident would not be correct resulting in a possible confusion on the residents' care. She said inaccurate assessment could also result in the resident not getting the appropriate care needed. She said she would make an audit to make sure the MDS would reflect the current condition of the residents.</p> <p>In an interview with the ADON on 07/18/2024 at 8:51 AM, the ADON stated if a resident had an impairment, it should be reflected on the system to make sure all the needed care was given to the residents. She added if a resident still had his g-tube, it should be reflected on the resident's profile because even though the resident was not using it, the g-tube site should still be observed. She added if the resident had an impairment, it should be reflected on the MDS. The ADON said if there was no accurate assessment, there could be a misunderstanding about the care needed by the resident and the resident might not be able to get the treatment needed. She said she would coordinate with the DON and MDS Nurse to address the issues.</p> <p>In an interview with the Administrator on 07/18/2024 at 9:21 AM, the Administrator stated that if a resident had an impairment or a g-tube, it should be on the MDS to reflect the current condition of the resident. She said, by doing so, the needs of the residents would be addressed. She said she would coordinate with the clinical managers to evaluate the situation, discuss it during quality assurance and do in-services.</p> <p>Record review of facility policy, Resident assessment Instrument 2001 MED-PASS 2001, Inc. Rev. December 2006 revealed Policy Interpretation . 3. The Purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for two (Resident #40 and Resident #43) of eight residents reviewed for Care Plans.</p> <p>The facility failed to ensure Resident #40 and Resident #43 were care planned for their g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) not being used for nutrition but was still connected to the residents.</p> <p>This failure could place the residents at risk of not receiving necessary care and services.</p> <p>Findings included:</p> <p>Resident #40</p> <p>Review of Resident #40's Face Sheet, dated 07/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #40 was diagnosed with dysphagia (difficulty in swallowing).</p> <p>Review of Resident #40's Quarterly MDS Assessment, dated 04/13/2024, reflected Resident #40 had a severe cognitive impairment with a BIMS score of 04. Resident #40's Quarterly MDS Assessment did not indicate that the resident still had a g-tube.</p> <p>Review of Resident #40's Comprehensive Care Plan on 07/16/2024 reflected no care plan for a feeding tube not being in use.</p> <p>Observation and interview with Resident #40 on 07/16/2024 at 8:46 AM revealed Resident #40 was sitting on his bed eating breakfast. After eating breakfast, Resident #40 stood up to fix his tray. It was observed that Resident #40 had a g-tube. Resident #40 stated he had a g-tube but he was not using it anymore. He said he was already eating through his mouth.</p> <p>Resident # 43</p> <p>Review of Resident #43's Face Sheet, dated 07/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #43 was diagnosed with dysphagia.</p> <p>Review of Resident #43's Quarterly MDS Assessment, dated 04/30/2024, reflected Resident #43 had a severe cognitive impairment with a BIMS score of 03. Resident #43's Quarterly MDS Assessment did not indicate that the resident still had a feeding tube.</p> <p>Review of Resident #43's Comprehensive Care Plan on 07/16/2024 reflected no care plan for a feeding tube not being in use.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 07/16/2024 at 8:51 AM revealed that Resident #43 was on his bed, awake. It was observed that he had a g-tube to the right lower quadrant of his abdomen. Resident did not reply when asked how long he had his g-tube.</p> <p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated every resident needed a comprehensive care plan to make sure the residents receive the appropriate care needed. The DON said the care plan should be in place so that the staff providing care would be on the same page. The DON said the care plan served as a tool for all individuals caring for the residents. He said the care plan should be comprehensive and should show what specific care the resident needed. He said the expectation was for all residents to have a complete and detailed care plan. He said he was responsible in checking if the care plans of the residents were comprehensive and in accordance with the current condition of the residents. He said he would audit the care plans of the residents and then make an in-service about care plans.</p> <p>In an interview with the MDS Nurse on 07/18/2024 at 8:38 AM, the MDS Nurse stated care plans were important to ensure the residents were getting the care needed. The MDS Nurse said care plans served as guides on how the staff will take care of the residents. The MDS Nurse said care plans were comprised of the problem lists, the goals, and the interventions appropriate to the needs of the residents. The MDS Nurse added that without the care plans, the staff could miss out significant interventions needed by the residents. She added if a resident still had his g-tube, there should be a care plan on how to take care of the g-tube while waiting to discontinue it. The MDS Nurse said she would go ahead and add the care plan for both residents.