

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  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Regent Care Center of Woodway		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172</b></p> <p>Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse for one (Resident #1) of five residents reviewed for abuse.</p> <p>The facility failed to protect Resident #1 from physical abuse when CNA A was slapped by Resident #1 across the face and CNA A slapped Resident #1 back across their face on 1/5/2025.</p> <p>An Immediate Jeopardy (IJ) was identified on 01/22/2025. The IJ template was provided to the facility on [DATE] at 5:43 PM. While the IJ was removed on 01/23/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on abuse/neglect.</p> <p>This failure placed residents at risk of abuse, trauma, and/or psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #1's Quarterly MDS dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including traumatic brain dysfunction (an injury to the brain caused by external mechanical force), dementia (a group of symptoms affecting memory, thinking, and social abilities), senile degeneration of brain (progressive deterioration of brain tissue and function that occurs beyond what's considered normal aging), and age-related physical debility. Resident #1 had a BIMS score of 00 indicating severe cognitive impairment.</p> <p>Review of Resident #1's care plan, dated last reviewed 01/12/2025, reflected she had impaired cognitive function and impaired thought processes with interventions to cue, reorient, and supervise as needed, and to not correct her if she gets confused to reality.</p> <p>Review of a witness statement, dated 1/5/2025 and documented by CNA B, reflected the following: I witnessed [Resident #1] coming up to [CNA A] and hit her in the face [CNA A] slapped [Resident #1] on the left cheek and [Resident #1] sat by her afterwards. I went to the restroom afterwards came back got the administrators number called then went to inform the nurse. I did ask 2 coworkers on what to do I've never experienced situation before.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a written statement dated 1/5/25 and documented by CNA A, reflected the following: I was sitting on the brown table when [Resident #1] walked up to me and started talking to me from there she slapped me in my face from there I did reach and pushed her back with my hand in her face. Just to make myself clear I did not slap the resident on the face I put my heel of my hand on her left cheek and pushed her back. When I realized I may contact with her I apologized to the resident.</p> <p>Review of a video footage provided by the facility with a date/time stamp of 01/05/2025 11:51 am reflected CNA A seated on a bench/table with Resident #1 to her right-side adjusting items on the bench/table. Resident #1 then walked to the front of CNA A and the two appeared to be in conversation. Resident #1 could be seen moving both of her arms while talking and then raised her right arm and slapped CNA A across the right side of her face. CNA A was then seen raising her right arm all the way up and slapping Resident #1 back across the left side of her face and Resident #1 can be seen being turned about 45-degrees due to the slap. After that, Resident #1 and CNA A can be seen in conversation again, and Resident #1 turns to walk to her left when CNA A grabbed the back of Resident #1's shirt and pulled toward her, making Resident #1 fall into a seated position to the right side of CNA A on the bench/table.</p> <p>Review of CNA A's time stamp card dated 01/05 revealed she clocked in at 06:02 AM and clocked out at 10:04 PM, working a total of 16.03 hours.</p> <p>During a phone interview on 01/22/2025 at 12:37 PM with RN A she stated that she was the charge nurse during the morning of 01/05/2025 and that CNA A did not tell her that she had slapped Resident #1 back. It was not until after CNA B contacted the ADM and then went to speak with RN A that she was notified that CNA A had slapped the resident. She stated that after she was informed by CNA B, she immediately went to go assess Resident #1, who exhibited no signs of trauma, and had no redness or signs of bruising.</p> <p>During a phone interview on 01/22/2025 at 12:47 PM with CNA B, she revealed from her phone log that she called the ADM on 01/05/2025 at 2:17 PM to notify him of the alleged abuse of Resident #1 by CNA A that happened earlier that day at 11:51 AM. CNA B was instructed by the ADM to then go and write a statement of the events that occurred as well as to inform the charge nurse.</p> <p>During a phone interview on 01/22/2025 at 1:00 PM with the ADM (who is the abuse coordinator), when asked why CNA A was allowed to finish her shift, he stated that at that point in time and after getting [CNA A's] statement it was unclear whether [the alleged abuse] was incidental or intentional, he had no concern about other residents being harmed at that time. CNA A had spoken with the charge nurse and there was no concern. CNA A was moved out of the MC unit and allowed to finish the remainder of her shift working another hall of the facility. CNA A was terminated the next day.</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy dated last revised 01/08/2023 reflected the following:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protection of Resident</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.