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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676160 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/16/2024 |
| NAME OF PROVIDER OR SUPPLIER Regent Care Center of Kingwood | | STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572</p> <p>Based on interviews, observations, and record review, the facility failed to ensure residents were provided with a reasonable accommodation to access the ability to call for staff assistance through a communication system for one of twenty-four (Resident #79) reviewed for call system placement.</p> <p>-Resident #79's call light cord was wrapped around the call light base on the wall in an area inaccessible to the resident.</p> <p>This failure could place this resident or other residents at risk for not having their call light answered timely in an emergency and staff not being aware of an emergency situation for an extended period of time, injury, or death.</p> <p>Findings include:</p> <p>Record review of Resident #79's face sheet revealed a [AGE] year-old man admitted on [DATE].</p> <p>Record review of Resident #79's diagnoses detail report dated 5/15/2024 revealed his diagnoses included metabolic encephalopathy (brain disease, damage, or malfunction usually related to inflammation within the body), pulmonary embolism (condition in which one of the pulmonary arteries in the lungs was blocked by a blood clot), type 2 diabetes mellitus (condition resulting from insufficient production of insulin, causing high blood sugar), chronic kidney disease (condition that impairs kidney function), dementia (group of symptoms that affects memory, thinking and interferes with daily life), syncope and collapse (fainting), conversion disorder (mental condition in which a person experiences blindness, paralysis, or other nervous symptoms that cannot be explained by illness or injury) with seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness) or convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement), affective disorder (a set of psychiatric disorders, also called mood disorders), need for assistance with personal care, and anxiety disorder (group of mental illnesses that cause constant fear and worry).</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #79's quarterly MDS dated [DATE] with an ARD of 3/25/2024 revealed a BIMS score was not completed because he was rarely or never understood. The MDS documented he had long and short-term memory problems, and his cognitive skills for daily decision making were severely impaired. Per the MDS, Resident #79 was unable to recall the current season, location of his room, staff names and faces, or that he was in a bed in a nursing facility. The MDS revealed he had no impairment of either his upper or lower extremities, and he used a wheelchair for mobility. The MDS documented he required assistance, or was totally dependent on staff, for all ADL's.</p> <p>Record review of Resident #79's care plan undated care plan revealed a focus on his ADL care need with interventions including placing the call light within reach.</p> <p>Record review of Resident #79's EHR revealed he was receiving wound care daily.</p> <p>Observation on 5/14/2024 at 8:58 AM of Resident #79 revealed he was sleeping in his bed. Resident #79's bed was in a lowered position. Resident #79's call light was not in a position he could reach. The call light was wrapped around the call light station on the wall. There was no means for Resident #79 to get to or press the call button.</p> <p>Interview on 5/14/2024 at 9:00 AM with CNA A, she said a resident's call light should be in a position he/she could reach. CNA A said Resident #79's call light was not in a position he could reach as it was curled around the call light station on the wall. CNA A uncurled the call light cord and placed it on the bed by Resident #79's hand. CNA A said the purpose of a call light was to allow residents to call staff to assist them. CNA A said if a resident did not have access to the call light, he/she may have an emergency such as a fall and not be able to get needed assistance.</p> <p>Interview on 5/14/2024 at 9:22 AM with LVN B, she said the purpose of a call light was to allow residents to call for help. LVN B said if a resident's call light was not within reach, he/she could not call for assistance when needed. LVN B said the staff were to look at the call light placement every two hours. LVN B said a call light should not be wound up and hanging on the wall, in an area inaccessible to a resident. LVN B said if a call light was wound up on the wall, the resident could not call for help in an emergency.</p> <p>Interview on 5/14/2024 at 9:35 AM with the Admin, she said she expected the call lights should be answered timely and placed where the residents can use them. The Admin said a call light wrapped up on the wall, not near a resident, would not meet her expectations. The Admin said the resident could not call for help in an emergency. The Admin said the facility had provided staff with training related to call lights and their placements.</p> <p>Record review of the facility's undated Answering the Call Light policy revealed a policy statement which read The purpose of this procedure is to respond to the resident's requests and needs. The policy documented the call light should be within easy reach of the residents.</p> | | |

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| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722</p> <p>Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorders, intellectual disabilities, or a related conditions for level II resident review upon a significant change in status assessment for 1 of 18 residents (Resident #48) reviewed for PASARR evaluations.</p> <p>The facility failed to refer Resident #48 to the appropriate, State-designated authority when she was diagnosed with delusional disorder (firmly held false beliefs), mood disorder (psychiatric disorders that impact emotions), generalized anxiety disorder (over worry), psychosis (difficulty determining what is real or not), and bipolar disorder (mood disorder with ups and downs).</p> <p>This failure could place residents at risk for not receiving necessary PASARR mental health services, causing a possible decline in mental health.</p> <p>Findings included:</p> <p>Record review of Resident #48's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE], with diagnoses of high blood pressure, high cholesterol, anxiety, depression, psychosis (difficulty determining what is real or not), diabetes (body does not produce enough insulin or resists it), chronic obstructive pulmonary disease (lungs do not get enough oxygen), mood disorder (psychiatric disorders that impact emotions), and chronic back pain.</p> <p>Record review of Resident #48's Admission MDS assessment dated [DATE], revealed a BIMS score of 8 out of 15, which indicated moderately impaired cognition. The assessment revealed the resident was not evaluated by PASRR and did not have a Serious Mental Illness. Under the diagnoses, anxiety and depression were checked. The MDS revealed the resident had been taking antipsychotics and antidepressants.</p> <p>Record review of Resident #48's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 4 out of 15, which indicated severely impaired cognition. The assessment revealed the resident was not evaluated by PASRR and had no Serious Mental Illness. The resident had impairment on one side of her upper and lower extremities and used a wheelchair. She was dependent with toileting hygiene, showers/baths, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. She was always incontinent of bowel and bladder. She had diagnoses of anxiety, depression, and a psychotic disorder. She was taking antipsychotics and antidepressants.</p> <p>(continued on next page)</p> | | |

