STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675924	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/28/2024

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 - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 4 of 5 residents (Residents #1, #2, #3, & #4) reviewed for resident rights. The facility failed to ensure Residents #1, #2, #3, and #4's call light was within reach on 12/28/24. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #1's admission record dated 12/28/24 documented a [AGE] year-old female admitted on [DATE]. Resident #1 had diagnoses which included: need for assistance with personal care, major depressive disorder (loss of interest in activities), and essential primary hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause). Record review of Resident #1's Quarterly MDS assessment, dated 10/18/24, revealed the resident had a BIMS score of 03 indicating the resident had severe cognitive impairment. The MDS also revealed Resident #1 required substantial/maximal assistance in the areas of toileting hygiene, lower body dressing, upper body dressing, and putting on /taking off footwear. Record review of Resident #1's care plan, dated 12/28/24, revealed Resident #1 was care planned for ADL self-care performance deficit r/t activity intolerance, impaired balance, limited mobility, and limited ROM. Observation on 12/28/24 at 11:30 a.m., revealed Resident #1's call light was lying on the floor, right side of the bed, and out of her reach. During an interview on 12/28/24 at 11:30 a.m., Resident #1 stated she had wanted her blanket and a Dr. Pepper but was not able to get anyone to assist her because the call light was on the floor. Resident # 1 was not able to state how long the call light had been on the floor or when the last time staff had come in to assist her. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's admission record dated 12/28/24 documented an [AGE] year-old female admitted on [DATE]. Resident #2 had diagnoses which included: anemia (blood does not have enough healthy red blood cells and hemoglobin), acute kidney failure (kidneys suddenly can't filter waste from blood), and unspecified dementia (loss of memory can't be categorized as a specific type). Record review of Resident #2's Quarterly MDS assessment, dated 10/14/24, revealed the resident had a BIMS score of 03 indicating the resident had severe cognitive impairment. The MDS also revealed Resident #1 required partial/moderate assistance in the areas of toileting hygiene, lower body dressing, upper body dressing, and putting on /taking off footwear. Record review of Resident #2's care plan, dated 12/28/24, revealed Resident #1 was care planned for assistance with ADL's r/t impaired mobility and dementia. Resident #2's goal was to receive assistance as needed with ADL's daily and ongoing. Observation on 12/28/24 at 11:34 a.m., revealed Resident #2's call light was wrapped around her headboard, behind her head, not within reach under the pillow. During an interview on 12/28/24 at 11:34 a.m., Resident #2 did not respond when asked where her call light was. Resident # 2 closed her eyes and appeared to be sleeping. Resident #2 was not able to be asked how long her call light was not in reach. Record review of Resident #3's admission record dated 12/28/24 documented a [AGE] year-old male admitted on [DATE]. Resident #3 had diagnoses which included: type 2 diabetes (body has trouble controlling blood sugar and using it for energy), acute kidney failure (kidneys suddenly can't filter waste from the blood), and essential primary hypertension (high blood pressure with no identifiable cause). Record review of Resident #3's Admission MDS assessment, dated 12/16/24, revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. The MDS also revealed Resident #3 was dependent in the area of shower/bathe self. Resident #3 required partial/moderate assistance in the areas of toileting hygiene, personal hygiene, upper body dressing, and putting on/taking of footwear. Record review of Resident #3's care plan, dated 12/28/24, revealed Resident #3 was care planned requiring assistance to perform functional abilities in self-care and mobility r/t other orthopedic conditions-bilateral knee contractures. Observation on 12/28/24 at 11:38 a.m., revealed Resident #3's call light on the floor, on the left side of the bed, and out of his reach. During an interview on 12/28/24 at 11:38 a.m., Resident #3 stated that he had been looking for his call light to get care staff to empty the bedside urinal. Resident # 3 stated he did not know where his call light was and could not recall how long it was missing. Resident # 3 was not able to provide how long it had been since staff came in to assist him. Or he had to holler out for staff. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's admission record dated 12/28/24 documented an [AGE] year-old female admitted on [DATE]. Resident #4 had diagnoses which included: essential primary hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition), chronic kidney disease (waste built up in kidneys), and pulmonary hypertension (affects arteries in the lungs and the right side of the heart). Record review of Resident #4's Quarterly MDS assessment, dated 10/14/24, revealed the resident had a BIMS score of 12 indicating the resident had moderate cognitive impairment. The MDS also revealed Resident #4 required substantial/maximal assistance in the areas of toileting hygiene, shower/bathe self, lower body dressing, upper body dressing, personal hygiene, and putting on /taking off footwear. Record review of Resident #4's care plan, dated 12/28/24, revealed Resident #4 was care planned for assistance with all ADL's r/t weakness, impaired mobility, and dementia. Resident #4's goal was to receive assistance as needed with ADL's daily and ongoing. Observation on 12/28/24 at 11:40 a.m., revealed Resident #4''s call light was behind her, at the middle of her back, unable to be reached. During an interview on 12/28/24 at 11:40 a.m., Resident #4 stated she could not reach her call light because it was under her towards her back. Resident #4 stated she did not know the last time staff had come in or how long the call light was under her. During an interview on 12/28/24 at 1:15 p.m., CNA A stated CNAs should make rounds at least every two hours or as needed. CNA A stated that CNAs should be looking to see if a resident needed assistance, ensured call lights were within reach, and made sure all residents were comfortable. CNA A stated if a resident's call light was not within reach, then the resident's needs would not be met. During an interview on 12/28/24 at 1:29 p.m., the ADON stated that all staff that entered the resident's room was responsible for ensuring the call light was within reach. The ADON stated it was expected for all staff that entered a resident's room to make sure the call light was in reach so residents could notify staff that they needed assistance. The ADON stated if a resident's call light was not in reach, then the resident's needs would not have been met. An interview on 12/28/24 at 4:00 p.m., the ADM stated it was everyone's responsibility to ensure call lights were always within reach of the resident. The ADM stated that if a call light was not within reach, then a resident's needs would not be met. The ADM stated that it was expected for call lights to be always within reach of the residents. Review of the facility's Call Lights: Accessibility and Timely Response policy, revised 02/23, reflected, The purpose of this this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to staff member or centralized location to ensure appropriate response.