</p> <p>Investigation of Alleged Abuse, Neglect and Exploitation</p> <p>12. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p> <p>The IDON, ADON, and ADM were notified on 01/22/2025 at 5:43 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.</p> <p>The following POR was accepted on 01/23/2025 at 5:15 PM:</p> <p>PLAN OF REMOVAL</p> <p>Name of facility: [name of facility]</p> <p>Date: 1/22/25</p> <p>F 600 - Problem: The facility failed to keep the residents free from abuse.</p> <p>Resident #1 Was immediately assessed by the nurse without noted injuries and remains in the facility in stable condition.</p> <p>Immediate action:</p> <p>1. On 1/22/25 The facility IDON/ADON/Designee immediately initiated skin assessments to ensure no s/s of physical injuries were present in all residents currently residing at the facility- no issues noted. Completed 1/23/25</p> <p>2. On 1/22/25 The facility Adm/IDON/Designee initiated Life safety rounds with interviewable residents, interviews revealed no negative outcomes. Non-interviewable residents' responsible parties will also be interviewed. Any issues identified will be addressed immediately. Completed 1/23/25</p> <p>3. On 1/22/25 The VPO conducted a 1:1 in-service with the facility administrator on the company abuse and neglect policy focusing on immediately suspending employees pending allegations of abuse and neglect. This included returned verbalized understanding of the process. This was documented on a signed in-service sheet. Any reportable incidents will also be reported to the corporate VP of Operation and or VP of Clinical to ensure an appropriate investigation, interventions and follow-up takes place. Any issues identified with this process will be addressed through further education and or disciplinary action.</p> <p>Interventions</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>4. On 1/22/25 The Adm initiated an in-service with the facility management staff on expectations to assure residents safety, abuse and neglect policy and reporting incidents immediately, this includes removing/suspending any staff members involved with any allegations or suspicion of abuse. Comprehension was verified by successfully completing a questionnaire on the subject, Completed 1/23/25</p> <p>5. On 1/22/25 The facility Adm/IDON/Designee initiated an in-service with the staff on the corporate compliance hot line to report unusual events. Comprehension was verified by successfully completing a questionnaire on the subject, Completed 1/23/25</p> <p>On 1/22/25 The facility Adm/DON/Designee initiated in-service with the facility staff on Abuse and Neglect focusing on ensuring residents safety and immediately reporting suspected abuse or neglect to the abuse prevention coordinator and or the corporate compliance hot line. The Abuse prevention coordinator contact information is posted throughout the facility. The abuse prevention coordinator will suspend, investigate, rule out, or report any allegation of abuse and neglect within the allotted time frame. Completed 1/23/25.</p> <p>Ongoing Projected completion 1/23/25.</p> <p>Any staff member not present during initial in-servicing/training will not be allowed to assume their duties until in-service. Ongoing In-service will be completed by IDON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, PRN, and agency staff in completed.</p> <p>Monitoring</p> <p>1. The facility IDT conduct residents Angel Rounds at least 5xweek to ensure residents do not have unknown safety concerns. Any concerns will be documented on the rounding sheet then turned to the administrator/Designee for immediately follow up. VP of Ops and/or Regional Nurse will provide additional oversight to ensure steps are completed. On going 1/22/25.</p> <p>2. On 1/22/23 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 1/23/25.</p> <p>3. On 1/22/25 An impromptu QAPI meeting was conducted with the facility's Medical Director to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on 1/22/25.</p> <p>4. Any reportable incidents will also be reported to the corporate VP of Operation and or VP of Clinical to ensure an appropriate investigation, interventions and follow-up takes place. Any issues identified with this process will be addressed through further education and or disciplinary action 1/22/25.</p> <p>The surveyor monitored the POR on 01/23/2025 as followed:</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interviews on 01/23/2025 from 4:30pm -5:20pm 3 CNA's, 1 LVN, and 1 MA (from all 3 shifts) all stated they were in-serviced before starting their shift on 01/23/2025 and then given questionnaires to complete to verify their knowledge. All were able to state that their abuse coordinator was the ADM, if he were not available, they were to notify the ADON, IDON, or charge nurse. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting abuse the first time they see or hear it. All know where the corporate compliance hotline number is posted and know when to contact if needed.</p> <p>During interviews on 01/23/2025 from 3:55pm-4:20pm with 3 alert and oriented residents revealed they had recently had communication with management regarding their satisfaction with living at the facility and that they have no concerns about their safety, the staff that provide their daily care, or the management at the facility.