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| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #48's undated care plan, revealed a Focus: Resident was at risk or potential for anxious/agitation d/t dx: anxiety (Onset: 6/8/23). Goal: Resident would minimize episodes of anxiety daily and ongoing over the next 90 days; AEB: anxiety would not interfere with functional abilities through the next 90 days (Start: 1/12/24, Review: 7/3/24). Interventions: Administered anti-anxiety medications as ordered and reported effects and effectiveness to physician as indicated. Observed resident for episodes of anxiety, such as: excessive worrying, fear, feeling of impending doom, insomnia (trouble sleeping), nausea, palpitation (heart skips a beat) or trembling and implemented interventions as ordered by physician. Focus: Resident was at risk or potential for feeling down, depressed or hopeless d/t dx: depression (Onset: 6/8/23). Goal: Resident would exhibit no signs and symptoms of depression daily and ongoing over the next 90 days (Start: 6/12/23, Review: 7/3/24). Interventions: Administered anti-depression (Zoloft/Trazodone) medication as ordered and reported effects and effectiveness to physician as indicated. Focus: Resident was at risk or potential for behavior's r/t psychosis (difficulty determining what is real or not) with delusions (firmly held false beliefs) and mood disorder, aeb: combative/aggressive behaviors with hx of bipolar (mood disorder with ups and downs) with delusions (firmly held false beliefs) (Onset: 6/16/23). Goal: Resident would minimize episodes of psychosis (difficulty determining what is real or not) with delusions (firmly held false beliefs) daily and ongoing over the next 90 days (Start: 6/12/23, Review: 7/3/24). Interventions: Administered anti-psychotic (Seroquel) medication as ordered and reported effects and effectiveness to physician as indicated. Focus: Resident was at risk for adverse reaction to psychotropic drug use d/t anti-depressant (Zoloft/Trazodone) drug use r/t dx: depression (Onset: 6/8/23). Goal: Resident would have no injury related to antidepressant medication usage/side effects daily and ongoing over the next 90 days (Start: 6/12/23, Review: 7/3/24). Interventions: Administered anti-depression (Zoloft/Trazodone) medication as ordered and reported effects and effectiveness to physician as indicated. Resident was at risk for adverse reaction to psychotropic drug use d/t antipsychotic (Seroquel) drug use r/t dx: psychosis (difficulty determining what is real or not) with delusions (firmly held false beliefs) and mood disorder and dx: bipolar (mood disorder with ups and downs) (Onset: 6/16/23). Goal: Resident would have no injury related to anti-psychotropic medication usage/side effects daily and ongoing over the next 90 days (Start: 6/12/23, Review: 7/3/24). Interventions: Administered anti-psychotic (Seroquel) medication as ordered and reported effects and effectiveness to physician as indicated.</p> <p>Record review of Resident #48's previous hospital records from 6/9/23, revealed she had a history of depression/mood disorder (psychiatric disorders that impact emotions). She was discharged to the facility on antipsychotics and antidepressants.</p> <p>Record review of Resident #48's PASRR Level 1 Screening from 6/12/23 performed by the MDS Coordinator, revealed the resident had no evidence or indication of Mental Illness.</p> <p>Record review of Resident #48's Physician Orders from MD A revealed the following orders:</p> <p>-Trazodone 50mg, 1 PO QHS for insomnia (trouble sleeping). Ordered on 8/9/23 at 2:51pm.</p> <p>-Levetiracetam 250mg, 1 PO BID for psychosis (difficulty determining what is real or not). Ordered on 11/1/23 at 4:45pm.</p> <p>-Sertraline HCL 50mg, 1 PO QD for depression. Ordered on 11/16/23 at 4:59pm.</p> <p>(continued on next page)</p> | | |

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| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Behavioral-Monitor and document any behaviors, every day 6:30am and 6:30pm. Ordered on 1/17/24 at 3:55pm.</p> <p>-Behavioral-Monitor and document and side effects related to use of antipsychotic medication, every day 6:30am and 6:30pm. Ordered on 1/17/24 at 3:56pm.</p> <p>-Behavioral-Monitor and document any side effects related to use of antidepressant medication, every day 6:30am and 6:30pm. Ordered on 1/17/24 at 3:57pm.</p> <p>-Quetiapine Fumarate 300mg, 1 PO QHS for delusional disorders (firmly held false beliefs). Ordered on 2/13/24 at 10:30am.</p> <p>Record review of Resident #48's Psychiatric Initial Assessment from 10/16/23 by NP A, revealed the resident was being treated for Bipolar disorder.</p> <p>Record review of Resident #48's May 2024 MAR revealed she was receiving Sertraline 50mg for depression, Levetiracetam 250mg for psychosis, and Quetiapine Fumarate 300mg for delusional disorders.</p> <p>In an interview with the MDS Coordinator on 5/16/24 at 12:50pm, she said when Resident #48 came to the facility she was on Seroquel for a mood disorder and that was all. She did not think that qualified for a mental disorder. She said she did not receive any of the resident's medical records until a couple months later. She said the hospital's PASRR was negative, so she did not know she needed to do anything else. She did not realize until 5/15/24 when the State Surveyor asked about the PASRR being negative, that she realized the resident had several mental health diagnoses. She said she submitted a new PASRR on 5/15/24 and someone was supposed to come and screen the resident within a few days. She said if the resident was not screened properly, they would fall through the cracks and not get services they might need.