</p> <p>In an interview with the ADON on 07/18/2024 at 8:51 AM, the ADON stated it was important that residents have a care plan to fully provide the care and services the residents needed. The ADON said that for this case, there should be a care plan for g-tube like flushing it every shift so it will not be clogged up. She added if the g-tubes were not taken care for, there could be complications like infection to the g-tube site. She said the expectation was all the issue of the residents were care planned.</p> <p>In an interview with the Administrator on 07/18/2024 at 9:21 AM, the Administrator stated all the residents should have a care plan appropriate to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. The Administrator concluded that the expectation was for the staff will ensure that every issue of the residents was care planned. She said she would coordinate with the DON and MDS Nurse to make sure all the residents were care planned accordingly.</p> <p>Record review of facility's policy, Care Planning - Interdisciplinary Team 2001 MED - PASS, Inc. rev. September 2013 revealed Policy Statement: Our facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident . 7. Care plans are updated to reflect items that are specific to the resident's care.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on interviews and record reviews the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 (Residents #26 and #63) of 2 residents reviewed for (ADLs) care provided to dependent residents.</p> <p>1. The facility failed to ensure Resident #26 received scheduled showers reviewed for the past 30 days (06/16/24 - 07/16/24).</p> <p>2. The facility failed to ensure Resident and #63 received scheduled showers reviewed for the past 30 days (06/16/24 - 07/16/24).</p> <p>These failures placed residents at risk of not receiving necessary services to maintain good personal hygiene and decreased self- esteem.</p> <p>Findings included:</p> <p>1. Record review of Resident #26's Face Sheet, dated 07/17/2024, revealed he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included Kidney Failure and required ADL assistance.</p> <p>Record review of Resident #26's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, he had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and for ADL care it stated, for transfers, toileting, and bathing, the resident required moderate assistance.</p> <p>In an interview on 07/16/24 at 11:38 AM with Resident #26, he stated he had not been getting his showers at the facility. He stated he had never refused any showers and he was scheduled to receive three showers a week. He stated he wanted his showers.</p> <p>2. Record review of Resident #63's Face Sheet, dated 07/17/2024, revealed he was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included Kidney Failure and required ADL assistance.</p> <p>Record review of Resident #63's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, he had a Brief Interview for Mental Status (BIMS) score of 09 (moderate cognitive impairment) and for ADL care it reflected, for transfers, toileting, and bathing, the resident required moderate assistance.</p> <p>In an interview on 07/16/24 at 10:46 AM with Resident #63, he stated he had not been getting his showers at the facility. He stated he had never refused any showers and he was scheduled to receive three showers a week. He stated he wanted his showers.</p> <p>Record review of the facility's shower sheet binder for the past 30 days (06/16/24 - 07/16/24) reflected no shower sheets on file for Resident # 26 and #63.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/17/24 at 10:15 AM CNA S stated she had been at the facility for [AGE] years, she stated she works the 100 hall and she cares for Resident #26 and #63. She stated they were required to complete the shower sheets for all residents, whether a shower was provided or refused. She was advised that neither resident had shower sheets in the shower sheet binder provided by the facility for the past 30 days reviewed. She stated that she did provide the residents their showers, but she just forgot to complete the shower sheet. She stated the risk of the resident not receiving their scheduled showers and she stated that they could get sores and redness.</p> <p>An interview on 07/17/24 at 10:15 AM LVN A stated she had been at the facility since December (2023). She stated she monitored the 100 hall and Resident #26. She advised that all CNAs were required to complete shower sheets for all residents. She stated she usually monitored the showers and ensured that the shower sheets were completed correctly and completely. She stated that she did not do a great job monitoring Resident#26 showers. She stated CNA S covered both the 100 and 300 halls and sometimes got overwhelmed. LVN A stated Resident #26 was receiving showers, but it was not being recorded. She was asked why the resident stated they were not receiving showers and she could not explain why the resident stated he was not receiving his showers. She stated the risk of the resident not receiving showers could result in skin breakdown and skin irritation.