STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675030	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of Laredo	7001 McPherson Rd Laredo, TX 78041

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14408 Based on observation, interview, and record review, the facility failed to provide an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community, for 5 of 7 residents (Residents #17, #19, #26, #33, and #56) reviewed for individual in-room activity programming, as evidenced by: 1. Resident #17 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. 2. Resident #19 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. 3. Resident #26 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. 4. Resident #33 did not have an in-room activity plan developed and implemented to meet his individual interests, abilities, and needs. 5. Resident #56 did not have an in-room activity plan developed and implemented to meet her individual interests, abilities, and needs. This failure could place the residents at risk for isolation, decline in cognitive status, and decreased feelings of well-being within their environment. The findings included: 1. Resident #17 (continued on next page)

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

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident #17's Face Sheet, dated 3/14/2024, revealed an [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: hypertension (high blood pressure); atrial fibrillation (abnormal heartbeat); congestive heart failure (the heart does not pump blood as well as it should and cannot supply enough blood to meet the body's needs); cerebral infarction (stroke); speech and language deficits following cerebrovascular disease (difficulty or not able to speak); chronic obstructive pulmonary disease (lung disorder that affects breathing); hypothyroidism (thyroid disorder); and gastro-esophageal reflux disease (back-up of stomach acid into the throat). Review of Resident #17's Annual MDS Assessment, dated 6/04/23, revealed the BIMS was not able to be completed and the resident had short-term and long-term memory problems. The assessment documented the staff had assessed the resident's activity preferences as listening to music. Review of Resident #17's comprehensive care plan revealed a care plan dated 10/17/23 that documented the resident was unable to participate in activities due to bedrest. The documented goal was for the resident to enjoy individual activities and maintain the highest level of independence daily and ongoing over the next 90 days. The documented approaches were to schedule activities in room daily and to create an activity plan based on the resident's preferences. Review of the Activity Progress Note dated 2/15/24 revealed Resident #17 had attended the valentine party along with her family and everyone was in good spirits. The note documented the resident would continue to be brought to music events. Observation on 3/12/24 at 10:05 AM revealed Resident #17 was lying on her left side in bed with positioning pillows between legs. The resident's feet were swollen. She was using oxygen via nasal cannula and had a feeding tube. Resident #17's eyes were open, and she was making vocal noises and coughing. The head of the bed was elevated. She did not respond verbally when her name was spoken. Observation on 3/12/24 at 4:25 PM revealed Resident #17 was in bed with oxygen in use and the tube feeding infusing via pump. Resident #17 made eye contact but did not speak. In an interview on 3/14/24 at 11:36 AM, the Activity Director stated she talked with Resident #17 in her room and the resident understood. She stated Resident #17 could look at magazines. The Activity Director stated Resident #17 did not verbalize a lot, but she did understand and did try to respond. She sated she tried to see Resident #17 in her room [ROOM NUMBER] times per week and tried to engage the resident in conversation. The Activity Director stated she though Resident #17 would benefit from outdoor activity, such as sitting on the patio. She stated she needed to let the CNAs know in the morning if she had something planned for the residents who were usually in their beds in their rooms. 2. Resident #19 Review of Resident #19's Face Sheet, dated 3/14/2024, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: hemiplegia affecting left nondominant side (left sided weakness); osteoporosis (deterioration of bone tissue causing bones to become weak and brittle); cerebral infarction (stroke); hypertension (high blood pressure); fractured right femur (right hip fracture); osteoarthritis (degenerative joint disease that results from breakdown of joint cartilage and underlying bone); pain; hyperlipidemia (high cholesterol); anxiety disorder; and major depressive disorder. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nursing Note, dated 1/22/24, revealed Resident #19 fell from her wheelchair and landed on her right hip. She was transferred to the emergency room and was admitted to hospital. Review of the Nursing Note, dated 1/26/24, revealed Resident #19 returned to the facility from the hospital with a diagnosis of fracture of unspecified part of neck of right femur (right hip fracture). Review of Resident #19's comprehensive care plan revealed it was revised 1/26/24 to address history of falls, fracture right hip, and pain. Review of Resident #19's Activity Assessment, dated 1/26/24, revealed the following: Average Time Involved in Activities: Some - from 1/3 to 2/3 of time. Recent Changes to Activity Involvement: Decrease in activity involvement. Reason for Recent Activity Change: other - fall injury. Review of Resident #19's Medicare 5-day MDS Assessment, dated 2/02/24, revealed a BIMS score of 13 out of 15 (cognitively intact); pain management; fall with major injury; activity preferences: participate in religious practices - very