</p> <p>Record review of the facility's policy and procedure on Preadmission Screening (PASRR) (version 11/2017) read in part: Our facility will ensure that all new admission are appropriately screened prior to admission to determine that the individual requires nursing facility level of care and to identify any specialized services that may be necessary. The facility does not admit any new resident with serious mental illness or mental retardation unless a preadmission screening has been completed and the state has determined that the facility can supply the care and services appropriate to the resident's condition (and the state will provide any specialized services that are required to treat the special condition). This policy is applicable to all residents [regardless of payor source] being admitted to a nursing facility bed that is certified for Medicare and/or Medicaid. Upon or before application for admission, the admissions coordinator will obtain the following information for each candidate: recent medical history and physical and/or; record of recent or current hospital stay; listing of medications; listing of diagnoses; recent nursing notes .personal information; information regarding payment source. Ensure positive Preadmission PL1s are submitted via state software to the Local Intellectual and Developmental Disability Authority (LIDDA) or Local Mental Health Authority (LMHA) .Review the recommended Specialized Services on the PASRR Evaluation (PE) when an alert is received. Certify the ability to meet the individuals needs on the PL1. Invite LIDDA/LMHA to the PASRR Interdisciplinary Team (IDT) meeting and to all care plan meetings. Finalize Specialized Services to be delivered by the NF and LIDDA/LMHA. Document Specialized Services to be delivered by the NF and LIDDA/LMHA in the resident's comprehensive care plan. Initiate delivery of Specialized Services within 20 business days of the IDT meeting date.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #35) of 18 residents reviewed for quality of care.</p> <p>-LVN M failed to document notification to NP B of Resident #35's blood sugar of 422 on 5/13/24, and failed to document and/or give 10u of Insulin that was ordered by NP B for Resident #35's blood sugar.</p> <p>This failure could place the resident at risk for high blood sugar, and possible hospitalization .</p> <p>Findings include:</p> <p>Record review of Resident #35's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with an original admitted [DATE]. He had diagnoses of Type 2 Diabetes (body does not produce insulin or resists it), benign prostatic hypertrophy (enlarged prostate), cerebrovascular accident (stroke), anxiety, depression, hypertension (high blood pressure), insomnia (trouble sleeping), high cholesterol, constipation, gout (build up of acid in joints), over active bladder, and dysphagia (trouble swallowing).</p> <p>Record review of Resident #35's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15, which indicated normal cognition. The MDS revealed a diagnosis of Diabetes Mellitus (body does not produce insulin or resists it) and confirmed the resident was receiving Insulin injections.</p> <p>Record review of Resident #35's undated care plan revealed a Focus: Resident was at risk or potential for hyper/hypoglycemia (high/low blood sugar) episodes secondary to dx: diabetes mellitus with neuropathy (nerve pain) (Onset: 11/13/20). Goal: Resident would minimize risk for hyper/hypoglycemia (high/low blood sugar) episodes daily and ongoing over the next 90 days (Start: 7/14/23, Review: 7/20/24). Interventions: Assisted with maintaining stable blood sugars; obtained blood sugars as ordered and reported any abnormalities. Assessed response to the Insulin (Lantus/Trulicity) adjustments and reported to Physician; Observed for symptom of hyper/hypoglycemia (high/low blood sugars).</p> <p>Record review of Resident #35's May 2024's blood sugars revealed a blood sugar of 422 (normal is 70-120) on 5/13/24 at 10:55pm, by LVN M.</p> <p>Record review of Resident #35's May 2024 Nurse MAR Notes, revealed on 5/13/24 at 10:57pm LVN M documented she checked off the task of Diabetic: Fingerstick blood sugars every AC/HS, Notify NP if BLOOD SUGARS ARE < 70 or > 120 and that the resident's blood sugar was 422. There was no documentation that she notified the NP or that Insulin was given.</p> <p>Record review of Resident #35's Physician Orders revealed an order from NP B from 11/7/23 at 1:48pm that read:</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Diabetic: Fingerstick blood sugars every AC/HS, Notify NP if BLOOD SUGARS ARE < 70 or > 120. Every day at 7:00am, 12:00pm, 5:00pm, and 8:00pm.</p> <p>Record review of Resident #35's Progress Notes on 5/16/24, revealed there were no notifications to the NP of the blood sugar of 420 on 5/13/24.</p> <p>Record review of Resident #35's Physician Orders and Discontinued Physician Orders on 5/16/24, revealed there were no orders for Insulin on 5/13/24.</p> <p>Interview with NP B on 5/16/24 at 10:00am, she said she entered orders to notify her of blood sugars less than 70 or more than 120 for all of her diabetic residents. She said she expected staff to call her every time that parameter was met. She said she had that order to keep the lines of communication open between the staff and her regarding the resident's blood sugar, so she knew what was going on. She said she received a lot of phone calls, but it did not bother her. She said she also received notifications in person when she was at the facility. NP B said she was pretty sure LVN B called her about Resident #35's blood sugar of 422 but she could not find it in her phone. She said she would have given LVN B orders to give the resident Insulin since his blood sugar was so high.</p> <p>Interview with RN P on 5/16/24 at 10:44am, she said if there was an order with parameters to call the NP if the blood sugar was less than 70 or greater than 120, then they called the NP each time and documented it in the progress notes. She said the NP would usually give orders for Insulin and they would put the order in as a one-time dose. The order and the conversation would be entered in the progress note. She said if the NP was not notified, the resident's blood sugar would remain high and it could cause problems for the resident.</p> <p>Interview with the ADON on 5/16/24 at 1:16pm, she said her expectation was that the staff would call the NP each time the blood sugar was out of range from the order. She said the notification would be entered in the progress notes of the resident and then an order for Insulin would be entered as a one-time order or a PRN order. Per the ADON, she said NP B texted her and informed her that she ordered 10u of Insulin for Resident #35. The ADON said maybe LVN M forgot to put the orders in since there were no orders for the Insulin found in the resident's records. The ADON said if the nurse did not notify the NP, the blood sugar could get too high, and the resident would have to be hospitalized .