</p> <p>Interview with the ADM on 1/23/2025 at 5:10pm, he stated he was in-serviced one-on-one with the VPO regarding the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and that he was to notify the VPO anytime an allegation was made of ANE. The ADM stated that all employees will be in-serviced before the start of their next shift. The ADM also stated that CNA A was terminated on 1/6/2025.</p> <p>Review of skin assessments dated 1/22/2025-1/23/2025 of all residents revealed no new skin issues/concerns.</p> <p>Review of one-on-one in-service dated 1/22/2025 titled Health and Human Services Reportable Guidelines presented by the VPO to the ADM revealed he went over review of the facility abuse, neglect, and exploitation policy. Included a review of policy section III. Prevention of abuse, neglect, and exploitation, and section VI. Investigation of alleged abuse, neglect and exploitation and section VII. Protection of resident.</p> <p>Review of in-service dated 1/22/2025 titled 'Abuse and Neglect policy: prevention and reporting' was provided by the ADM to department managers.</p> <p>Review of in-service dated 1/22/2025 titled 'Abuse and Neglect policy: It is our policy to ensure resident safety and immediately report suspected abuse or neglect to the abuse coordinator', and listed the ADM's telephone number, was provided to direct care staff.</p> <p>Review of in-service dated 1/22/2025 titled 'Company Compliance Program' revealed information on the company's compliance hotline for employees to contact and was provided to direct care staff.</p> <p>Review of in-service titled 'Angel/Ambassador Rounds Policy' with the policy attached was provided to Angel Round staff members.</p> <p>Review of 'Responsible Party Contact Log' dated week of 1/20/2025 revealed 48 residents' responsible parties were contacted and notes were written regarding complaints/praises/remarks. No notes made regarding suspected abuse/neglect.</p> <p>Review of Safe Surveys dated week of 1/20/2025-1/24/2025 revealed no residents expressing concerns regarding their safety or abusive staff.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of multiple employee Abuse/Neglect and Compliance Questionnaire's dated between 1/22/2025-1/23/2025 revealed staff answered questions based on the in-services provided.</p> <p>Review of QAPI meeting notes dated 1/22/2025 revealed an email from the MD stating his agreement to their path moving forward.</p> <p>The ADM was informed the IJ was removed on 01/23/2025 at 5:15 PM. The facility remained out of compliance at a severity level of no actual harm and a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172</b></p> <p>Based on interview and record review, the facility failed to implement their written policies and procedures regarding investigating abuse for one (Resident #1) of five residents reviewed for abuse and neglect.</p> <p>The facility failed to ensure CNA A was suspended/terminated or removed from working with all residents after she slapped a resident in the memory care unit, potentially causing additional abuse and/or emotional distress.</p> <p>An Immediate Jeopardy (IJ) was identified on 01/22/2025. The IJ template was provided to the facility on [DATE] at 5:43 PM. While the IJ was removed on 01/23/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on abuse/neglect.</p> <p>This failure placed residents at risk of abuse, trauma, and psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #1's Quarterly MDS dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including traumatic brain dysfunction (an injury to the brain caused by external mechanical force), dementia (a group of symptoms affecting memory, thinking, and social abilities), senile degeneration of brain (progressive deterioration of brain tissue and function that occurs beyond what's considered normal aging), and age-related physical debility.</p> <p>Review of Resident #1's care plan, dated last reviewed 01/12/2025, reflected she had impaired cognitive function and impaired thought processes with interventions to cue, reorient, and supervise as needed, and to not correct her if she gets confused to reality.</p> <p>Review of a witness statement, dated 1/5/2025 and documented by CNA B, reflected the following: I witnessed [Resident #1] coming up to [CNA A] and hit her in the face [CNA A] slapped [Resident #1] on the left cheek and [Resident #1] sat by her afterwards. I went to the restroom afterwards came back got the administrators number called then went to inform the nurse. I did ask 2 coworkers on what to do I've never experienced situation before.</p> <p>Review of written statement dated 1/5/25 and documented by CNA A, reflected the following: I was sitting on the brown table when [Resident #1] walked up to me and started talking to me from there she slapped me in my face from there I did reach and pushed her back with my hand in her face. Just to make myself clear I did not slap the resident on the face I put my heel of my hand on her left cheek and pushed her back. When I realized I may contact with her I apologized to the resident.