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	03/04/2026

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

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview, the facility failed to establish a grievance policy to ensure the prompt resolution of all grievances for 2 (#2 and #8) of 29 sampled residents. The facility failed to:Establish a grievance policy which identified a Grievance Official;Establish a grievance policy which included the contact information of the Grievance Official with whom a grievance can be filed; andMaintain evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.This deficient practice had the potential to effect all 44 residents residing in the home.Review of the facility's policy titled, Resident and Family Grievances revised 09/01/2024 revealed, in part. (1) (Name and Title) has been designated as the Grievance Official and can be reached at (list contact information), and (11) Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision.Resident #2Review of Resident #2's electronic medical record revealed an admission date of 04/21/2023 with diagnoses including Alzheimer's Disease, Dementia, and Oropharyngeal Dysphagia.Interview with Resident #2's RP on 03/03/2026 at 9:41 a.m. revealed she met with S1 ADM the previous week to complain about the consistency of Resident #2's food.Review of the facility's Monthly Grievance Log for 02/2026 failed to reveal a grievance for Resident #2.Resident #8Review of Resident #8's electronic medical record revealed an admission date of 02/04/2026 with diagnoses including Metabolic Encephalopathy, Alzheimer's Disease, Dementia, Anxiety, Major Depressive Disorder, and Abnormalities of Gait and Immobility.Interview with Resident #8's RP on 03/03/2026 at 1:59 p.m. revealed he previously complained to staff because Resident #8's call light was not within reach.Review of the facility's Monthly Grievance Log for 01/2026 and 02/2026 failed to reveal a grievance for Resident #8.Interview with S1 ADM on 03/04/2026 at 10:10 a.m. revealed Resident #8's family previously complained about her toilet not working, her bed remote not working, her toilet not being cleaned, and her call light not being within reach. S1 ADM revealed when residents or their families complained to him, he documented the information on a sticky note, which he discarded after he went and corrected it myself. S1 ADM confirmed he did not maintain any documentation of Resident #8's RP's grievances, but should have.Interview with S1 ADM on 03/04/2026 at 2:30 p.m. confirmed the facility's Resident and Family Grievances policy did not identify a Grievance Official, or include the contact information of the Grievance Official, but should have. S1ADM confirmed he met with Resident #2's RP last week and she complained about the consistency of his food. S1 ADM confirmed he did not maintain evidence demonstrating the result of the grievance, but should have.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to develop and implement a comprehensive person-centered plan of care for each resident and ensure that care and services were furnished to attain the resident's highest practicable physical, mental, and psychosocial needs that were identified in the comprehensive assessment for 2 (Resident #34 and #51) of 29 sampled residents by the facility failing to:1. Develop and implement a plan of care related to Resident #34's oxygen use.2. Develop and implement a plan of care related to Resident #51's Hospice service.Resident #34Review of Resident #34's medical record revealed an admit date of 01/12/2026 with diagnoses which included in part.Chronic Obstructive Pulmonary Disease, Pneumonia Unspecified Organism, Acute on Chronic Diastolic (Congestive) Heart Failure and Chronic Kidney Disease Unspecified.Review of Resident #34's 03/2026 Physician Orders read in part.Change O2 Mask/Nasal Cannula and tubing weekly; every night shift every Wednesday and as needed. O2 at 2 liters per minute via nasal cannula for diagnosis of Chronic Obstructive Pulmonary Disease.Review of Resident #34's care plan revealed no documented evidence of a care plan related to Resident #34's oxygen use.Interview on 03/03/2026 at 10:10 a.m. with S7 MDS/CP Nurse confirmed Resident #34 did not have a care plan related to her oxygen use, but should have.Resident #51Review of Resident #51's medical record revealed an admit date of 12/25/2025 with diagnoses that included in part.Type II Diabetes, Moderate Protein-Calorie Malnutrition, Dysphagia, Congestive Heart Failure and Anemia.Review of Resident #51's 03/2026 Physician Orders read in part.Admit to Hospice for Protein-Calorie Malnutrition with an order dated 10/28/2025.Review of Resident #51's care plan revealed no documented evidence of a care plan related to Resident #51's Hospice service.Interview on 03/03/2026 at 12:20 p.m. with S4 IP Nurse confirmed Resident #51 did not have a care plan related to his Hospice service, but should have.