</p> <p>Interview with Resident #35 on 5/16/24 at 1:35pm, he said he remembered his blood sugar being high a few days back, but he felt okay and did not feel dizzy, shaky, or weak. He did not remember if the nurse gave him insulin or not.</p> <p>A message was left for LVN M on 5/16/24 at 1:40pm, but she did not return the call.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of the facility's Policy and Procedure on Charting and Documentation (no date) read in part: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. All observations, medications administered, services performed, etc., must be documented in the resident's clinical record .All incidents, accidents, or changes in the resident's condition must be recorded .Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: The date and time the procedure/treatment was provided; The name and title of the individual(s) who provided the care; The assessment data and/or any unusual findings obtained during the procedure/treatment .Notification of family, physician or other staff, if indicated .</p> <p>Record review of the facility's Policy and Procedure on Change in a Resident's Condition or Status (Revised May 2017) read in part: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's Attending Physician or physician on call when there has been a(n): .Specific instruction to notify the Physician of changes in the resident's condition .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</p> <p>Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 4 of 8 residents (Resident #68, Resident #18, Resident #25, and Resident #3) reviewed for pharmacy services.</p> <p>-LVN J and LVN C failed to ensure the narcotic count was correct during shift change for Resident #68, Resident #18, Resident #25, and Resident #3.</p> <p>- LVN J failed to document the administration of narcotic medications in a correct manner for Resident #68, Resident #18, Resident #25, and Resident #3.</p> <p>-Staff administered Tramadol 50 mg instead of Tramadol 37.5 mg - Acetaminophen 325 mg as ordered by the Physician to Resident #68 for an unknown period.</p> <p>These failures could place residents at risk for drug diversion and delay in medication administration.</p> <p>Findings include:</p> <p>Resident #68</p> <p>Record review of Resident #68's face sheet dated 5/16/24 revealed an [AGE] year-old male who readmitted on [DATE]. His diagnoses included pain, chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), acute respiratory failure, and type 2 diabetes.</p> <p>Record review of Resident #68's significant change MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. He required supervision from staff with ADL care.</p> <p>Record review of Resident #68's care plan dated 3/26/24 revealed he was a risk for pain. Interventions were to administer pain medication as ordered.</p> <p>Record review of Resident #68's Physician Orders for May 2024 revealed an order for Tramadol 37.5 mg - Acetaminophen 325 mg tablet give 1 tablet twice a day, order date 3/26/24. There were no orders for Tramadol 50 mg.</p> <p>Record review of Resident #68's Nurse MAR for May 2024 revealed Tramadol 37.5 mg - Acetaminophen 325 mg tablet was scheduled for 8:00 a.m. and 8:00 p.m. There was a check mark documented by LVN J on 5/15/24 at 8:00 p.m. that indicated it was administered. Tramadol 50 mg was not listed on Resident #68's MAR.</p> <p>(continued on next page)</p> |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of Resident #68's Controlled Substance Log for Tramadol 50 mg twice a day revealed the last administration documented was on 5/16/24 at 8 a.m. with a quantity of 20 tablets remaining. The previous documentation was on 5/15/24 at 8 a.m. There was no documentation for 5/15/24 at the 8:00 p.m. dose by LVN J.</p> <p>In an observation and interview on 5/16/24 at 12:03 p.m. of Resident #68's Tramadol 50 mg oral tablet (not Tramadol 37.5 mg - Acetaminophen 325 mg as ordered by the Physician) on the 200-hall nurse cart with LVN C revealed there were 19 tablets remaining. LVN C said the night nurse might not have documented the administration of the night dose from 5/15/24 on the narcotic log.</p> <p>Interview on 5/16/24 at 3:26 p.m. LVN C said he was administering the Tramadol 50 mg to Resident #68 instead of the combination medication (Tramadol 37.5 mg - Acetaminophen 325 mg) that was ordered by the MD for a while. He said he did not notice it was a different medication and believed the hospice company made a mistake when assisting with filling the medication. He said the Tramadol 50 mg was the only medication on the nurse cart. He said he should check the MD order and make sure it was the right medication and same milligram.</p> <p>Resident #18</p> <p>Record review of Resident #18's face sheet dated 5/16/24 revealed a [AGE] year-old male who admitted on [DATE]. His diagnoses included nondisplaced fracture shaft of left tibia, osteoarthritis (inflammation of one or more joints), need for assistance with personal care, and pain.</p> <p>Record review of Resident #18's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment.</p> <p>Record review of Resident #18's care plan dated 5/16/24 revealed he was a risk for pain. Interventions were to administer pain (Tylenol #3) medication as ordered.</p> <p>Record review of Resident #18's Physician Orders for May 2024 revealed an order for Acetaminophen (Tylenol)-Codeine #3 every 6 hours as needed for pain, order date 11/8/22.</p> <p>Record review of Resident #18's Nurse MAR for May 2024 revealed Acetaminophen-Codeine #3 was documented as administered by LVN J on 5/15/24 at 10:29 p.m.</p> <p>Record review of Resident #18's Controlled Drug Administration Record for Acetaminophen-Codeine 300-30 mg every 6 hours as needed revealed the last administration documented was on 5/15/24 at 10 a.m. with a quantity of 15 tablets remaining. There was no documentation for 5/15/24 at 10:29 p.m. by LVN J.</p> <p>In an observation and interview on 5/16/24 at 12:12 p.m. of Resident #18's Acetaminophen-Codeine 300-30 mg on the 200-hall nurse cart with LVN C revealed there were 14 tablets remaining on the blister pack. LVN C said the night nurse gave Resident #18 the medication last night (5/15/24) but did not sign the narcotic log. He said he did not notice the discrepancy when he and LVN J counted the narcotics during shift change.</p> <p>Resident #25</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of Resident #25's face sheet dated 5/16/24 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included paraplegia (paralysis of the legs and lower body caused by a problem with the spinal cord or nerves), vascular dementia, and chronic pain syndrome.</p> <p>Record review of Resident #25's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment.</p> <p>Record review of Resident #25's care plan dated 5/16/24 revealed she was at risk for pain. Interventions were to administer pain medication as ordered.