</p> <p>In an interview on 01/17/24 at 01:57 PM with LVN R, she stated she had been there four weeks. She stated resident are required to complete shower sheet for residents on their scheduled days whether they received or refused one. She was advised that the shower sheet book was reviewed, and no shower sheet was observed. She stated Resident #63 was scheduled to receive his showers in the evening and it was the evening nurse responsibility to ensure that the resident received his showers. She stated they do communicate during shift change but not about Resident #63's showers. She stated she really did not know if the resident ever refused shower or was given a shower. She stated the risk of the resident not receiving their shower could result in dirty skin, breakdown, and infection.</p> <p>In an interview on 07/17/24 at 02:15 PM ADON stated she had been at the facility 18 months. She stated she was familiar with Residents #26 and #63. She stated her nursing staff had made her aware that there were no shower sheets for either resident. She stated she was sure the residents were receiving their showers and she thought that they may have refused a few of them. She was advised that the two residents had stated they were not receiving their showers. She stated she was not sure why they would have made those comments, but she was sure that they received them when scheduled.</p> <p>Record review of facility policy on Bath, Bed, Tub, Shower, dated 05/25/2017 reflected, Purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: The following information should be recorded on the resident's ADL record and or in the resident's medical record:</p> <ol style="list-style-type: none"> 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual who assisted the resident with the shower/tub bath. 3. All assessments data obtained during the shower/bath. 4. If the resident refused the shower/bat, the reason why and the intervention taken.

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based observation, interview, and record review, the facility failed to ensure residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infection for one (Resident #44) of twelve residents observed for incontinent care .</p> <p>The facility failed to ensure that CNA D did not wipe from front to back while providing incontinent care to Resident 44 on 07/16/24.</p> <p>These failures could place the residents at risk of cross-contamination and development of urinary tract infections.</p> <p>Findings included:</p> <p>1. Review of Resident #44's Face Sheet, dated 07/16/2024, reflected resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included post COVID-19 condition and pneumonia.</p> <p>Review of Resident #44's Comprehensive MDS Assessment, dated 06/01/2024, reflected Resident #44 was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #44 was always incontinent for bowel and bladder.</p> <p>Review of Resident #44's Comprehensive Care Plan, dated 06/15/2024, reflected resident was incontinent for bowel and bladder: wears incontinent briefs and requires staff assistance for incontinent care and one of the interventions was incontinent care by staff every two hours and prn.</p> <p>Observation on 07/16/2024 at 11:59 AM revealed Resident #44 was on her bed, awake. CNA D told the resident that he was going to clean her up. CNA D washed his hands and put on a pair of gloves. CNA D then lowered the head of the bed, unfastened the brief on both sides, and tucked the front part of the brief between the legs of the resident. CNA D cleaned the front part of the resident using the front to back technique. After cleaning the front part, CNA D told the resident to roll to one side. Resident #44 had a small bowel movement. CNA D then started to clean the bottom. CNA D wiped the resident from back to front. The wipes had feces on them. He wiped the resident's bottom towards the front resident's front part five times. CNA D took off his gloves, sanitized his hands, and put on a new pair of gloves. CNA D then took the new brief, placed it on the resident's bottom, and fixed it. He then told the resident to roll back. The resident rolled back and CNA D fastened the brief. CNA D fixed the blanket and gave the resident her call light.</p> <p>In an interview with CNA D on 07/16/2024 at 12:19 PM, CNA D stated he used the front to back technique when he cleaned Resident #44's front part. CNA D said for the bottom, the wiping should not be towards the front to prevent the microorganisms from the anal area going to the front part of the resident. He said this could cause a urinary tract infection. He said he was unaware he did the wrong wiping. He said he should be mindful of how he does incontinent care because the resident would be at risk for infection.