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure a resident's comprehensive care plan was revised after a change in the residents advance directive status for 1 (Resident #22) of 29 sampled residents.Findings: Review of Resident #22's medical record revealed an admission date of 01/16/2026 with diagnoses of Unstable Burst Fracture of Second Lumbar Vertebra, Subsequent Encounter for Fracture with Routine Healing and Type 2 Diabetes Mellitus with Diabetic Nephropathy. Review of the 5 day Medicare Minimum Data Set (MDS) for Resident #22 revealed a Brief Interview Mental Status (BIMS) score of 14, indicating intact cognition. Review of Care Plan for Resident #22 with an initiate date of 01/20/2026 revealed in part. Advanced Directives: I have the following advance directive of full code. Review of Louisiana Physician Orders for Scope of Treatment (LaPOST) for Resident #22 revealed in part. Do Not Resuscitate (DNR). Review of Resident #22's medical record failed to reveal an order for an advance directive. Interview with S2 ADON on 03/04/2026 at 10:48 a.m., S2 ADON confirmed Resident #22's code status was a full code in the Care Plan, but should have been Do Not Resuscitate (DNR).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to provide care and services that met professional standards of quality by failing to follow physician's orders for 1 (Resident #10) of 29 sampled residents. Findings: Review of the facility's policy titled, Medications Administration on 04/30/2025 with a review date of 09/01/2024 read in part .Policy: Medications are administered as ordered by the physician and in accordance with professional standards of practice. Review MAR (Medication Administration Record) to identify medication to be administered. Compare medication source (bubble pack, vial, etc.,) with MAR to verify medication dose. Observation on 03/03/2026 at 8:21 a.m. revealed S6 RN performed medication administration for Resident #10. Observation revealed S6 RN placed 8 tablets into medication cup for administration. S6 RN compared medication blister packs to MAR on screen and proceeded to administer the medications to Resident #10. Medication administered to Resident #10 at the time of observation was Duloxetine HCl (Hydrochloride) Oral Capsule Delayed Release Sprinkle 60 mg (milligram). Review of Resident #10's facesheet revealed an admit date [DATE] with diagnoses that included in part . Major Depressive Disorder and Generalized Anxiety Disorder. Review of Resident #10's 03/2026 physician orders read in part.Duloxetine HCl Capsule Delayed Release Particles 30 mg (order date of 02/04/2026). Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 mg discontinued 02/03/2026. Review of Resident #10's 03/2026 eMAR (Electronic Medication Administration Record) revealed S6 RN documented she administered Duloxetine HCl Capsule Delayed Release Particles 30 mg. Interview on 03/03/2026 at 1:14 p.m., S6 RN unlocked medication cart and reviewed blister pack with this surveyor that read Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 mg and confirmed she administered it this morning to Resident #10. S6 RN confirmed that Resident #10 should have received the correct medication dosage of Duloxetine HCl 30 mg according to physician's orders, but did not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure that a resident received adequate supervision to prevent incidents and accidents. The facility failed to ensure a resident received 1:1 supervision as ordered for 1 (Resident #7) of 1 resident reviewed for accidents.Findings: Review of the facility's policy titled, Accidents and Supervision with a review date of 12/31/2024 revealed in part, Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. defined by type and frequency and b. based on the individual resident's assessed needs and identified hazards in the resident environment. Review of Resident #7's medical record revealed he was admitted to facility on 06/10/2025 and had diagnoses that included in part Traumatic Subdural Hemorrhage with Loss of Consciousness, Major Depressive Disorder, Unspecified Dementia, severe, with Psychotic Disturbance, and Other Alzheimer Disease. Record review of Resident #7's Quarterly MDS with an ARD of 12/31/2025 reveled Resident #7 had a BIMS of 08, which indicated moderate cognitive impairment. Record review of Resident #7's 03/2026 physician orders revealed: 02/26/2026-1:1 supervision while resident is awake and line of sight supervision while sleeping. Resident will be reevaluated every 24 hours for continued supervision needs. 