</p> <p>Record review of Resident #25's Physician Orders for May 2024 revealed an order for Norco 10-325 mg give 1 tablet every 4 hours as needed for pain, order date 11/8/22.</p> <p>Record review of Resident #25's Nurse MAR for May 2024 revealed Norco 10-325 mg was documented as administered by LVN J on 5/15/24 at 11:08 p.m.</p> <p>Record review of Resident #25's Controlled Drug Administration Record for Hydrocodone-APAP (Norco) 10-325 mg as needed revealed the last administration documented was on 5/14/24 at 8 p.m. with a quantity of 57 tablets remaining. There was no documentation for 5/15/24 at 11:08 p.m. by LVN J.</p> <p>In an observation and interview on 5/16/24 at 12:16 p.m. of Resident #25's Norco 10-325 mg on the 200-hall nurse cart with LVN C revealed there were 56 tablets remaining on the blister pack. LVN C said the night gave Resident #25 the medication last night (5/15/24) but did not sign the narcotic log.</p> <p>Resident #3</p> <p>Record review of Resident #3's face sheet dated 5/16/24 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included cerebral infarction (stroke), pain disorder exclusively related to psychological factors (mental and emotional aspects that affect our behavior, health, and personality), hypertension (high blood pressure), and pain.</p> <p>Record review of Resident #3's annual MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #3's care plan dated 2/12/24 revealed she was at risk for pain. Interventions were to administer pain medication as ordered.</p> <p>Record review of Resident #3's Physician Orders for May 2024 revealed an order for Tramadol 50 mg give 1 tablet as needed every 6 hours, order date 5/16/24. There were no additional Tramadol orders listed prior to 5/16/24.</p> <p>Record review of Resident #3's Nurse MAR for May 2024 revealed Tramadol 50 mg had an order and start date of 5/16/24. There was no documentation of administration from 5/1/24 - 5/15/24.</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of Resident #3's Controlled Drug Administration Record for Tramadol 50 mg 1 tablet by mouth every 6 hours as needed revealed Tramadol was documented as administered on 5/3/24 at 8 p.m. and 5/13/24 at 8 p.m. The last administration documented was on 5/14/24 at 8 p.m. with a quantity of 13 tablets remaining.</p> <p>In an observation on 5/16/24 at 12:23 p.m. of Resident #3's Tramadol 50 mg on the 200-hall nurse cart with LVN C revealed there were 12 tablets remaining on the blister pack.</p> <p>In a telephone interview on 5/16/24 at 12:17 p.m. LVN J said she worked on 5/15/24 from 6 p.m. - 6 a.m. She said she recalled administering the narcotic medications to Resident #68, Resident #18, Resident #25, and Resident #3 but may have forgotten to sign it on the narcotic sheet. She said she normally signed on the narcotic sheet when she administered the medication. She said she and LVN C conducted the narcotic count during shift change this morning, 5/16/24 and did not recall any discrepancies. She said it was important to ensure accuracy of the narcotics to verify if a pill was missing or administered. She said any discrepancies would be reported to the DON.</p> <p>Interview on 5/16/24 at 12:35 p.m. LVN C said LVN J was in a hurry this morning, 5/16/24 while doing narcotic counts during shift change. He said that may be the reason Resident #68, Resident #18, Resident #25, and Resident #3's narcotic count was not accurate. He said he was responsible for ensuring the narcotics were accurate. He said when administering narcotic medication, he should document on the computer and on the narcotic log after administering the medication to ensure nothing is missed.</p> <p>Interview on 5/16/24 at 12:58 p.m. the ADON said the off going and on coming nurse should conduct a narcotic count during shift change to ensure the number of pills match the number listed on the narcotic log. She said it was best practice for nursing staff to document on the narcotic sheet as soon as the narcotic was administered. She said if there were any discrepancies, nursing staff should call management.</p> <p>Interview on 5/16/24 at 1:44 p.m. the Administrator said she expected all narcotics to be accounted for.</p> <p>Record review of the facility's undated Controlled Substances policy read in part: .Policy Statement: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled medications. Policy Interpretation and Implementation: .4 . a control sheet must be made for each substance . The record must contain: . c. quantity received; d. number on hand; h. date and time received; i. time of administration . l. signature of nurse administering medication . 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services .</p> | | |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572</p> <p>Based on interviews and record review the facility failed to ensure a psychotropic drug that affects brain activities associated with mental processes and behavior is free from unnecessary drugs for one of five residents (Resident #79) reviewed for unnecessary drugs.</p> <p>-The facility failed to document a correct diagnosis, monitor its effectiveness, and side effects of Seroquel (antipsychotic medication) prescribed for Resident #79.</p> <p>This failure affected one resident and placed him at risk of receiving unnecessary medications.</p> <p>Findings include:</p> <p>Record review of Resident #79's face sheet revealed a [AGE] year-old man admitted on [DATE].</p> <p>Record review of Resident #79's diagnoses detail report dated 5/15/2024 revealed his diagnoses included: dementia (group of symptoms that affects memory, thinking, and interferes with daily life), affective disorder (a set of psychiatric disorders, also called mood disorders), and anxiety disorder (group of mental illnesses that cause constant fear and worry).</p> <p>Record review of Resident #79's quarterly MDS dated [DATE] with an ARD of 3/25/2024 revealed a BIMS score was not completed because he was rarely or never understood. The MDS documented he had long and short-term memory problems, and his cognitive skills for daily decision making was severely impaired. Per the MDS, Resident #79 was unable to recall the current season, location of his room, staff names and faces, or that he was in a bed in a nursing facility. The MDS revealed he had no impairment of either his upper or lower extremities, and he used a wheelchair for mobility. The MDS documented he required assistance, or was totally dependent on staff, for all ADL's. Per the MDS, Resident #79 had been administered injectable insulin and antipsychotic medications. The MDS revealed a GDR was attempted on 12/28/2023.