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of video footage provided by the facility with a date/time stamp of 01/05/2025 11:51 am reflected CNA A seated on a bench/table with Resident #1 to her right-side adjusting items on the bench/table. Resident #1 then walked to the front of CNA A and the two appeared to be in conversation. Resident #1 could be seen moving both of her arms while talking and then raised her right arm and slapped CNA A across the right side of her face. CNA A is then seen raising her right arm all the way up and slapping Resident #1 back across the left side of her face and Resident #1 can be seen being turned about 45-degrees due to the slap. After that, Resident #1 and CNA A can be seen in conversation again, and Resident #1 turns to walk to her left when CNA A grabbed the back of Resident #1's shirt and pulled toward her, making Resident #1 fall into a seated position to the right side of CNA A on the bench/table.</p> <p>Review of CNA A's time stamp card dated 01/05 revealed she clocked in at 06:02 AM and clocked out at 10:04 PM, working a total of 16.03 hours.</p> <p>During a phone interview on 01/22/2025 at 12:37 PM with RN A she stated that she was the charge nurse during the morning of 01/05/2025 and that CNA A did not tell her that she had slapped Resident #1 back. It was not until after CNA B contacted the ADM and then went to speak with RN A that she was notified that CNA A had slapped the resident. She stated that after she was informed by CNA B, she immediately went to go assess Resident #1.</p> <p>During a phone interview on 01/22/2025 at 12:47 PM with CNA B, she revealed from her phone log that she called the ADM on 01/05/2025 at 2:17 PM to notify him of the alleged abuse of Resident #1 by CNA A that happened earlier that day at 11:51 AM. CNA B was instructed by the ADM to then go and write a statement of the events that occurred as well as to inform the charge nurse.</p> <p>During a phone interview on 01/22/2024 at 1:00 PM with the ADM, when asked why CNA A was allowed to finish her shift, he stated that at that point in time and after getting [CNA A's] statement it was unclear whether [the alleged abuse] was incidental or intentional, he had no concern about other residents being harmed at that time. CNA A had spoken with the charge nurse and there was no concern. CNA A was moved out of the MC unit and allowed to finish the remainder of her shift working another hall of the facility. CNA A was terminated the next day.</p> <p>During a phone interview on 01/22/2025 at 1:41 PM with the NP she stated that she expected facilities to immediately suspend an employee who had abused a resident and report it to HHSC. She stated that you can never tell if it could happen again. If the perpetrator were to stay working with the resident it could get worse for the resident.</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy dated last revised 01/08/2023 reflected the following:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.</p> <p>Protection of Resident</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/22/25 The Adm initiated an in-service with the facility management staff on expectations to assure residents safety, abuse and neglect policy and reporting incidents immediately, this includes removing/suspending any staff members involved with any allegations or suspicion of abuse. Any staff member not present during initial in-servicing/training will not be allowed to assume their duties until in-service. Ongoing In-service will be completed by IDON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Comprehension was verified by successfully completing a questionnaire on the subject. Completed 1/23/25</p> <p>4. On 1/22/25 The facility Adm/IDON/Designee initiated an in-service with the staff on the corporate compliance hot line to report unusual events. Comprehension was verified by successfully completing a questionnaire on the subject. Completed 1/23/25</p> <p>5. On 1/22/25 The facility Adm/DON/Designee initiated in-service with the facility staff on Abuse and Neglect focusing on ensuring residents safety and immediately reporting suspected abuse or neglect to the abuse prevention coordinator and or the corporate compliance hot line. The Abuse prevention coordinator contact information is posted throughout the facility. The abuse prevention coordinator will suspend, investigate, rule out, or report any allegation of abuse and neglect within the allotted time frame. Comprehension was verified by successfully completing a questionnaire on the subject, Completed 1/23/25.</p> <p>Ongoing Projected completion 1/23/25.</p> <p>Any staff member not present during initial in-servicing/training will not be allowed to assume their duties until in-service. Ongoing In-service will be completed by IDON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed.</p> <p>Monitoring</p> <p>1. The facility IDT conduct residents Angel Rounds at least 5xweek to ensure residents do not have unknown safety concerns. Any concerns will be reported to the Adm/Designee immediately for proper follow up. VP of Ops and/or Regional Nurse will provide additional oversight to ensure steps are completed. On going 1/22/25.</p> <p>2. On 1/22/23 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 1/23/25.</p> <p>3. On 1/22/25 An impromptu QAPI meeting was conducted with the facility's Medical Director to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on 1/22/25.