STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195637	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency House of Alexandria	5131 Masonic Drive Alexandria, LA 71301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195637	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency House of Alexandria	5131 Masonic Drive Alexandria, LA 71301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide care and services that met professional standards of quality for 1(Resident #1) of 3 residents by failing to ensure controlled medications that were ordered for Resident R1 were not administered to Resident #1. The facility census was 47.Findings: Review of the facility's policy and procedure dated 09/01/2024, and titled Medication Administration read in part. Policy: Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice.Policy Explanation and Compliance Guidelines:10. Ensure that the six rights of medication administration are followed:a. Right Residentf. Right documentation12. Compare medication source (bubble pack, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.23. Correct any discrepancies and report to nurse manager. Review of Resident #1's medical record revealed an admit date of 11/18/2025 with the following diagnoses: Chronic Obstructive Pulmonary Disease Unspecified, Type II Diabetes Mellitus with Diabetic Neuropathy, Unspecified Asthma, Unspecified Dementia Severe with Agitation, Presence of Right Artificial knee Joint, Opioid Dependence and Anxiety Disorder. Review of Resident #1's admission MDS with a Target Date of 11/28/2025 revealed a BIMS score of 14 (indicating intact cognition). Resident #1 required set up or clean up assistance for eating, toileting, bathing and transfers. Resident #1 was independent with personal hygiene, and upper body dressing. Review of Resident #1's Baseline care plan dated 11/18/2025 and updated on 11/28/2025 revealed in part. Pain-monitor medications, side effects and effectiveness, Provide comfort and care. Review of Resident #1's Physician Orders dated 12/2025 read in part.Order dated 11/18/2025 by physician: Hydrocodone-Acetaminophen Oral Tablet 10-325 Milligrams (Hydrocodone-Acetaminophen Give 1 tablet by mouth every six hours as needed for pain.Interview on 12/15/2025 at 9:44 a.m. with S2 DON revealed she was called by S1 Administrator and S4 RN Weekend Supervisor that Resident #1 was out of his pain medication. S2 DON stated Resident #1 received Hydrocodone-Acetaminophen 10-325 Milligrams 1 every six hours PRN pain. S2 DON revealed Resident #1's family was at the facility and heard S3 LPN say she would borrow the pain medication from Resident R1 to give to Resident #1. S2 DON revealed she notified the physician and explained the above situation. Interview on 12/16/2025 at 10:30 a.m. with S3 LPN revealed she provided care for Resident #1 on the 6:00 a.m. to 6:00 p.m. shift. S3 LPN revealed Resident #1 was cooperative and took his medications without difficulty. S3 LPN stated Resident #1 complained of mild back pain at times, but did not request pain medications daily. S3 LPN revealed she was off duty on 12/03/2025 and 12/04/2025, and returned back to work on 12/05/2025. S3 LPN stated on 12/05/2025 she was informed by S5 LPN that Resident #1 was out of his pain medication, but it had been ordered. S3 LPN revealed when she returned to work on 12/06/2025 Resident #1's pain medication had not been delivered from the pharmacy on 12/05/2025. S3 LPN stated Resident #1 was reporting pain of a 4 to his lower back and his family was upset because the facility did not have his pain medication available. S3 LPN stated she borrowed a Hydrocodone-Acetaminophen 10/325 Milligram pill from Resident R1 and administered it to Resident #1. S3 LPN stated she knew she shouldn't have. Interview on 12/16/2025 at 3:45 p.m. with S2 DON confirmed the facility failed to have Resident #1's PRN pain medication (Hydrocodone-Acetaminophen 10-325 mg one by mouth every six hours as needed for pain) available and it should have been, that S3 LPN had borrowed pain medication from Resident R1 and administered it to Resident #1, and she shouldn't have. Interview on 12/17/2025 at 10:30 a.m. with S4 RN Supervisor revealed on 12/06/2025 S3 LPN informed her that Resident #1 was out of his pain medication. S4 RN supervisor stated she looked in the computer and saw Resident #1 had been out of his Hydrocodone-Acetaminophen 10-325 Milligrams PRN pain medication for a few days. S4 RN Supervisor stated she could not pull it from the ER kit because she didn't have a prescription. S4 RN Supervisor stated S3 LPN later informed her she had administered Resident R1's Hydrocodone-Acetaminophen 10-325 MG PRN pain medication to Resident #1. S4 RN Supervisor stated she informed S3 LPN to never borrow a resident's medication to administer to another resident. S4 RN Supervisor stated she then notified the Administrator and DON of the situation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195637	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency House of Alexandria	5131 Masonic Drive Alexandria, LA 71301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195637	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency House of Alexandria	5131 Masonic Drive Alexandria, LA 71301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to provide pharmaceutical services to ensure procedures that assure the acquiring and dispensing of a controlled medication (Hydrocodone-Acetaminophen) to meet the needs of the resident for 1 (Resident #1) of 3 sampled residents. Total facility census was 47.Findings: Review on 12/15/2025 at 11:10 a.m. of the facility's policy and procedure with a review date of 09/01/2024, and titled Controlled Substance Administration and Accountability read in part.Policy Explanation and Compliance Guidelines:3. Ordering and Receiving Controlled Substances:The amount on hand is checked against the amount used daily from the documentation records;The designated order form is completed and sent to the appropriate pharmacy making sure it contains the following:a. Unit/Wing ordering the medication;b. Signature of person making the request;c. Date;d. Medications and quantities required. Review of Resident #1's medical record revealed an admit date of 11/18/2025 with the following diagnoses: Chronic Obstructive Pulmonary Disease Unspecified, Type II Diabetes Mellitus with Diabetic Neuropathy, Unspecified Asthma, Unspecified Dementia Severe with Agitation, Presence of Right Artificial knee Joint, Opioid Dependence and Anxiety Disorder.Review of Resident #1's admission MDS with a Target Date of 11/28/2025 revealed a BIMS score of 14 (indicating intact cognition). Resident #1 required set up or clean up assistance for eating, toileting, bathing and transfers. Resident #1 was independent with personal hygiene, and upper body dressing. Review of Resident #1's Baseline care plan dated 11/18/2025 and updated on 11/28/2025 revealed in part.Pain: Monitor medications, side effects and effectiveness, and provide comfort and care.Review of Resident #1's Physician Orders dated 12/2025 read in part.Order dated 11/18/2025 by physician: Hydrocodone-Acetaminophen Oral Tablet 10-325 Milligrams (Hydrocodone-Acetaminophen Give 1 tablet by mouth every six hours as needed for pain.Order date: 11/18/2025 Pain scale: assess pain every shift.Review of an incident report dated 12/06/2025 at 2:40 p.m. by S1 Administrator revealed in part.on 12/06/2025, I was notified that the resident had not received his PRN pain medication since 12/03/2025. Once notified, I called the Director of Nursing who notified the doctor to obtain a new order. The order was obtained, and the prescription was delivered. On 12/07/2025, the DON contacted the Responsible Party to follow up on the 12/06/2025 complaint. The Responsible Party alleged neglect related to pain management due to the resident not having his PRN pain medication. On 12/11/2025 at 9:45 a.m. S1 Administrator wrote in part.The family requested that the resident be transferred to the hospital for pain management. (12/06/2025).Review of Nurse's progress notes dated 12/06/2025 at 5:31 p.m. read in part.Family request resident be transferred to the hospital for pain management. Resident up with walker outside smoking with his family at this time. 12/06/2025 at 5:41 p.m. Resident transferred to the hospital. Interview on 12/15/2025 at 9:44 a.m. with S2 DON revealed she was called by S1 Administrator and S4 RN Weekend Supervisor and that Resident #1 was out of his pain medication on 12/03/2025. S2 DON stated Resident #1 received Hydrocodone-Acetaminophen 10-325 Milligrams 1 every six hours PRN pain. S2 DON revealed Resident #1's family was at the facility and heard S3 LPN say she would borrow the pain medication from another resident to give to Resident #1. S2 DON revealed she notified the physician and explained the above situation. S2 DON revealed the physician ordered the pain medication and it was set to arrive on the evening of 12/06/2025, but the family wanted Resident #1 sent to the hospital. S2 DON revealed she had spoken to Resident #1's POA and she had stated she was concerned that Resident #1 had run out of pain medication, because he had been on it for so long. S2 DON stated Resident #1 admitted into the facility with 14 Hydrocodone-Acetaminophen pills and when he ran out of pills S5 LPN gave the empty card to S6 RN. S2 DON revealed S6 RN laid the card on S7 LPN/ADON desk, but S7 LPN/ADON revealed she never saw the card and no one told her the pain medication needed to be refilled. S2 DON stated that all nurses were responsible for ordering their own medications.Interview on 12/16/2025 at 10:30 a.m. with S3 LPN revealed she provided care for Resident #1 on the 6:00 a.m. to 6:00 p.m. shift. S3 LPN revealed Resident #1 was cooperative and took his medications without difficulty. S3 LPN revealed Resident #1 was ambulatory with a walker and smoked independently. S3 LPN stated Resident #1 was able to make his needs known and to ask for pain medication if he needed it. S3 LPN stated Resident #1 complained of mild back pain at times, but did not request pain medications daily. S3 LPN revealed she was off duty on 12/03/2025 and 12/04/2025, and returned back to work on 12/05/2025. S3 LPN stated on 12/05/2025 she was informed by S5 LPN that Resident #1 was out of his pain medication, but it had been ordered. S3 LPN stated Resident #1 complained