</p> <p>Record review of Resident #79's undated care plan revealed a focus on his depression with interventions including monitoring for adverse medication reactions, medication administration, and monitoring for signs and symptoms of depression. The care plan included a focus on Resident #79's psychotropic medication use with interventions including medication administration and monitoring for signs and/or symptoms of adverse drug reactions.</p> <p>Record review of Resident #79's orders report dated 5/15/2024 revealed prescriptions included:</p> <p>-Seroquel 100mg tablet one tablet twice daily for dementia,</p> <p>Record review of Resident #79's May 2024 CMA MAR documented he was administered a 100mg tablet of Seroquel at 8:00 AM and 8:00 PM daily from 5/1/2024 through 5/14/2024 and at 8:00 AM on 5/15/2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #79's MRR dated 1/29/2024 revealed he was admitted on /or had a new order for Seroquel. The MRR documented the medication should be prescribed for an appropriate psychiatric diagnosis.</p> <p>Record review of Resident #79's Consultant Pharmacist's MRR dated between 3/1/2024 and 3/21/2024 revealed he had a prescription for the antipsychotic medication Seroquel 100mg twice daily for dementia. The MRR documented the medication required an appropriate psychiatric diagnosis for long-term therapy.</p> <p>Record review of Resident #79's note to the attending physician/prescriber dated 3/22/2024 revealed he had a prescription for the antipsychotic medication Seroquel 100mg twice daily for dementia. The note documented the medication required an appropriate psychiatric diagnosis for long-term therapy. The note was signed by his NP.</p> <p>Observation on 5/14/2024 at 8:58 AM of Resident #79 revealed he was sleeping in his bed. Resident #79's bed was in a lowered position.</p> <p>Telephone call on 5/16/2024 at 9:55 AM from NP A, she said she was the consultant pharmacist and she recommended that Resident #79's Seroquel prescription have an appropriate psychiatric diagnosis, not the current dementia diagnosis as Seroquel was not appropriate for dementia. NP A said Resident #79's Seroquel was prescribed for his delusion disorder and not for his dementia. NP A said resident #79's prescription should be altered to identify the delusion disorder not the dementia. NP A said the prescription was not correct in identifying the underlying diagnosis of dementia.</p> <p>Interview on 5/16/2024 at 10:13 AM with the ADON revealed when the facility received recommendations from the pharmacist consultant, they would contact the physician to determine if he/she agreed with the recommendation. The ADON said if the physician agreed, the facility had seventy-two hours to complete the recommendations. The ADON said if a resident's recommendation was to have the underlying diagnosis changed the facility would change the diagnosis in the EHR. The ADON said Resident #79's underlying diagnosis of dementia for his Seroquel prescription should have been altered in March of 2024 when the recommendation was agreed to by the physician. The ADON said Resident #72 had an underlying diagnosis of bipolar disorder with delusions and he required the Seroquel. The ADON said she had just changed the underlying diagnosis as recommended by the pharmacist and agreed to by the physician. The ADON said she did not know why the underlying diagnosis was not changed previously when the recommendation was made. The ADON said the facility completed audits continuously on psychotropic medications to ensure appropriate administration and diagnoses. The ADON said there would have been no negative outcomes with the diagnosis not being changed. The ADON said the prescription needed to be changed as Seroquel was inappropriate for dementia, but it was appropriate for bipolar disorder.</p> <p>Record review of the facility's Medication Regimen Reviews policy dated April 2007 revealed a policy statement which read The Consultant Pharmacist shall review the medication regimen of each resident at least monthly. The policy documented the pharmacist would identify medication errors, including those related to documentation.</p> | | |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 11% based on 3 errors out of 27 opportunities, which involved 2 of 7 residents (Residents #2 and #59) reviewed for medication errors.</p> <p>-LVN N did not administer the full dose of Lacosamide (a medication used to prevent and control seizures) to Resident #59 until State Surveyor intervention.</p> <p>-MA V administered Sucralfate (a medication used to treat and prevent ulcers in the intestines) to Resident #2 at 9:06 a.m. instead of 6:30 a.m. as scheduled and did not administer Lexapro (a medication used to treat depression and anxiety) to Resident #2 as ordered by the Physician.</p> <p>These failures could place residents at risk of inadequate therapeutic outcomes.</p> <p>Findings include:</p> <p>Resident #59</p> <p>Record review of Resident #59's face sheet dated 5/16/24 revealed a [AGE] year-old female readmitted on [DATE]. Her diagnoses included urinary tract infection, Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), end stage renal disease, and hypertension (high blood pressure).</p> <p>Record review of Resident #59's quarterly MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were severely impaired-never/rarely made decisions. She was dependent on staff for ADL care.</p> <p>Record review of Resident #59's care plan dated 4/28/24 revealed she was at risk for injury related to seizure disorder. The intervention was to administer anticonvulsant medication as ordered.</p> <p>Record review of Resident #59's Physician Orders for May 2024 revealed an order for Lacosamide 10 mg/mL administer 10 mL via feeding tube (a way to deliver liquid nutrition through a flexible tube to your digestive system) 8 a.m., 8 p.m. every day.</p> <p>(continued on next page)</p> |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an observation and interview on 5/16/24 at 8:55 a.m. with LVN N revealed she prepared Resident #59's Lacosamide 10 mL liquid, Cinacalcet 30 mg tablet, and Nephro 1 tablet. She crushed the tablets individually and prepared to administer the medication via feeding tube. She flushed Resident #59's tube with 30 cc of water. Next, she administered via feeding tube a water flush, medication, water flush, approximately 5 ml of Lacosamide liquid, water flush, medication, and the final water flush. There was approximately 5 mL of Lacosamide liquid remaining in the medication cup. LVN N connected Resident #59's feeding tube back to the formula and turned the pump on. LVN N said she was done (administering the medication) and began to clean up the bedside tray. This State Surveyor asked LVN N about the liquid that remained in the medication cup. LVN N said it was Lacosamide liquid and was able to identify it because of the thick consistency. She said there was approximately 2.5 mL to 5 mL remaining in the cup and said she would administer the rest to Resident #59. LVN N administered the remaining Lacosamide to Resident #59.