03/02/2026-Level of Supervision 1:1 every shift for behaviors Review of Resident #7's Care plan revealed description of: I am at risk for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, violent behavior toward staff. Intervention: 1:1 Supervision (initiated 03/02/2026). I am at risk wanderer related to violent behavior, combative, verbally abusive towards staff, and refuses care. Intervention: 1:1 supervision started on 02/25/2026 while awake and line of sight. (Revised 03/02/2026). Record review of the facilities progress notes revealed in part . 02/25/2026 notified Psych NP of Resident #7 behaviors and recent incidents including discharge from behavioral facility, combative behavior with another resident, and combative, aggressive behaviors with staff today. Observation on 03/02/2026 at 8:13 a.m. revealed Resident #7 sitting in day area in wheelchair unsupervised. Resident #7 was at the edge of his wheelchair when a staff member helped him back up in his wheelchair. Staff member then proceeded to walk off and left Resident #7 sitting alone, unsupervised. Observation on 03/02/2026 at 11:36 a.m. revealed Resident #7 sitting at a dining table with two other residents unsupervised. Observation on 03/02/2026 at 1:46 p.m. revealed Resident #7 sitting alone, unsupervised at the end of a hallway in his wheelchair. Interview on 03/02/2026 at 1:50 p.m. with S2 ADON observed Resident #7 sitting alone, unsupervised at the end of the hallway. S2 ADON revealed Resident #7 had been having some behaviors and required 1:1 supervision. S2 ADON confirmed Resident #7 was left unsupervised, but shouldn't have been. Interview on 03/02/2026 at 2:00 p.m. with S5 Corporate Nurse revealed Resident #7's 1:1 supervision was revised today to reflect 1:1 supervision at all times, even during sleeping hours. S5 Corporate Nurse revealed that Resident #7 should have been on 1:1 supervision but was not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to provide respiratory care consistent with professional standards for 1 (Resident #34) of 29 sampled residents. The facility failed to ensure respiratory equipment was properly labeled. Findings:Review of Resident #34's medical record revealed an admit date of 01/12/2026 with diagnoses which included in part.Chronic Obstructive Pulmonary Disease, Pneumonia Unspecified Organism, Acute on Chronic Diastolic (Congestive) Heart Failure and Chronic Kidney Disease Unspecified.Review of Resident #34's 03/2026 Physician Orders read in part.Change O2 (oxygen) Mask/Nasal Cannula and tubing weekly; every night shift every Wednesday and as needed. O2 (oxygen) at 2 liters per minute via nasal cannula for diagnosis Chronic Obstructive Pulmonary Disease.Observation on 03/02/2026 at 7:58 a.m. revealed Resident #34 sitting on the side of her bed with oxygen infusing via nasal cannula. Resident #34's oxygen tubing and oxygen canister were undated. Resident #34 stated she did not know when the oxygen tubing had been changed.Interview on 03/02/2026 at 8:07 a.m. with S4 IP Nurse confirmed Resident #34's oxygen tubing and oxygen canister were not dated but should have been.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview, the facility failed to ensure nursing staff had the appropriate knowledge and skill sets to provide care and respond to each resident's individualized needs as identified in his/her assessment and care plan. The facility failed to verify the presence of a Louisiana nursing license prior to hire for 1 (S12 LPN) of 2 licensed nurses whose employee records were reviewed.Interview on 03/03/2026 at 9:50 a.m. with S12 LPN revealed she began working in the facility on 03/02/2026. S12 LPN revealed she was supposed to be orienting with the nurse who was pulled to do treatments. S12 LPN revealed she had been orienting with S6 RN, but S6 RN had been reassigned to perform resident treatments. S12 LPN revealed she was assigned residents and was waiting for a login for the computer.Review of S12 LPN's employee record revealed a hire date of 03/02/2026. Further review failed to reveal verification of a Louisiana nursing license prior to hire.Interview with S8 HR 03/04/2026 at 8:23 a.m. revealed verification of Louisiana nursing license was printed and placed into the employee record of all licensed nurses prior to hire. S8 HR confirmed the facility did not have verification of S12 LPN's Louisiana nursing license prior to hire, but should have.