important; listen to music, animals/pet, current news, group activities, go outside - somewhat important. Review of Resident #19's comprehensive care plan revealed a care plan dated 2/05/2024 that documented the resident was unable to participate in activities due to bedrest. The documented goal was for the resident to enjoy individual activities and maintain the highest level of independence daily and ongoing over the next 90 days. The documented approaches were to schedule activities in room daily and to create an activity plan based on the resident's preferences. Review of the Activity Note, dated 2/20/24, revealed documentation Resident #19 has decreased her attendance in activities due to a fall at the facility but will return to attend when she recovers. Resident is visited in her room to check in with her and hope for a speedy recovery. Review of Resident #19's Social Service Note, dated 2/20/24, revealed documentation the annual / readmission care plan was reviewed with the IDT at this time. Resident has decreased activities participation due to having fall incident and fracture recovery process. Resident continues yelling at times during the day when wanting attention or needing pain medication. Sometimes resident will request to be seated in wheelchair but at this time is not safe for her to be up in wheelchair due to history of falls and fracture. Continue to monitor her behavior. Observation on 3/11/24 at 12:34 PM revealed Resident #19 was lying in a low bed and had not yet been served the lunch meal. Observation on 3/11/24 at 12:41 PM revealed Resident #19 was lying in bed, was awake, and the television was on in the room. During an observation and interview on 3/12/24 at 5:21 PM, Resident #19 was resting in bed. She stated she liked to attend parties and singing activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/14/24 at 12:10 PM, the Activity Director stated Resident #19 had been on bedrest since she fell a couple weeks ago. She stated the resident liked to color, enjoyed pet visits (dog) every month, and playing loteria (Spanish bingo). The Activity Director stated the resident attended group activities when able and used to lead the rosary prayer group. The Activity Director stated she only visited Resident #19 last week for this month and had brought her a Coke. 3. Resident #26 Review of Resident #26's Face Sheet, dated 3/14/24, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: unspecified intellectual disabilities; nonpsychotic mental disorder; epileptic seizures (a brain condition that causes recurring seizures); chronic kidney disease (gradual loss of kidney function that can lead to kidney failure); hypothyroidism (thyroid disorder); hyperlipidemia (high cholesterol); dysphagia (swallowing problem); and gastrostomy status (feeding tube). Review of Resident #26's Annual MDS Assessment, dated 8/16/2023, revealed the BIMS was not able to be completed. The assessment documented the staff had assessed the resident's activity preferences as listening to music. No other activity preferences had been selected. Review of Resident #26's comprehensive care plan, dated 1/24/2018, revealed a care plan documented the resident did not demonstrate interest in organized activities and documented a goal for the resident to participate in activities within her capabilities. The documented approaches included in-room visits 3 times weekly for sensory stimulation, invite the resident to activities, and familiarize the resident with the nursing home environment and activity programs on a regular basis. Review of Resident #26's Quarterly Activity Assessment, dated 2/25/24, revealed documentation for the resident's goal to accept one-to-one activity visits for at least 15 minutes 2 times weekly. The assessment documented the resident was in good health and would be visited in-room [ROOM NUMBER] times weekly for conversation and sensory stimulation and would attend any special events during the next 90 days. The assessment documented to remind the resident of special events and escort her to and from her room. Observation on 3/12/24 at 10:37 AM revealed Resident #26 was lying in bed, rolling around, and making grunting noises. She was observed to have a feeding tube. The resident's bed had padded half side rails and a fall mat was on the floor at the bedside. In an interview on 3/14/24 at 6:03 PM, the Activity Director stated she did not have documentation of in-room visits with Resident #26. She stated she was in Resident #26's room last week and hung some pictures in her room and played some music, but she did not document this. 4. Resident #33 Review of Resident #33's Face Sheet, dated 3/14/2024, revealed a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: mood disorder with depressive features; pain; and dementia with anxiety. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33's Admission MDS Assessment, dated 10/12/23, revealed a BIMS score of 12 out of 15 (moderate cognitive impairment) and his activity preferences of current news and favorite activities were somewhat important. Review of Resident #33's comprehensive care plan revealed a care plan dated 10/19/23 which documented the resident had very little participation in activities. The documented goal was for the resident to participate in activities of choice over the next 90 days. The approaches included Social Service visits to discuss interests and past social patterns in the community, refer to psychological counseling/mental health specialist, provide privacy for family and friend visits, provide opportunities for increased socialization, introduce to other residents, encourage social conversations, and one-to-one visits. Review of the Activity Assessment, dated 1/26/24, revealed the resident participated in Socialization activities and had attended a coffee social and one-to-one activity visits 2 times weekly. (The