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated he would do an in-service about infection control for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control.</p> <p>In an interview with the Administrator on 07/18/2024 at 9:21 AM, the Administrator She said she would collaborate with the clinicians to in-service the staff about infection control.</p> <p>Review of facility policy, Perineal Care revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections . Steps in the Procedure . 11. For a female resident . d. Cleanse the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral (intake of food through a tube in the gastrointestinal tract) feeding for one (Resident #43) of four residents reviewed for gastrostomy tube management.</p> <p>The facility failed to ensure that Resident #43 had orders to observe the g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) even though it was not used by the resident.</p> <p>The facility failed to ensure that Resident #43 had order to flush and check the placement of the g-tube every shift.</p> <p>These failures could place residents who had g-tube at risk for having a clogged g-tube.</p> <p>Findings include:</p> <p>Review of Resident #43's Face Sheet, dated 07/16/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #43 was diagnosed with dysphagia (difficulty in swallowing).</p> <p>Review of Resident #43's Quarterly MDS Assessment, dated 04/30/2024, reflected Resident #43 had a severe cognitive impairment with a BIMS score of 03. Resident #43's Quarterly MDS Assessment did not indicate that the resident still had a feeding tube.</p> <p>Review of Resident #43's Comprehensive Care Plan, dated 06/01/2024, reflected Resident #43 required enhanced barrier precautions due to having an enteral feeding tube.</p> <p>Review of Resident #43's Physician Orders on 07/16/2024 reflected no orders to check for placement of the g-tube.</p> <p>Review of Resident #43's Physician Orders on 07/16/2024 reflected no orders to flush the g-tube.</p> <p>Review of Resident #43's Physician Orders on 07/16/2024 reflected no orders to observe the g-tube insertion site.</p> <p>Observation and interview on 07/16/2024 at 8:52 AM revealed Resident #43 had a g-tube to the right lower quadrant of his abdomen. Resident #43 did not reply when asked how long he had not been using the g-tube.</p> <p>(continued on next page)</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated a resident with g-tube should be flushed to maintain patency (keeping it from becoming blocked or clogged). He said the g-tube was still with the resident when the resident was being weaned off from formula. He said there should still be an order for the resident with g-tube even if the resident was not using it to prevent clogging and complications. He said the expectation was that there were orders to monitor, flush, and check the placement of the g-tube even though the resident was not using it. He said he would do an in-service about g-tube care and making sure there was an order for monitoring, flushing, and checking for placement.</p> <p>Record review of facility's policy Maintaining Patency of a Feeding Tube revealed Purpose: The purpose of this procedure is to maintain patency of a feeding tube . General Guidelines . 1. Flush enteral feeding tubes every four (4) to six (6) hours.</p> <p>Record review of facility's policy Medication Orders revealed Purpose: the purpose of this procedure is to establish uniform guidelines . recording of medications orders . 2. A current list of orders must be maintained . 3. Orders must be written.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that Residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Residents #1) of four residents reviewed for respiratory care.</p> <p>The facility failed to ensure that Resident #1's mask for CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) was properly stored.</p> <p>The facility failed to ensure that Resident #1's humidifier had water in it.</p> <p>This failure could place the residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 07/16/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included pneumonia (inflammation of the lungs) and acute respiratory failure with hypoxia (insufficient amount of oxygen in the body).</p> <p>Review of Resident #1's Comprehensive MDS Assessment, dated 04/03/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #1as on oxygen therapy and on non-invasive mechanical ventilator while a resident of the facility.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 07/05/2024, reflected that the resident was experiencing sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep) and required BiPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs)/CPAP.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 07/05/2024, reflected that the resident was receiving oxygen therapy continuously and one of the interventions was provide with humidification.</p> <p>Review of Resident #1's Physician's Order, dated 02/21/2023, reflected, BiPAP OFF @ 6 AM.