</p> <p>The surveyor monitored the POR on 01/23/2025 as followed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Regent Care Center of Woodway		STREET ADDRESS, CITY, STATE, ZIP CODE  7801 Woodway Dr Waco, TX 76712	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interviews on 01/23/2025 from 3:55pm-4:20pm with 3 alert and oriented residents revealed they had recently had communication with management regarding their satisfaction with living at the facility and that they have no concerns about their safety, the staff that provide their daily care, or the management at the facility.</p> <p>During interviews on 01/23/2025 from 4:30pm -5:20pm 3 CNA's, 1 LVN, and 1 CMA (from all 3 shifts) all stated they were in-serviced before starting their shift on 01/23/2025 and then given questionnaires to complete to verify their knowledge. All were able to state that their abuse coordinator was the ADM, if he were not available, they were to notify the ADON, IDON, or charge nurse. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting abuse the first time they see or hear it. All know where the corporate compliance hotline number is posted and know when to contact if needed.</p> <p>Interview with the ADM on 1/23/2025 at 5:10pm, he stated he was in-serviced one-on-one with the VPO regarding the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and that he is to notify the VPO anytime an allegation is made of ANE. The ADM stated that all employees will be in-serviced before the start of their next shift. The ADM also stated that CNA A was terminated on 1/6/2025.</p> <p>Review of skin assessments dated 1/22/2025-1/23/2025 of all residents revealed no new skin issues/concerns.</p> <p>Review of one-on-one in-service dated 1/22/2025 titled Health and Human Services Reportable Guidelines presented by the VPO to the ADM revealed he went over review of the facility abuse, neglect, and exploitation policy. Included a review of policy section III. Prevention of abuse, neglect, and exploitation, and section VI. Investigation of alleged abuse, neglect and exploitation and section VII. Protection of resident.</p> <p>Review of in-service dated 1/22/2025 titled 'Abuse and Neglect policy: prevention and reporting' was provided by the ADM to department managers.</p> <p>Review of in-service dated 1/22/2025 titled 'Abuse and Neglect policy: It is our policy to ensure resident safety and immediately report suspected abuse or neglect to the abuse coordinator', and listed the ADM's telephone number, was provided to direct care staff.</p> <p>Review of in-service dated 1/22/2025 titled 'Company Compliance Program' revealed information on the company's compliance hotline for employees to contact and was provided to direct care staff.</p> <p>Review of in-service titled 'Angel/Ambassador Rounds Policy' with the policy attached was provided to Angel Round staff members.</p> <p>Review of 'Responsible Party Contact Log' dated week of 1/20/2025 revealed 48 residents' responsible parties were contacted and notes were written regarding complaints/praises/remarks. No notes made regarding suspected abuse/neglect.</p> <p>Review of Safe Surveys dated week of 1/20/2025-1/24/2025 revealed no residents expressing concerns regarding their safety or abusive staff.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of multiple employee Abuse/Neglect and Compliance Questionnaire's dated between 1/22/2025-1/23/2025 revealed staff answered questions based on the in-services provided.</p> <p>Review of QAPI meeting notes dated 1/22/2025 revealed an email from the MD stating his agreement to their path moving forward.</p> <p>The ADM was informed the IJ was removed on 01/23/2025 at 5:15 PM. The facility remained out of compliance at a severity level of no actual harm and a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47172</p> <p>Based on interview and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported immediately, but not later than 2 hours after the allegation was made for one (Resident #1) of five residents reviewed for abuse and neglect.</p> <p>The facility failed to report alleged violations related to abuse within prescribed timeframes when CNA A witnessed abuse at 11:51 AM on 1/5/2025, did not report it to the ADM until 2:17 PM on 1/5/2025, and the ADM did not report to HHSC until 1/6/2025 at 8:43 PM.</p> <p>This failure placed residents at risk of abuse, trauma, and/or psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #1's Quarterly MDS dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including traumatic brain dysfunction (an injury to the brain caused by external mechanical force), dementia (a group of symptoms affecting memory, thinking, and social abilities), senile degeneration of brain (progressive deterioration of brain tissue and function that occurs beyond what's considered normal aging), and age-related physical debility. Resident #1 had a BIMS score of 00 indicating severe cognitive impairment.</p> <p>Review of Resident #1's care plan, dated last reviewed 01/12/2025, reflected she had impaired cognitive function and impaired thought processes with interventions to cue, reorient, and supervise as needed, and to not correct her if she gets confused to reality.</p> <p>Review of Provider Investigation Report Form 3613-A revealed the date reported to HHSC as 1.6.25 and time 8:43 PM, with the date of incident being 1.5.25 and the time of incident as 2:30 PM.