assessment did not specify the type or topic of one-to-one activity.) Observation on 3/12/24 at 10:55 AM revealed Resident #33 was lying on his back on low bed with floor mats on both sides of bed. The resident's eyes were closed. A geri-chair was observed in a corner of the room. (A geri-chair is a specialized reclining chair that offers more versatility and support than a conventional wheelchair can provide.) Observation on 3/12/24 at 4:41 PM revealed Resident #33 was lying on his back in bed and was hollering loudly speaking in Spanish. In an interview on 3/14/24 at 12:03 PM, the Activity Director stated Resident #33 had been brought to group activities in a geri-chair. She stated he started yelling and screaming. She stated he was very hard of hearing. She stated he came to a coffee social and was calm while he drank coffee, and then became anxious. The Activity Director stated Resident #33 had hearing impairment and behavioral concerns. 5. Resident #56 Review of Resident #56's Face Sheet, dated 3/14/2024, revealed an [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included: Parkinson's disease (chronic and progressive movement disorder with tremors, stiffness, and slowing of movement); chronic obstructive pulmonary disease (lung disorder affecting breathing); anxiety disorder; restlessness and agitation; depression; hypertension (high blood pressure); dementia; hyperlipidemia (high cholesterol); chronic embolism and thrombosis of lower extremities (blood clots in legs); and edema (fluid retention). Review of Resident #56's Annual MDS Assessment, dated 9/04/2023, revealed a BIMS score of 3 out of 15 (severely cognitively impaired). The resident's activity preferences had been completed by staff and no activity preferences were selected. Review of Resident #56's comprehensive care plan revealed a care plan dated 3/07/2023 that documented the resident was unable to tolerate usual activities due to poor endurance. The care plan goal was to continue one-to-one visits. The care plan was revised 2/09/2024 and included a documented approach to assess the resident's response to new activity plan and modify as needed, and create an activity plan based on resident's preferences. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/11/24 at 1:29 PM revealed Resident #56 was resting on her right side in bed using oxygen via nasal cannula. She was awake, alert, and made eye contact when her name was spoken. Floor mats were located on both sides of her bed. Observation on 3/12/24 at 3:57 PM revealed Resident #56 was resting on her back in bed. In an interview on 3/14/24 at 11:16 AM, the Activity Director stated she visited Resident #56 in her room. She stated Resident #56 was sometimes assisted into a geri-chair but she was never taken out of her room. The Activity Director stated Resident #56 could not participate in physical activities. The Activity Director stated she would open the window blinds, turn on the television, or play music on her iPhone for the resident. The Activity Director stated she did not document any notes in the resident's record or complete an activity assessment. She stated she only completed assessments for new admissions, re-admissions, and yearly's (annual assessments). The Activity Director stated she spoke with the Super CNA (lead CNA) about getting Resident #56 up in a geri-chair to see if she could tolerate sitting up and how long. She stated Resident #56 had not attended any group activities. The Activity Director stated she did not think she had seen Resident #56 this month. She stated she tried to see all the residents every month. In an interview on 3/14/24 at 11:36 AM, the Activity Director stated she had not developed specific in-room activity plans for the residents who remained in their rooms. She stated she did not keep documented records of one-to-one visits with individual residents and did not document the date, time, or what she did during her visits with individual residents. The Activity Director stated she completed Activity Assessments when they populated for residents who were new admissions or re-admissions from the hospital after she received a prompt to complete an assessment in the electronic health record system. In an interview on 3/14/24 at 7:41 PM, the DON stated the Activity Director should have an activity log with documentation of in-room activities. She stated the Activity Director was probably nervous because it was her first survey. She stated she would explain to her what was needed. Review of the facility's Recreation Services policy and procedure for Individual Programming, dated 12/1999, revealed [in part]: Policy Regularly scheduled programming will be provided to all residents who are unable and/or unwilling to attend group activities. Purpose Individual programming ensures that all residents who are unable and/or unwilling to participate in group programs have consistent, goal-oriented, and individualized recreation opportunities. Individual interventions: Structured individual programs will be developed based on each resident's assessed needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Scheduling: The individual program will be provided according to a consistent schedule identifying specific days of the week, the time frame in which the program will occur, and residents who will receive services within the specified time frames. Each resident's individual program will include interventions which meet the resident's assessed social, emotional, physical and cognitive functioning needs. These approaches will reflect the resident's lifestyle and interests and will be incorporated into the interdisciplinary care plan . Individual participation record: Specific service provided and resident response to the activity will be documented on an Individual Participation Record and utilized to evaluate progress toward goal attainment.