</p> <p>Review of Resident #1's Physician's Order, dated 02/21/2023, reflected, BiPAP ON @ 11 PM.</p> <p>Review of Resident #1's Physician's Order, dated 08/14/2023, reflected Oxygen: Administer Oxygen @ 2-4 L/minute via nasal cannula or mask PRN for SOB/Cyanosis (bluish skin color due to decreased amounts of oxygen) if O2 < 93%.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #1 on 07/16/2024 at 10:04 AM revealed resident was on her bed, awake. Resident #1 had a CPAP machine on top of her bed side table and a CPAP mask was connected to the machine. The CPAP mask was noted on top of the CPAP machine. The CPAP mask was not bagged. Resident #1 stated she used the CPAP machine at night. The resident said the staff would put the CPAP on her at night and a staff would take it off in the morning. She said she never saw a plastic bag for the CPAP mask and nobody told her to put the mask on it on a bag if ever she would take it off. It was also observed that Resident #1 was on oxygen therapy at 3 liters per minute via nasal cannula. The nasal cannula was connected to an oxygen concentrator. The oxygen concentrator had no water in it. Resident #1 said she did not notice there was no water on her humidifier.</p> <p>In an interview with LVN A on 07/16/2024 at 10:07 AM, LVN A stated she did not notice that Resident #1's mask for CPAP was not bagged when she did her morning round. She also said she did not notice the water in the humidifier was running low. She said the mask should be bagged to prevent cross contamination. She said there should be water in the humidifier to prevent irritation in the nasal passage. She said she would get a plastic bag for the CPAP mask and a new pre-filled humidifier for the resident.</p> <p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated the CPAP mask should be bagged when not in use. He said if the CPAP mask was not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said it could also result in cross contamination and respiratory infections. He said the humidifier should have water in it to prevent irritation of the nose and throat. He said the expectation was for the CPAP mask to be stored properly and the humidifier to have water in it always. The DON concluded that moving forward, he would do an in-service about bagging the CPAP mask and monitoring if the humidifier had water in it. He said he would continually remind them to be diligent in making sure the procedures for respiratory care were followed.</p> <p>In an interview with the ADON on 07/18/2024 at 8:51 AM, the ADON stated the CPAP mask should be bagged when the resident was not using it to prevent cross contamination and infection. She said the staff who take off the mask should put it in a bag. She said if the resident was the one taking it off, there should be a bag ready for them to put the mask in. She also said that the resident should be educated why the mask should be bagged. The ADON said there should be water in the humidifier to prevent irritation of the nasal passage. She said the expectation was for the staff to bag the CPAP mask. She said she would coordinate with the DON to do an in-service pertaining to bagging the CPAP mask and making sure there was water in the humidifier.</p> <p>In an interview with the Administrator on 07/18/2024 at 9:21 AM, the Administrator stated that in general, the CPAP masks should be stored properly to prevent respiratory issues or exacerbation of whatever respiratory issues the residents already had. The Administrator said there was water in the humidifier for a reason. The Administrator said the expectation was for the staff to be mindful during their rounds and make sure the CPAP masks were bagged and there was water in the humidifier. The Administrator said she would check if the clinicians already did correct the issue.</p> <p>Record review of facility policy, Oxygen Administration 2001 MED - PASS, Inc. revised March 2004 revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administrator. Steps in the Procedure. 12. be sure there is water in the humidifying.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on interviews, and record reviews, the facility failed to assist a resident in obtaining routine dental care for one (Resident #31) of one resident reviewed for dental services.</p> <p>The facility failed to ensure assist Resident #31 with getting a dental appointment when requested by the responsible party in March 2024</p> <p>This failure could place the resident at risk of not receiving required dental services to avoid complications with her eating.</p> <p>Findings included:</p> <p>Review of Resident #31's Face Sheet, dated 07/17/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included denture use.</p> <p>Review of Resident #31's Quarterly MDS Assessment, dated 04/20/2024, reflected that Resident #31 had a severe impairment in cognition with a BIMS score of 08 (moderate cognitive impairment).