</p> <p>Review of video footage provided by the facility with a date/time stamp of 01/05/2025 11:51 am reflected CNA A seated on a bench/table with Resident #1 to her right-side adjusting items on the bench/table. Resident #1 then walked to the front of CNA A and the two appeared to be in conversation. Resident #1 could be seen moving both of her arms while talking and then raised her right arm and slapped CNA A across the right side of her face. CNA A is then seen raising her right arm all the way up and slapping Resident #1 back across the left side of her face and Resident #1 can be seen being turned about 45-degrees due to the slap. After that, Resident #1 and CNA A can be seen in conversation again, and Resident #1 turns to walk to her left when CNA A grabbed the back of Resident #1's shirt and pulled toward her, making Resident #1 fall into a seated position to the right side of CNA A on the bench/table.</p> <p>During a phone interview on 01/22/2025 at 12:47 PM with CNA B, she revealed from her phone log that she called the ADM on 01/05/2025 at 2:17 PM to notify him of the alleged abuse of Resident #1 by CNA A that happened earlier that day at 11:51 AM. CNA B was instructed by the ADM to then go and write a statement of the events that occurred as well as to inform the charge nurse. CNA A stated she had to ask 2 coworkers what she needed to do in this situation because she had never experienced something like that before.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 01/22/2024 at 1:00 PM with the ADM, when asked why CNA A was allowed to finish her shift, he stated that at that point in time and after getting [CNA A's] statement it was unclear whether [the alleged abuse] was incidental or intentional, he had no concern about other residents being harmed at that time. CNA A had spoken with the charge nurse and there was no concern. CNA A was moved out of the MC unit and allowed to finish the remainder of her shift working another hall of the facility. CNA A was terminated the next day.</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy dated last revised 01/08/2023 reflected the following:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.</p> <p>Reporting</p> <p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172</b></p> <p>Based on interview and record review, the facility failed to, in response to allegations of abuse, prevent further potential abuse for one (Resident #1) of five residents reviewed for abuse and neglect while the investigation of alleged abuse was in progress.</p> <p>The facility failed to ensure CNA A was suspended/terminated or removed from working with all residents while the investigation of alleged abuse was ongoing. CNA A was moved to another wing to continue the remainder of her shift working with other residents for approximately 10 additional hours on the day she slapped a resident in the memory care unit.</p> <p>An Immediate Jeopardy (IJ) was identified on 01/22/2025. The IJ template was provided to the facility on [DATE] at 5:43 PM. While the IJ was removed on 01/23/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on abuse/neglect.</p> <p>This failure placed residents at risk of abuse, trauma, and/or psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #1's Quarterly MDS dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including traumatic brain dysfunction (an injury to the brain caused by external mechanical force), dementia (a group of symptoms affecting memory, thinking, and social abilities), senile degeneration of brain (progressive deterioration of brain tissue and function that occurs beyond what's considered normal aging), and age-related physical debility. Resident #1 had a BIMS score of 00 indicating severe cognitive impairment.</p> <p>Review of Resident #1's care plan, dated last reviewed 01/12/2025, reflected she had impaired cognitive function and impaired thought processes with interventions to cue, reorient, and supervise as needed, and to not correct her if she gets confused to reality.</p> <p>Review of a witness statement, dated 1/5/2025 and documented by CNA B, reflected the following: I witnessed [Resident #1] coming up to [CNA A] and hit her in the face [CNA A] slapped [Resident #1] on the left cheek and [Resident #1] sat by her afterwards. I went to the restroom afterwards came back got the administrators number called then went to inform the nurse. I did ask 2 coworkers on what to do I've never experienced situation before.</p> <p>Review of written statement dated 1/5/25 and documented by CNA A, reflected the following: I was sitting on the brown table when [Resident #1] walked up to me and started talking to me from there she slapped me in my face from there I did reach and pushed her back with my hand in her face. Just to make myself clear I did not slap the resident on the face I put my heel of my hand on her left cheek and pushed her back. When I realized I may contact with her I apologized to the resident.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of video footage provided by the facility with a date/time stamp of 01/05/2025 11:51 am reflected CNA A seated on a bench/table with Resident #1 to her right-side adjusting items on the bench/table. Resident #1 then walked to the front of CNA A and the two appeared to be in conversation. Resident #1 could be seen moving both of her arms while talking and then raised her right arm and slapped CNA A across the right side of her face. CNA A is then seen raising her right hand all the way up and slapping Resident #1 back across the left side of her face and Resident #1 can be seen being turned about 45-degrees due to the slap. After that Resident #1 and CNA A can be seen in conversation again, and Resident #1 turns to walk to her left when CNA A grabbed the back of Resident #1's shirt and pulled toward her, making Resident #1 fall into a seated position to the right side of CNA A on the bench/table.