</p> <p>Interview on 5/16/24 at 9:14 a.m. LVN N said she did not administer all the Lacosamide to Resident #59 because she did not have her glasses on. She said she did not realize some medication was remaining in the cup until this State Surveyor alerted her. She said she had to look to ensure all medication was given especially since Lacosamide was a narcotic seizure medication. She said if Resident #59 did not receive all her medication she could have a seizure.</p> <p>Interview on 5/16/24 at 10:34 a.m. the ADON said nursing staff should ensure all medication was given. She said Resident #59 not receiving all her medication was not good. She said the facility did a feeding tube medication administration competency check initially, yearly, and as needed.</p> <p>Resident #2</p> <p>Record review of Resident #2's face sheet dated 5/16/24 revealed a [AGE] year-old female readmitted on [DATE]. Her diagnoses included polyneuropathy (damage to multiple peripheral nerves), major depressive disorder, and generalized anxiety disorder.</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15 which indicated intact cognition. She required supervision to maximal assistance from staff with ADLs.</p> <p>Record review of Resident #2's care plan dated 1/5/24 revealed she was at risk for GI (gastrointestinal) complications related to the diagnosis of GERD (a common condition in which the stomach contents move up into the esophagus) such as: belching, indigestion, esophageal/tooth erosion, and/or bad chest discomfort. She received antidepressant medication and was at risk for side effects. Interventions were to administer medications as ordered.</p> <p>Record review of Resident #2's Physician Orders for May 2024 revealed an order Carafate (Sucralfate) 1 gram: give 1 tablet by mouth at 6:30 a.m., 11:30 a.m., and 4:30 p.m. every day for gastro-esophageal reflux disorder with esophagitis (inflammation of the esophagus) without bleed, order date 1/8/24. Lexapro (Escitalopram) 5 mg 8:00 a.m. in the morning every day, order date 4/9/24.</p> <p>Record review of Resident #2's MAR for May 2024 revealed Carafate (Sucralfate) 1 gm was scheduled for three times per day at 6:30 a.m., 11:30 a.m., and 4:30 p.m. Lexapro (Escitalopram) 5 mg was scheduled for 8:00 a.m. every day. There was a N documented for Lexapro (Escitalopram) on 5/15/24 at the 8:00 a.m. scheduled time by MA V. The N indicated Not Administered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an observation and interview on 5/15/24 at 9:06 a.m. with MA V revealed she prepared Resident #2's morning medications for administration. She prepared and administered Carafate (Sucralfate) 1 gm - 1 tablet. The eMAR indicated the Carafate (Sucralfate) was scheduled for 6:30 a.m. and the caution label on the Carafate (Sucralfate) blister pack read to give before meals. She also prepared and administered Gabapentin 600 mg, Furosemide 20 mg, Pantoprazole 40 mg, Potassium ER 10 mEq, Loratadine 10 mg, Senna, Dicyclomine 20 mg, and Fluticasone nasal spray. She did not administer Lexapro (Escitalopram) 5 mg to Resident #2. She said she did not have Resident #2's Lexapro (Escitalopram) on the cart and would notify her nurse.</p> <p>Interview on 5/15/24 at 9:15 a.m. LVN F said the Pyxis machine (an automated medication dispenser) did not have Resident #2's Lexapro (Escitalopram) and he would notify the pharmacy to send it to the facility stat (immediately).</p> <p>Interview on 5/15/24 at 9:30 a.m. MA V said Resident #2's Carafate (Sucralfate) was supposed to be given before breakfast but was unsure why. She said her shift started at 8:00 a.m. and she had two halls of residents to administer medications to. She said nursing staff should know the medication was not being administered before breakfast.</p> <p>Interview on 5/16/24 at 10:29 a.m. the ADON said medication should be available because the resident needed it and staff should reorder the medication 7 days ahead of time. She said Lexapro (Escitalopram) was used for depression and was unsure if Resident #2 would experience any negative effects from missing one dose. She said Carafate (Sucralfate) was used to coat the stomach and should be given before meals. She said she was unsure of any negative effects that Resident #2 could experience. She said the first morning dose (6:30 a.m.) of Sucralfate should be moved to the nurses' cart.</p> <p>Interview on 5/16/24 at 11:31 a.m. MA V said Resident #2's Lexapro (Escitalopram) arrived from the pharmacy late yesterday (5/15/24) and she did not administer it to her.</p> <p>In an interview on 5/16/24 at 1:44 p.m. the Administrator said she expected medication to be administered correctly and according to the MD order.</p> <p>Record review of the facility's Administering Medications policy dated December 2012 read in part, . Medications shall be administered in a safe and timely manner, and as prescribed . 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676160 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/16/2024 |
| NAME OF PROVIDER OR SUPPLIER Regent Care Center of Kingwood | | STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339 | |
| 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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722</p> <p>Based on interviews, observations, and record reviews, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 2 (Resident #48 and Resident #63) of 18 residents reviewed for accurate medical records.</p> <p>-The facility failed to update Resident #48's oxygen order to PRN instead of continuous, when she no longer wore it.</p> <p>-The facility failed to order Resident #63's oxygen, when he was on it continuously.</p> <p>This failure could place residents at risk of receiving unnecessary oxygen or the wrong amount of oxygen.</p> <p>Findings include:</p> <p>Resident #48</p> <p>Record review of Resident #48's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE], with diagnoses of high blood pressure, high cholesterol, aphasia (trouble speaking), cerebrovascular accident (stroke), seizures, diabetes (body does not produce enough insulin or resists it), anxiety, depression, chronic obstructive pulmonary disease (lungs do not get enough oxygen), respiratory failure (lungs stop working), mood disorder, and chronic back pain.</p> <p>Record review of Resident #48's Annual MDS assessment dated [DATE], revealed a BIMS score of 4 out of 15, which indicated severely impaired cognition. She had impairment on one side of her upper and lower extremities and used a wheelchair. She was dependent on toileting hygiene, showers/baths, upper/lower dressing, putting on/taking off footwear, and personal hygiene. The MDS revealed she had diagnoses of respiratory failure and COPD (lungs do not get enough oxygen) and was on oxygen.</p> <p>Record review of Resident #48's undated care plan revealed a Focus: Resident was at risk or potential for SOB d/t dx: COPD (lungs do not get enough oxygen) with acute respiratory failure with hypercapnia (not enough oxygen in the blood) with SOB and hx of pneumonia (lung infection) and was receiving oxygen therapy (Onset: 6/9/23). Goal: Resident would minimize episodes of SOB daily and ongoing over the next 90 days (Start: 6/12/23, Review: 7/3/24). Interventions: Administered oxygen therapy as ordered by physician; reported any abnormalities as indicated. Ensured that supply was available at all times and changed tubing per protocol; provided with humidification.</p> <p>Record review of Resident #48's Physician Orders revealed an order from MD A that read:</p> <p>-Administer O2 at 2L/min via nasal cannula continuously, every day. Ordered on 1/17/24 at 3:48pm.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Regent Care Center of Kingwood | | STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339 | |