</p> <p>Review of Resident #31's Comprehensive Care Plan updated on 03/08/24 reflected that Resident #31 was care planned for Maintain adequate nutritional status and good oral hygiene daily and ongoing over the next 90 days. One of the interventions was for the resident to receive an oral exam (from a dentist).</p> <p>In an interview on 07/16/24 at 11:23 AM, Resident #31's responsible party, stated he had been trying to get a dental appointment since March 2024 and he had been getting the run around by the social worker. He stated he had been told that the facility had to find a new dentist and when they did have the resident scheduled for an appointment, the dentist had a family emergency and never rescheduled. He stated he had concerns with his mother's dentures and gums causing her problems.</p> <p>In an interview on 07/17/24 at 10:15 AM with MDS Nurse M, she stated she had been at the facility for 7 years and she was familiar with Resident #31 because she attended the resident's MDS meeting. She stated the resident's responsible party had been making several requests for the resident to see a dentist, but she was unsure why it was not scheduled previously. She stated the Social Worker was the person responsible for scheduling residents to see the dentist. She stated she was unsure if the resident was having any dental concerns, which may be why it was care planned.</p> <p>In an interview on 07/17/24 at 10:20 AM with the ADON, she stated she had been at the facility for 18 months. She stated she was familiar with Resident #31. She stated the resident's responsible party had requested a dentist, but she had not heard anything recently. She stated it had been months since the dentist had last visited the facility. She stated she overheard that the resident's responsible party wanted the resident to see a dentist, but she was unsure why it took so long. She stated the risk of the resident not seeing a dentist if there was a problem could result in an infection. She stated the resident did wear dentures.</p> <p>(continued on next page)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/17/24 at 10:35 AM with the Social Worker, she stated she had been at the facility for three years. She stated that Resident #31 was last seen by a dentist in October 2023. She stated the resident's responsible party was notified in March 2024. She stated there was an issue with the hygienist and the appointment was canceled. She stated the resident's responsible party attempted to contact the dentist, but they could not get in touch with each other. She stated the resident was refusing any dental work. She stated she was finally able to make an appointment with the dentist for 07/16/24. She stated the dentist they use in the past had to leave and since then they had issues getting a dentist to address the concerns. She stated the dentist was scheduled to visit the facility on 07/16/24 and the resident was seen at that time. She stated the risk of the resident not being treated sooner could result in his having an infection and having issues throughout their body.</p> <p>In an interview on 07/18/24 and 12:07 PM with the Administrator, she stated they had problems getting a dentist for the facility and she had suggested to the Responsible Party to see an outside dentist, but the resident had refused. She stated there was a lot of miscommunications. She stated the Responsible party had concerns with the social worker communicating with the responsible party. She stated the risk of the resident going without addressing any dental concerns could result in an infection or abscess tooth.</p> <p>Review of the facility's Policy on Dental Services dated August 2006, reflected Routine and emergency dental services are available to meet the resident's oral health serviced in accordance with the resident's assessment and plan of care.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on interviews, and record review the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for since April 2024.</p> <p>The facility failed to have either a full-time dietitian or certified dietary manager on staff since April 2024.</p> <p>This failure could place the residents at risk of not receiving sufficient food and nutritional services, which could negative impact overall resident nutrition.</p> <p>Findings included:</p> <p>Record review of the facility's key staff report reflected no dietary manager or dietitian listed.</p> <p>In an interview on 07/18/24 at 10:21 AM with the Head Cook/Supervisor in Training, he stated he had been at the facility for three years. He stated the Dietary Manager had left the facility about four months ago. He stated the Dietitian visits the facility at least three or four times a month to ensure concerns she had previously observed was corrected. He stated the previous dietary manager had trained him on maintaining the kitchen and he had been a cook for over [AGE] years.