</p> <p>Review of CNA A's time stamp card dated 01/05 revealed she clocked in at 06:02 AM and clocked out at 10:04 PM, working a total of 16.03 hours.</p> <p>During a phone interview on 01/22/2025 at 12:37 PM with RN A she stated that she was the charge nurse during the morning of 01/05/2025 and that CNA A did not tell her that she had slapped Resident #1 back. It was not until after CNA B contacted the ADM and then went to speak with RN A that she was notified that CNA A had slapped the resident. She stated that after she was informed by CNA B she immediately went to go assess Resident #1.</p> <p>During a phone interview on 01/22/2025 at 12:47 PM with CNA B, she revealed from her phone log that she called the ADM on 01/05/2025 at 2:17 PM to notify him of the alleged abuse of Resident #1 by CNA A that happened earlier that day at 11:51 AM. CNA B was instructed by the ADM to then go and write a statement of the events that occurred as well as to inform the charge nurse.</p> <p>During a phone interview on 01/22/2025 at 1:00 PM with the ADM, when asked why CNA A was allowed to finish her shift he stated that at that point in time and after getting [CNA A's] statement it was unclear whether [the alleged abuse] was incidental or intentional, he had no concern about other residents being harmed at that time. CNA A had spoken with the charge nurse and there was no concern. CNA A was moved out of the MC unit and allowed to finish the remainder of her shift working another hall of the facility. CNA A was terminated the next day.</p> <p>During a phone interview on 01/22/2025 at 1:41 PM with the NP she stated that she expected facilities to immediately suspend an employee who had abused a resident and report it to HHSC. She stated that you can never tell if it could happen again. If the perpetrator were to stay working with the resident it could get worse for the resident.</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy dated last revised 01/08/2023 reflected the following:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.</p> <p>Protection of Resident</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.</p> <p>Investigation of Alleged Abuse, Neglect and Exploitation</p> <p>12. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p> <p>The DON, ADON, and ADM were notified on 01/22/2025 at 5:43 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.</p> <p>The following POR was accepted on 01/23/2025 at 5:15 PM:</p> <p>PLAN OF REMOVAL</p> <p>Name of facility: [name of facility]</p> <p>Date: 1/22/25</p> <p>F 610 -Problem: The facility failed to prevent further potential abuse while the investigation was in progress. Resident #1 Was immediately assessed by the nurse without noted injuries Remains in the facility in stable condition.</p> <p>Immediate action:</p> <p>1. On 1/22/25 The facility IDON/ADON/Designee immediately initiated skin assessments to ensure no s/s of physical injuries were present in all residents currently residing at the facility- no issues noted. Completed 1/23/25</p> <p>2. On 1/22/25 The facility Adm/IDON/Designee initiated Life safety rounds with interviewable residents, Interviews revealed no new negative events. Completed 1/23/25.</p> <p>3. On 1/22/25 The VPO conducted a 1:1 in-service with the facility administrator on the company abuse and neglect policy focusing on immediately suspending employees pending allegations of abuse and neglect. This included returned verbalized understanding of the process. This was documented on a signed in-service sheet. Any reportable incidents will also be reported to the corporate VP of Operation and or VP of Clinical to ensure an appropriate investigation, interventions and follow-up takes place. Any issues identified with this process will be addressed through further education and or disciplinary action.</p> <p>Interventions</p> <p>4. On 1/22/25 The Adm initiated an in-service with the facility management staff on expectations to assure residents safety, abuse and neglect policy and reporting incidents immediately, this includes removing/suspending any staff members involved with any allegations or suspicion of abuse. Comprehension was verified by successfully completing a questionnaire on the subject</p> <p>Completed 1/23/25</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5. On 1/22/25 The facility Adm/IDON/Designee initiated an in-service with the staff on the corporate compliance hot line to report unusual events. Comprehension was verified by successfully completing a questionnaire on the subject Completed 1/23/25.</p> <p>6. On 1/22/25 The facility Adm/DON/Designee initiated in-service with the facility staff on Abuse and Neglect focusing on ensuring residents safety and immediately reporting suspected abuse or neglect to the abuse prevention coordinator and or the corporate compliance hot line. The Abuse prevention coordinator contact information is posted throughout the facility. The abuse prevention coordinator will suspend, investigate, rule out, or report any allegation of abuse and neglect within the allotted time frame. Comprehension was verified by successfully completing a questionnaire on the subject Completed 1/23/25.