

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455908	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Schulenburg Regency Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 111 College St Schulenburg, TX 78956	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a person-centered comprehensive care plan, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, physical, mental, and psychosocial needs for 1 of 7 residents (Resident #1) reviewed for care plans. The facility failed to develop and implement a care plan for Resident #1 that was individualized to her care needs, which included ADLs, activities, specialized diet, dementia and related behaviors. This deficient practice could place residents at risk of not having their needs met to attain their highest practicable well-being. Findings included: Record review of Resident #1's Face Sheet dated [DATE] reflected a [AGE] year-old female with an admitted to facility on [DATE] and discharged on [DATE]. Resident #1 had diagnoses included acute pulmonary edema (life threatening medical emergency where excess fluid rapidly accumulates in the lungs air sacs), heart failure, unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), muscle weakness (a feeling or objective observation that reduced effort, such as attempting to lift or move, fails to produce normal muscle contraction), and coronavirus infection. Record review of Resident #1's admission MDS dated [DATE] reflected Resident #1 had a BIMS of 04, indicating severe cognitive impairment. The MDS also reflected Resident #1 had Dementia, Malnutrition, Therapy Services, Mechanically Altered Diet, and she required substantial / maximal assistance (helper does more than half the effort) with eating, oral hygiene, and toileting. Resident #1 was dependent on staff with showers and lower body dressing. Record review of Resident #1's Comprehensive Care Plan, reviewed on [DATE], with a start date of [DATE] reflected only 2 problem areas. Resident #1's Diet, Malnutrition, Dementia, Therapy, and ADLs were not documented on the comprehensive care plan. Interview conducted on [DATE] at 4:13PM, the Social Worker stated she has been employed at the facility for almost two years. She stated the MDS nurses place information on the comprehensive care plans. She stated the facility previously had another individual assist with developing the care plans; however, that person was no longer employed with the facility. The Social Worker stated that residents' activities of daily living (ADLs), diet, dementia, and behaviors are important areas that should be included in the comprehensive care plan. She stated the potential harm to residents is that staff may not be aware of the resident's goals, needs, and planned interventions if this information was not included in the comprehensive care plan. Interview conducted on [DATE] at 4:35 PM, the MDS Nurse A stated she had worked at the facility for one year. She stated the MDS nurses were currently responsible for developing and maintaining comprehensive care plans. She stated the facility previously had a (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dedicated care plan coordinator; however, that individual was terminated approximately one week after the facility's full book survey. She stated the MDS department assumed responsibility for the care plans again. The MDS Nurse A stated a comprehensive care plan should include essentially everything related to the resident's care. She stated areas such as ADLs, diet, activities, and treatments should be included in the care plan. She stated that when she completed Resident #1's last revision on [DATE], she probably entered enough information to clear the electronic alert. She stated she did not recall noticing that no additional care plan information had been entered. The MDS Nurse A stated the potential effect of an incomplete comprehensive care plan is that a resident may not receive the care and services needed. Interview conducted on [DATE] at 4:53 PM, the DON stated the facility identified in March during the annual recertification (full book) survey that resident care plans were not being completed as required. The DON stated the facility had hired an employee whose responsibility was to complete the resident care plans; however, the employee was terminated shortly after the full-book survey. The DON stated Resident #1's comprehensive care plan was in the process of being updated following completion of the resident's last MDS assessment. However, the resident expired before the care plan revision was completed. The DON stated the MDS nurse should have corrected the resident's care plan when it was last revised on [DATE]. The DON stated the potential outcome of an inaccurate care plan could lead to a resident receiving the wrong care. Record review of the facility's Care Plans, Comprehensive Person-Centered Policy, dated 2001, revised [DATE] reflected: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation I. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. 7. The comprehensive, person-centered care plan includes measurable objectives and timeframes. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. any specialized services to be provided as a result of PASARR recommendations; and which professional services are responsible for each element of care. includes the resident's stated goals upon admission and desired outcomes. builds on the residents' strengths; and reflects currently recognized standards of practice for problem areas and conditions.		