</p> <p>In an interview on 07/18/24 and 12:07 PM Administrator stated they had been without a Dietary Manager for couple of months now, but the acting supervisor was now taking all the required courses to get certified. She stated that she works closely with him to ensure that he was keeping the kitchen within guideline. She stated they did have a dietitian, but she was contracted and not a permanent member. She stated the risk of not having a full-time dietitian or certified dietary manager at the facility could impact the resident's ability to have nutritional meals.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055</p> <p>Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure food in the facility's refrigerator was labeled and dated according to guidelines. 2. The facility failed to ensure the ice machine in the kitchen area was thoroughly cleaned. 3. The facility failed to ensure food in the facility's freezer was labeled and dated according to guidelines. 4. The facility failed to ensure kitchen equipment in the kitchen area, was thoroughly cleaned. 5. The facility failed to ensure food in the facility's dry food area was labeled and dated according to guidelines. <p>These failures could place residents at risk for cross contamination and other air-borne illnesses.</p> <p>Findings included:</p> <p>Observations on 07/16/24 from 08:35 AM to 08:50 AM in the facility's only kitchen reflected:</p> <p>One large container of diced pineapples in the refrigerator was not labeled with item name and did not have the date stored.</p> <p>One small cup of pudding was unlabeled with item name and undated with the date stored.</p> <p>A tray of beverages containing cups of apple juice and milk was unlabeled with item name and undated with the date stored.</p> <p>Three 5-pound bags of salad were undated with date stored.</p> <p>Three loaves of wheat bread were undated with the date stored.</p> <p>Three bags of hamburger buns were undated with the date stored.</p> <p>The ice machine had dust and dirt particles along the outside of the unit. The inside of the unit had light dirt stains along the inside panel of the unit, which touched the ice. The upper inside of the door had a black substance on a metal bar that stretched horizontally along the inside door.</p> <p>Two zip locked bags of frozen meat were unlabeled with item name and undated with the date stored.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>One large frozen turkey was undated with dated stored.</p> <p>In an interview on 07/18/24 at 10:21 AM with the Head Cook/Supervisor in Training, stated he had been at the facility for three years. He stated the Dietary Manager had left the facility about four months ago. He stated the Dietitian visits the facility at least three or four times a month to ensure concerns she had previously observed was corrected. He stated the previous dietary manager had trained him on maintaining the kitchen and he had been a cook for over [AGE] years. He was shown pictures of the concerns that were observed in the kitchen. He stated he had corrected some of the concerns. He stated he was the one in charge of ensuring inventory were labeled and dated when stored and he ensures that kitchen staff are wiping down the kitchen equipment and cleaning the ice machine. He stated he cleans the ice machine every two weeks but will start monitoring it more frequently. He stated the risk of not addressing the areas mentioned could in result in cross contamination and food contamination.</p> <p>In an interview on 07/18/24 and 12:07 PM with the Administrator, she stated they had been without a Dietary Manager for couple of months now, but the acting supervisor was now taking all the required courses to get certified. She stated he did tell her about the findings in the kitchen but not sure if he advised her of everything. She was advised of the concerns observed in the kitchen and she stated she expected all items to be labeled and dated and the kitchen cleaned. She stated the risk to the resident was the potential for contamination.</p> <p>Record Review of the Facility's policy on Food Storage dated 06/01/2019, revealed To ensure all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and U.S Food Codes and HACCP guidelines. The facility will maintain refrigerators, coolers and freezers in a clean and sanitary manner to minimize the risk of food hazards. Refrigerators, coolers and freezers will be kept clean on a daily basis and will be thoroughly cleaned every month or more often as needed . Procedure: 1 .d .all containers must be labeled and dated .2. Refrigerators .d. Date, label and tightly seal all refrigerated foods .</p> <p>Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based 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 one (Resident #51) of twelve residents observed for infection control.</p> <p>The facility failed to ensure that LVN B and RA F changed their gloves and performed hand hygiene while providing incontinent care to Resident #51.</p> <p>This failure could place the residents at risk of cross-contamination and development of infections.</p> <p>Findings included:</p> <p>Review of Resident #51's Face Sheet, dated 07/17/2024, reflected resident was a [AGE] year-old female admitted on [DATE]. Resident #51 was diagnosed with sepsis (an infection of the blood stream).