</p> <p>Ongoing Projected completion 1/23/25.</p> <p>Any staff member not present during initial in-servicing/training will not be allowed to assume their duties until in-service. Ongoing In-service will be completed by IDON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed.</p> <p>Monitoring</p> <p>1. The facility IDT conduct residents Angel Rounds at least 5xweek to ensure residents do not have unknown safety concerns. Any concerns will be reported to the Adm/Designee immediately for proper follow up. VP of Ops and/or Regional Nurse will provide additional oversight to ensure steps are completed On going 1/22/25.</p> <p>2. On 1/22/23 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 1/23/25.</p> <p>3. On 1/22/25 An impromptu QAPI meeting was conducted with the facility's Medical Director to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on 1/22/25.</p> <p>The surveyor monitored the POR on 01/23/2025 as followed:</p> <p>During interviews on 01/23/2025 from 4:30pm -5:20pm 3 CNA's, 1 LVN, and 1 CMA (from all 3 shifts) all stated they were in-serviced before starting their shift on 01/23/2025 and then given questionnaire's to complete to verify their knowledge. All were able to state that their abuse coordinator was the ADM, if he were not available, they were to notify the ADON, IDON, or charge nurse. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting abuse the first time they see or hear it. All know where the corporate compliance hotline number is posted and know when to contact if needed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interviews on 01/23/2024 from 3:55pm-4:20pm with 3 alert and oriented residents revealed they had recently had communication with management regarding their satisfaction with living at the facility and that they have no concerns about their safety, the staff that provide their daily care, or the management at the facility.</p> <p>During interviews on 01/23/2025 from 4:30pm -5:20pm 3 CNA's, 1 LVN, and 1 CMA (from all 3 shifts) all stated they were in-serviced before starting their shift on 01/23/2025 and then given questionnaires to complete to verify their knowledge. All were able to state that their abuse coordinator was the ADM, if he were not available, they were to notify the ADON, IDON, or charge nurse. They were all able to give examples of physical, verbal, and emotional abuse. All expressed the importance of reporting abuse the first time they see or hear it. All know where the corporate compliance hotline number is posted and know when to contact if needed.</p> <p>Interview with the ADM on 1/23/2025 at 5:10pm, he stated he was in-serviced one-on-one with the VPO regarding the timeliness of reporting alleged abuse to HHSC (within 2 hours of the alleged abuse), keeping residents safe, prevention of abuse, and that he is to notify the VPO anytime an allegation is made of ANE. The ADM stated that all employees will be in-serviced before the start of their next shift.</p> <p>Review of skin assessments dated 1/22/2025-1/23/2025 of all residents revealed no new skin issues/concerns.</p> <p>Review of one-on-one in-service dated 1/22/2025 titled Health and Human Services Reportable Guidelines presented by the VPO to the ADM revealed he went over review of the facility abuse, neglect, and exploitation policy. Included a review of policy section III. Prevention of abuse, neglect, and exploitation, and section VI. Investigation of alleged abuse, neglect and exploitation and section VII. Protection of resident.</p> <p>Review of in-service dated 1/22/2025 titled 'Abuse and Neglect policy: prevention and reporting' was provided by the ADM to department managers.</p> <p>Review of in-service dated 1/22/2025 titled 'Abuse and Neglect policy: It is our policy to ensure resident safety and immediately report suspected abuse or neglect to the abuse coordinator', and listed the ADM's telephone number, was provided to direct care staff.</p> <p>Review of in-service dated 1/22/2025 titled 'Company Compliance Program' revealed information on the company's compliance hotline for employees to contact and was provided to direct care staff.</p> <p>Review of in-service titled 'Angel/Ambassador Rounds Policy' with the policy attached was provided to Angel Round staff members.</p> <p>Review of 'Responsible Party Contact Log' dated week of 1/20/2025 revealed 48 residents' responsible parties were contacted and notes were written regarding complaints/praises/remarks. No notes made regarding suspected abuse/neglect.</p> <p>Review of multiple employee Abuse/Neglect and Compliance Questionnaire's dated between 1/22/2025-1/23/2025 revealed staff answered questions based on the in-services provided.</p> <p>(continued on next page)</p>		

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  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Regent Care Center of Woodway		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of QAPI meeting notes dated 1/22/2025 revealed an email from the MD stating his agreement to their path moving forward.</p> <p>The ADM was informed the IJ was removed on 01/23/2025 at 5:15 PM. The facility remained out of compliance at a severity level of no actual harm and a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		