STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675924	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of Woodway	7801 Woodway Dr Waco, TX 76712

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area for 1 of 12 residents (Residents #5) reviewed for call lights. The facility failed to place Resident #5's call light within reach to call staff for assistance. This failure placed residents at risk for having their needs go unmet. Findings included: Record review of Resident #5's undated face sheet revealed an [AGE] year-old woman who admitted to the facility on [DATE]. She was diagnosed with Unspecified Dementia (which was a disease that affected memory, thought, and interfered with daily life;) Syncope and Collapse (which was also known as fainting;) and, Dyspnea (which was a condition that causes shortness of breath.) Record review of Resident #5's Quarterly MDS, dated [DATE], reflected Section C., Cognitive Patterns; Resident #5 had a BIMS Score of 00. A BIMS Score of 00 indicated Resident #5 had severe cognitive impairment. Section GG., Functional Abilities and (Range of Motion;) Resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand.) Resident had impairment on both sides of lower extremities (hip, knee, ankle, and foot.) Resident #5 utilized a wheelchair for mobility. Section GG., Functional Abilities and Goals (Self Care;) Resident #5 was dependent upon staff for toileting hygiene, shower/bathe self, and personal hygiene. Dependent meant the helper did all the effort. Section H., Bladder and Bowel (Bladder) indicated Resident #5 was always incontinent; (Bowl) indicated Resident #5 was always incontinent. Interview and observation on 4/23/2024 at 12:29 PM with Resident #5 revealed resident resting in her bed. Resident #5 did not respond to verbal introductions. Resident #5's bed was at a lower level of height; the back rest was slightly elevated. The call button clip, the call button, and the call button cord were on the floor to the resident's right side of body. The resident did not have access to the call light button because the call light button was further than arms reach. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 4/25/2024 at 2:46 PM with Resident #5 revealed resident sleeping in her bed. The call button clip, the call button, and the call button cord were on the floor to the resident's right side of body. The resident did not have access to the call light button because the call light button was further than arms reach. Interview on 4/25/2024 at 2:49 PM with CNA A revealed she was a new employee and had been working at the facility for about 2-3 weeks. CNA A was trained to make sure the resident's call light was placed within arms reach after each resident contact. For example, the correct location of the cord would be with the resident in a chair or a bed. The location of the resident did not matter. CNA A performed room checks every 2 hours and to look for the call light's location and correct if needed. A resident's diagnosis, willingness to use the call light, or understanding the purpose for the call light did not negate the need for the call light to be within reach of the resident. Interview and observation on 4/25/2023 at 3:04 PM revealed CNA B exiting from Resident #5's room. CNA B stated he just performed his rounds for Resident #5. While performing rounds in Resident #5's room at 3:04 PM, he stated Resident #5's call light was located on the floor, out of reach of Resident #5, and that he placed the call light button in the correct location, within reach of Resident #5. He stated the call light was not in the correct position when he entered the room, a few moments ago. Interview on 4/25/2024 at 4:15 PM with the DON revealed staff was trained to place the resident's call light button within reach of each resident. If a staff member entered the room and noticed the call light out of reach of the resident, the call light button was supposed to be moved to the correct location, within arm's reach. Safeguards in place to make sure residents had access to their call light buttons was the use of angel rounds, which were daily room checks by administrative staff. Risks posed to a resident without access to their call button were falls, delayed assessments, and psychosocial harm. Interview on 4/25/2025 at 4:50 PM with the ADM revealed the facility had a policy for Answering the Call Ligh t and the policy stipulated the call light was supposed to be within reach of the resident. She expected her staff to follow the policy. There were no specific circumstances that would negate any resident from having or needing access to their call light button. Safeguards in place to ensure residents had access to their call lights were the policy and angel rounds. A resident without access to their call light button risked falls, lack of access to assistance, and frustration. Record review of the facility's [Answering the Call Light] policy, revised September 2003, reflected; (5) when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.