STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455908	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schulenburg Regency Nursing Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure 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.The facility failed to ensure that the medications stored in the medication storage room [ROOM NUMBER] were not expired.This deficient practice could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication or treatment.The findings included:During an observation in medication room [ROOM NUMBER] on 3/9/2026 at 10:30am it was revealed that the following medications and other items were expired:Two bottles of Pro - Stat Concentrated Liquid Protein 30 fluid ounces. The date of expiry printed on it was January 21, 2026. One Miconazole Nitrate Vaginal Cream 4% vaginal antifungal with 2 applications in the box. The expiry date printed on it was September 2025.Two dressing change kit with Stat Lock. The expiry date printed on it was 08/20/2025.Eight sterile saline syringes. The expiry date printed on them was 10/2025.One bottle of Chardonnay contains approx. 1/2 bottle of wine, stored in the residents' refrigerator in the medication room. The opened date written on it was 5/18/2025.During an interview on 03/11/26 at 09:21 a.m., RN J stated that she was new to the facility and understood that the nurse in charge was responsible for removing expired items from the medication room. She added that the last time the medication room was checked for expired medications was on 03/04/26. She stated she did not know why expired medications were still present among the medications. When asked about the procedure for adding new items to residents' refrigerators in the medication room, RN J explained that all items should be labeled with the resident's name, the item, and the date it was opened. She stated that all open, unused items were discarded after three days. She also mentioned that the shelf life of white wine in the refrigerator was one week after opening. RN J stated that consuming expired medications and food items poses health hazards for residents.In an interview on 03/11/26 at 10:00 a.m., RN K identified himself as the charge nurse on that day. When the investigator inquired about who was responsible for removing expired items from the medication room, RN K responded that everyone was responsible for maintaining the medication room. He stated that staff check for expired items whenever a new shipment arrives, which occurs every Tuesday, and he was confident the room had been checked for expired items the previous Tuesday (03/03/26). RN K explained that expired items were stored in a designated, locked cabinet for destruction and the expired medications should not have been among the active medications . Regarding the procedure for adding new items to residents' refrigerators in the medication room, he stated they are labeled with the resident's name and the date, and that such items are generally good for 72 hours. He said that the consumption of expired food could cause gastrointestinal upset, nausea, and vomiting, and that using expired medications could compromise therapeutic effects or cause serious side effects.A phone call was placed to the facility pharmacist on 03/11/26 at 12:13 p.m., leaving a voice message requesting a callback. As of 05:00 p.m. on the same day, there had been no response.In an interview on 3/11/26 at 12:55pm with ADON A, she stated that she served as both the Assistant Director of Nursing and the Infection (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
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Preventionist. She stated that maintaining the medication room was everyone's responsibility. She explained that the medication room was updated on order days, which were typically Monday or Tuesday, and that expired items were stored in a locked cabinet designated for destruction. She described the process for storing items in the refrigerator as labeling them with the resident's name and date, with a shelf life of 72 hours once opened. When asked about the potential negative outcomes of consuming expired items, she stated that it could result in illness like stomach viruses, nausea, and vomiting. ADON A stated there were in-services conducted very often and she needed to see when an in service was conducted on medication storage recently.Record review of in-services files from September 2025 to 03/11/26 revealed there were no in-services on labelling , storage and destruction of expired medications.Review of the facility policy titled Storage of Medications revised November 2020 reflected : .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident# 17, and Resident #92) reviewed for ADL care.The facility failed to ensure Resident #17's and Resident #91's nails were cleaned and did not have any rough edges.This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings included: Record review of Resident #17's face sheet, dated 03/10/2026, reflected a [AGE] year-old male, admitted [DATE], with diagnoses: type 2 diabetes mellitus without complications (a chronic metabolic disorder where the body develops insulin resistance and fails to use insulin properly without any complications), muscle weakness (a decrease in the ability to exert force with your muscles, meaning they do not contract or move as expected), cognitive communication deficit (an impairment in communications skills- such as speaking, listening, or organizing thoughts), and lack of coordination (an inability to produce smooth, precise, and voluntary muscle movements).Record review of Resident #17's admission MDS, dated [DATE] reflected it was in progress. Record review of Resident #17's Baseline Care Plan, dated 03/02/2026, reflected Resident #17 required one person assist with personal hygiene, eating, toileting, dressing, bathing, and transfers.Observation and interview on 03/09/2026 at 10:25 am, revealed Resident #17 was sitting in his specialty chair in the common area near the lobby. He had a blackish/ brownish substance underneath the middle and ring fingernails on his right hand. Resident #17's