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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #48's May 2024 Nurse MAR revealed from 5/1/24-5/15/24 from 6am-6pm and from 6pm-6am, it was signed off by nursing staff that the resident was receiving O2 at 2L/min via nasal cannula continuously.</p> <p>In an observation of Resident #48 on 5/14/24 at 9:29am, she was sitting in a wheelchair in her room and did not have any oxygen on. She had no complaints and was breathing fine.</p> <p>Interview and observation of Resident #48 on 5/15/24 at 9:45am, the resident was lying in bed and did not have any oxygen on. The resident said she did not use oxygen and did not need it.</p> <p>Interview with LVN G on 5/16/24 at 10:47am, he said there was discussion a couple days ago about putting an order in to discontinue her oxygen, and there was supposed to be an order to discontinue it. He did not see an order to discontinue the oxygen. He said the Nurse Manager should have discontinued the oxygen order. He said there could be confusion because there were not correct orders in the system.</p> <p>Interview with the ADON on 5/16/24 at 10:55am, she said the nursing staff should have seen there was an order for oxygen, that the resident was not on it, and should have said something. She said the staff should have also seen it when they signed off on the MAR/TAR and said something. However, she was the overarching person who oversaw everything and was ultimately responsible.</p> <p>Resident #63</p> <p>Record review of Resident #63's undated face sheet revealed he was an [AGE] year-old male admitted on [DATE], with diagnoses of Type 2 diabetes (body does not produce insulin or resists it), heart failure (heart does not pump well), depression, high cholesterol, dysphagia (trouble swallowing), and dementia.</p> <p>Record review of Resident #63's Admission MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15, which indicated moderately impaired cognition. The MDS revealed the resident was not using oxygen.</p> <p>Record review of Resident #63's undated care plan revealed a Focus: Resident was at risk or potential for SOB d/t dx: CHF (heart cannot pump fluid out of lungs) with SOB and hx of AKI (acute failure of kidneys), CKD (kidneys stop filtering) and BLE edema (swelling) (Onset: 4/2/24). Goal: Resident would minimize episodes of SOB daily and ongoing over the next 90 days (Start: 4/2/24, Review: 7/16/24). Interventions: Administered oxygen therapy as ordered by physician; reported any abnormalities as indicated; observed/monitored oxygen saturation levels. Monitored vital signs daily and PRN; reported any abnormalities as indicated.</p> <p>Record review of Resident #63's Physician Orders on 5/16/24, revealed no orders for oxygen.</p> <p>Record review of Resident #63's May 2024 MAR-TAR revealed no documentation of oxygen being administered.</p> <p>Interview and observation of Resident #63 on 5/14/24 at 8:57am, he was on 2L O2 via nasal cannula while laying on his back in bed. He said he did not know why he was on oxygen and did not like it being in his nose.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an observation of Resident #63 on 5/15/24 at 9:47am, he was awake sitting up in bed with O2 via nasal cannula on.</p> <p>In an observation of Resident #63 on 5/16/24 at 10:46am, resident had his oxygen via nasal cannula on.</p> <p>Interview and observation with LVN G on 5/16/24 at 10:47am, he confirmed Resident #63 was on oxygen and looked through the resident's chart to see what the settings were. LVN G said he could not find an order for the resident's oxygen. He said there should have been an order for the resident's oxygen, and he did not know why there was not one. He said the resident could have hyperventilated (breathing too fast and getting too much oxygen) if he was getting oxygen and did not need it. He said the Nurse Manager confirmed orders that were entered.</p> <p>Interview with the ADON on 5/16/24 at 10:55am, she said the nursing staff entered orders and they should have seen the resident was on oxygen and there was not an order for it. She said she was the ADON though, so everything fell back on her for ultimately overseeing any mistakes. She said there could be resident's receiving oxygen that did not need it.</p> <p>Record review of the facility's Policy and Procedure on Charting and Documentation (no date) read in part: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. All observations, medications administered, services performed, etc. must be documented in the resident's clinical records. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: The date and time the procedure/treatment was provided; The name and title of the individual(s) who provided the care; The assessment data and/or any unusual findings obtained during the procedure/treatment; How the resident tolerated the procedure/treatment; Whether the resident refused the procedure/treatment; Notification of family, physician or other staff, if indicated; The signature and title of the individual documenting.</p> <p>Record review of the facility's Policy and Procedure on Medication and Treatment Orders (no date) read in part: Orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the orders of a person daily licensed and authorized to prescribe such medications in this state. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to transcribe orders into the electronic medical record. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the Pharmacist on a monthly basis. All drug and biological orders shall be dated, and signed by the person lawfully authorized to give such an order. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order.</p> <p>Record review of the facility's Policy and Procedure on Charting Errors and/or Omissions (Revised December 2006) read in part: Accurate medical records shall be maintained by this facility.</p> | | |