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to ensure an annual performance review was completed for 1 (S11 CNA) of 3 CNAs whose employee records were reviewed.Review of S11 CNA's employee record revealed a hire date of 09/16/2024. Further review failed to reveal an annual performance review.Interview with S8 HR on 03/04/2026 at 8:23 a.m. revealed S11 CNA had an initial performance review on 02/24/2025. S8 HR confirmed S11 CNA did not have an annual performance review, but should have.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility failed to post the required nurse staffing data for licensed and unlicensed nursing staff directly responsible for resident care on a daily basis at the beginning of each shift.Observation on 03/03/2026 at 9:32 a.m. revealed a Staff Reporting Form dated 03/02/2026 posted on a clipboard at the nurse's station. Interview with S2 ADON on 03/03/2026 at 9:34 a.m. revealed the Staff Reporting Form was to be posted on a daily basis, at the beginning of each shift. S2 ADON confirmed the Staff Reporting Form for 03/03/2026 had not been posted, but should have been. Observation on 03/03/2026 4:02 p.m. revealed a Staff Reporting Form dated 03/02/2026 posted on a clipboard at the nurse's station. A Staff Reporting Form dated 03/03/2026 was not posted.Observation on 03/04/2026 8:11 a.m. revealed a Staff Reporting Form dated 03/02/2026 posted on a clipboard at the nurse's station. Staff Reporting Forms dated 03/03/2026 and 03/04/2026 were not posted.Observation on 03/04/2026 11:11 a.m. revealed a Staff Reporting Form dated 03/02/2026 posted on a clipboard at the nurse's station. Staff Reporting Forms dated 03/03/2026 and 03/04/2026 were not posted.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and interview, the facility failed to ensure that the planned menus were followed to meet the nutritional needs of the residents requiring a pureed diet. The facility failed to follow the established recipe during the preparation of pureed foods, which did not ensure the nutritional adequacy of the meals provided to residents who required a pureed diet. This had the potential to affect a total of two residents who received pureed diets. Findings:Review of a policy with a revision date of 09/01/2024 titled Puree Food Preparation read in part.It is the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance.5. Do not use water as an additive to prepare puree foods.7. Puree Food Preparation Guidelines per Serving:Meats: Add 1 teaspoon of beef broth or beef gravyVegetables (leaf, stem, or flower): Add 2 teaspoons of mashed potato flakes On 03/02/2026 at 11:11 a.m., an observation was made of S3DM preparing pureed diets. S3DM added several scoops of cabbage, three pieces of bread, and an unmeasured amount of water into the food processor. The mixture was processed to a pudding-like consistency.Next, S3DM added several scoops of pinto beans, three pieces of bread, and an unmeasured amount of water into the food processor. The mixture was processed to a pudding-like consistency.Lastly, S3DM added several pieces of fried pork chops, four pieces of bread, and an unmeasured amount of water into the food processor. The mixture was processed to a pudding like consistency. Review of the recipes for pureed cabbage, beans, and fried pork chops read in part. Measure the number of servings using the regular prepared recipe portion. Drain well to minimize the use of thickener to obtain appropriate consistency.Add liquid if needed (ex: reserved liquid, broth, milk, gravy, or sauce). Note: Water should not be used as a liquid when preparing puree foods.If needed, gradually add thickener (ex: mashed potato flakes, cream of rice or commercial thickener) until desired consistency is met. On 03/02/2026 at 11:35 a.m., interview with S3DM confirmed that the standardized recipes were not followed when preparing the pureed foods. S3DM stated the facility had established pureed recipes; however, the recipes were not readily available to the kitchen staff and would need to be printed. S3DM confirmed that water or bread should not have been used when preparing puree foods and acknowledge that the recipes were not followed during the pureeing process but should have been.