middle fingernail on his right hand was uneven around the edges. Resident #17 did not respond to questions or conversation about his nails. He was not interview able.Record review of Resident #91's face sheet, dated 03/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: unspecified osteoarthritis, unspecified site (joint disease when the specific joints had stiffness without specifying if it is in the knees, hips, hands or other locations), muscle weakness (a decrease in the ability to exert force with your muscles, meaning they do not contract or move as expected), need for assistance in personal care (help with bathing, dressing, grooming, toileting, meal preparation, mobility, medication management, and housekeeping), and stiffness in left and right shoulder (a limitation in range of motion, often caused by inflammation, injury, or tightness in the muscles).Record review of Resident #91's Quarterly MDS Assessment, dated 01/22/2026, reflected Resident #91 had a BIMS score of 15 indication cognition was intact. Resident #91 required assistance with personal hygiene (supervision or touching assistance- helper provides verbal cues and /or touching assistance). She required substantial/maximal assistance (helper does more than half the effort) with the following: toileting hygiene, showers, and lower body dressing. Record review of Resident #92's Comprehensive Care Plan, dated 01/28/2026, reflected Resident #92 had an ADL self-care performance deficit. Interventions: bathing/showering: check Resident #92's nail length and clean on bath day and as necessary. Report any changes to the nurse. Assist resident with one staff as needed with personal grooming with difficult areas of grooming. Observation and interview on 03/09/2026 at 11:01 a.m., revealed Resident #91was in her wheelchair watching her favorite soap opera on television. She had very long fingernails on both hands. Resident #91's middle ring and fore fingernails on her right hand were rough around the edges. She stated on Saturday (03/07/2026) she asked a staff if she would trim and file her nails. Resident #91 did not recall the employee's name or their position. Resident #91 stated the person stated her nails would be trimmed and filed sometime next week. She stated she did not ask anyone else to assist her with her nails. Resident #91 stated the staff believes I can do my own nails, but I am getting where it is hard for me to file my nails. She stated I have arthritis and it hurts for me to attempt to do my own nails. Resident #91 stated she did not need any medication for her pain. She stated she preferred the staff to trim and file her nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #91 pointed to a scratch on her left arm approximately 5 inches above her wrist where she scratched herself with one of her fingernails that was rough around the edges. In an interview on 03/11/2026 at 9:30 a.m., LVN L stated the nurses were responsible for residents with diagnosis of diabetes with nail care such as trimming, cleaning, filing. He stated the CNAs were responsible for all other residents' nail care. LVN L stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become ill such as stomach problems, nausea, and vomiting. LVN L stated if a resident refused any type of care, the nurse would document the refusal in the nurse's notes. He stated Resident #91 and Resident #17 did not refuse nail care. He stated if a resident had uneven fingernails there was a possibility a resident may scratch themselves or someone else and cause a skin tear. He also stated a resident may scratch their eye and cause a tear in the eye. He stated he had been in- serviced on nail care, however, he did not recall the date. In an interview on 03/11/2026 at 10:05 a.m., CNA T stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. She stated nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA T stated the residents' nails were usually cleaned on their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill such as vomiting and diarrhea or an infection in their stomach. CNA T stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated she was not aware of Resident # 92 or Resident #17 refusing nail care. She stated if any resident refused nail care, she reported it to the nurse. CNA T stated she was not sure where the nurse documented the refusal of nail care. She stated if a resident had long nails with rough edges there was a possibility the resident may scratch themselves and have a skin tear or scratch another resident causing a skin tear. She stated there was a possibility a resident may develop an infection if there were bacteria underneath the nail and the bacteria transferred to the open area on the skin. In an interview on 03/11/2026 at 10:25 a.m., the ADON stated the nurses were responsible to complete nail care such as trimming, filing, and cleaning once a week or as needed on residents with diagnosis of diabetes. The ADON stated the CNAs were responsible for nail care on all other residents (not diabetic) The ADON stated if a CNA noticed any concerns of a resident's nails, the CNA was expected to report any concerns to the nurse. The ADON stated if a resident had blackish substance underneath their nails there was a possibility a resident may become ill such as nausea or diarrhea depending on the type of bacteria. The ADON stated if a resident had rough edges around their nails, it was a possibility the resident may scratch themselves and develop a skin tear. She stated the nurse supervisors were responsible for monitoring the CNAs and nail care. Record review of the facility's policy on nail care, not dated, reflected to ensure residents receive routine nail care to maintain hygiene, comfort, and safety while preventing infection or injury. The facility will provide routine nail care to residents as part of daily personal hygiene and grooming. Nail care will be performed safely and in accordance with infection control standards, resident care plans, and applicable medical considerations. Basic hygiene services including cleaning under nails, filing nails, and trimming nails when appropriate. Routine