</p> <p>Review of Resident #51's Quarterly MDS Assessment, dated 07/05/2024, reflected resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated that the resident was always incontinent for bladder and bowel.</p> <p>Review of resident #51's Care Plan, dated 07/05/2024, reflected resident was incontinent of bladder and bowel, wears incontinent briefs and requires staff assistance for incontinent care and one of the interventions was incontinent care by staff every two hours and prn.</p> <p>Observation on 07/16/2024 at 9:36 AM revealed LVN B was about to do Resident #51's wound care at the sacral (bone at the buttocks) area. RA F was assisting LVN B to turn the resident. Both staff washed their hands. Both staff put on a pair of gloves. After putting on the new gloves, they instructed and assisted the resident to roll to one side. When they unfastened the brief, they saw that the resident had a bowel movement. LVN B said they would clean her up first before doing the wound care. RA F started to clean the resident's bottom. After wiping the resident's bottom, RA F took the new brief and placed it under the resident. She did not change her gloves. After fixing the brief, RA F changed her gloves. She did not sanitize her hands. While RA F was cleaning the bottom, LVN B touched the trash can twice so RA F could throw the wipes away. After touching the trash can, LVN B assisted in fixing and closing the brief. She did not change her gloves after touching the trash can or before touching the new brief.</p> <p>In an interview with RA F on 07/16/2024 at 9:54 AM, RA F stated she did not sanitize her hands when she changed her gloves. She said the right thing to do was to do hand hygiene every time the gloves were changed. She said she should have changed her gloves before touching the new brief. She said after cleaning the resident's bottom, the gloves were already dirty. If dirty gloves touched the new brief, the new brief would be considered dirty. She said if the resident's brief were dirty, the resident could have an infection.</p> <p>(continued on next page)</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	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN B on 07/16/2024 at 10:12 AM, LVN B stated she sanitized her hands when she changed her gloves. She said she did touch the trash can so RA F could throw her soiled wipes away but said she did not change her gloves before helping in fixing the brief. She said not changing the gloves from dirty to clean could cause cross contamination and infection.</p> <p>In an interview with the DON on 07/18/2024 at 8:24 AM, the DON stated the hands should be sanitized every time the gloves were changed. The DON said every staff should wash their hands before and after every care. She said gloves should be changed and the hands should be sanitized after cleaning the resident's buttocks. She said the gloves should have been changed when the trash can was touched. She said not washing the hands, not changing the gloves, and not sanitizing the hands in between changing of gloves could result in cross contamination and infection. The DON said the expectation was for the staff to wash their hands before and after every care, change their gloves when transitioning from a dirty area to a clean area, and sanitize their hands when changing their gloves. The DON said he would do a one-on-one in-service about washing of hands and changing of gloves. He added he would do an in-service about infection control for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control.</p> <p>In an interview with the ADON on 07/18/2024 at 8:51 AM, the ADON stated that during incontinent care, the staff must always change their gloves and sanitize the hands before touching the new brief. She added that after touching the trash can, the gloves should have been changed. She said not changing the gloves could result in cross contamination and probable infection. She said the expectation was for the staff to wash their hands, and change their gloves to prevent infection among the residents. She said she would coordinate with the DON on how to go forward.</p> <p>In an interview with the Administrator on 07/18/2024 at 9:21 AM, the Administrator stated not washing the hands nor sanitizing them when the gloves were changed could contribute to cross contamination. The Administrator said the expectation was for the staff to make sure all items and equipment used by the residents were sanitized and the gloves were changed during care for the basic reason of infection control. She said she would collaborate with the clinicians to in-service the staff about infection control.</p> <p>Review of facility policy, Handwashing/Hand Hygiene revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . 7. Use an alcohol-based hand rub . after removing gloves.</p> <p>Review of facility policy, Perineal Care revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections . Steps in the Procedure . 7. Put on gloves. 8. Remove soiled clothing and/or brief.</p> <p>9. Remove gloves, sanitize hands, and apply new gloves.</p>		