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety by failing to ensure open food items stored in the pantry and refrigerator were dated with an open date. This deficient practice had the potential to affect 43 residents who received meals served from the kitchen. Findings:An observation on 03/02/2026 at 6:08 a.m. of the facility pantry and refrigerator revealed one undated, open package of brown gravy mix, one undated, open bag of potato chips, and one undated, open package of sliced ham. On 03/02/2026 at 6:20 a.m., S3DM confirmed all opened food items stored in the pantry or refrigerator should be labeled with the date the item was opened. S3DM further confirmed that the items listed above should have been labeled with an open date, but were not.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help to prevent the development of communicable diseases and infection for 1 (Resident #49) of 1 resident reviewed for infection control. The facility failed to ensure:EBP were utilized as ordered; andA peripheral IV site was changed every 3 days.Review of the facility's policy titled Enhanced Barrier Precautions revised 09/01/2024 revealed, in part. 2b) An order for enhanced barrier precautions will be obtained for residents with.feeding tubes. 3a) Implementation of Enhanced Barrier Precautions: make gowns and gloves available immediately near or outside of the resident's room. Face protection may also be needed if performing activity with risk of splash or spray. 3b) PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. 4d) High-contact resident care activities include providing hygiene. 6) Therapists should use gown and gloves when working with resident on EBP.if they anticipate prolonged, close body contact where MDRO transmission is possible.Review of the facility's policy titled Nursing Management Manual dated 03/24/2024 revealed, in part.7) Peripheral IV sites are changed every three days unless otherwise ordered by the physician.Review of the facility's policy titled Infection Prevention and Control Program revised 09/01/2024 revealed, in part.4a) Standard Precautions: All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. 4c) All staff shall use PPE according to established facility policy governing the use of PPE.Review of Resident #49's electronic medical record revealed an initial admission date of 01/03/2026 with diagnoses including Extended Spectrum Beta Lactamase Resistance, Dysphagia, Gastrostomy Status, Resistance to Multiple Antibiotics, and Cognitive Communication Deficit.Review of Resident #49's current Physicians Orders revealed Enhanced Barrier Precautions during all high contact resident care and Enteral Feed Order of Jevity 1.5 at 50mL/hr via pump, dated 01/14/2026.Observation of Resident #49 on 03/02/2026 at 1:45 p.m. revealed tube feeding was infusing at 50mL/hour. No gowns or masks noted inside Resident #49's room or outside the door to his room. An undated IV site was noted to the distal dorsal surface of Resident #49's left arm.Observation on 03/02/2026 at 1:58 p.m. revealed S2 ADON entered Resident #47's room, without donning PPE, adjusted the head of his bed and repositioned his pillows. Interview was conducted with S2 ADON at that time. S2 ADON assessed the IV site upon request and confirmed the IV site was not dated, but should have been. S2 ADON confirmed Resident #47 was ordered to have EBP and she should have donned PPE prior to providing any direct care, but did not. Review of Resident #47's Health Status Note dated 02/25/2026 at 10:45 p.m. revealed, in part.IV restarted in left forearm.Observation on 03/02/2026 at 2:22 p.m. revealed S13 ST entered Resident #47's room, donned gloves, and proceeded to perform oral care and speech therapy while leaning over resident and against bedding. S13 ST did not don a gown or mask. Interview with S13 ST on 03/02/2026 at 2:29 p.m. revealed she knew a resident was on EBP if there was a sign on the door and a three-drawer bin containing PPE was outside the door. S13 ST confirmed Resident #47 did not have an EBP sign on his door, or a bin with PPE outside his door.Interview with S4 IP on 03/03/2026 at 2:40 p.m. confirmed staff should have donned and gown and gloves when providing high-contact care activities for Resident #47. S4 IP confirmed Resident #47's IV should have been labeled with the date and time it was inserted, and should have been removed after 72 hours to decrease risk of infection, but was not.