nail care may include the following:Cleaning under nailsFiling rough edgesTrimming fingernailsApplying lotion to surrounding skin as needed.Routine nail care will be provided during bathing or other personal care activities as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents received care, consistent with professional standards of care to prevent development or promote wound healing for one (Resident # 6) of 3 residents reviewed for pressure ulcers. The facility failed to perform Resident #6's thorough skin assessments on Sunday 03/08/2026 new skin issues to right gluteus (buttock), rear left thigh, and right fourth toe. These failures could place residents at risk for worsening skin concerns leading to discomfort, pain, and potential infections. Findings included:Record review of Resident #6's face sheet, dated 3/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE], diagnoses included type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic- hyperosmolar coma (extremely high blood sugar (> 600 mg/dL), severe dehydration, and high blood concentration without significant ketone- chemicals produced by the liver from fat breakdown when the body lacks sufficient glucose for energy- production or deep coma), morbid obesity due to excess calories (a chronic disease defined by a body mass index of 40 or higher, or 35-39.9 related to health conditions like diabetes or heart disease), and malignant neoplasm of vulva, unspecified (a rare, slow-growing cancer found on the external female genitalia, including the labia, clitoris, or perineum).Record review of Resident #6's Quarterly MDS Assessment, dated 02/25/2026, reflected Resident #6 had a BIMS score of 15 which indicated her cognition was intact. Resident #6 received PRN pain medications. She frequently was in pain. Resident #6 was at risk of Pressure ulcer/ injuries. She did not have any unhealed pressure ulcer/ injuries or other skin concerns. Resident #6 had a pressure reducing device for bed. She required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showers, and lower body dressing. Resident #6 required partial/moderate assistance - helper does less than half the effort with roll left to right, sit to lying, and lying to sitting on side of bed.Record review of Resident #6's Care plan revised on 03/09/2026 reflected Resident #6 was at risk for impaired skin integrity. Resident #6 had MASD to the right buttock and left thigh. Wound: Resident #6 had a diabetic ulcer on the 4th toe located on right foot. Interventions: MASD to right buttock and left thigh provide house barrier cream as needed, wound care/ treatments per orders, monitor resident and keep MASD clean and dry. Wound : Right foot- 4th toe- diabetic ulcer provide Corona Ointment every 2 hours or as needed. Wound Care- cleanse, pat dry, calcium alginate and dry dressing. Consult wound, ostomy (an opening in the abdomen , allowing waste - stool or urine- to exit the body into a wearable, odor proof pouch when the digestive or urinary systems are damaged or diseased.)Evaluate skin for areas of blanching (temporary whitening or [NAME] of the skin that occurs when pressure is applied, displacing blood from the area)or rednessEvaluate skin for redness or excoriation (skin picking or scratching that results in skin damage, such as sores, lesions, or scabs)Provide skin care per facility guidelines as needed.Utilize pressure relieving devices on appropriate surfacesEncourage Resident #6 to frequently shift weightEducate Resident #6 and family on factors to maintain skin integrity. Record review of Resident#6's Weekly Skin Assessment, dated 03/01/2026, reflected the following: Skin color normalTemperature of the skin normalDid not have any of the following: discoloration, skin tear, abrasion, laceration, surgical incision, rash or moisture associated skin damage (inflammation and erosion of the skin caused by prolonged exposure to moisture, such as urine, stool, sweat, or wound fluid).Did not have pressure, venous- poor drainage, arterial-poor blood flow or diabetic ulcer- from nerve damage.Did have supra pubic catheter and diagnosis of labia cancerThere were not any new areas that have not been communicated to the physician or family. Record review of Resident #6's Weekly Skin Assessment, dated 03/08/2026, reflected the following:Skin color normalTemperature of the skin normalDid not have any of the following: discoloration, skin tear, abrasion, laceration, surgical incision, and rash.Resident #6 did have Moisture Associated Skin DamageResident #6 did have a pressure, venous, arterial or diabetic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ulcer.Resident #6 had other skin findings not described above: 2 skin tears, red open areas to buttocks, and 1 open area to right toe. There was not any new areas that have not been communicated to the physician/NP or family. Signed by LVN L.In the skin assessment dated [DATE] did not have the following in the skin assessment: measurement of the areas of skin, did not specify where the areas was on the buttocks, did not specify if there was any drainage, did not specify if Resident #6 was in pain, and did not obtain pictures of the skin concerns.Record review of Resident #6's Skin Issues Assessment completed on 03/09/2026 by Treatment Nurse LVN N, reflected Resident #6 had a new wound. It was in-house acquired. The exact date was on 03/08/2026. There was no signs or symptoms of infection. The skin areas was staged by in-house nursing (Treatment Nurse LVN N)Record review of Resident #6's Nurses Notes, dated 03/08/2026, reflected LVN L did not document any further information on Resident #6's skin concerns after completing weekly skin assessment on 03/08/2026.Record review of Resident #6's Nurses Notes, dated 03/09/2026 at 9:58 a.m. reflected Resident #6 was given pain medication related to discomfort to right fourth digit (toe).Record review of Resident #6's Nurses Notes, dated 03/09/2026 at 10:04 a.m. reflected LVN M called and asked for a PRN order for corona ointment to Rt foot- 4th digit as a barrier. Physician Assistant gave order to apply corona ointment to the area. LVN M attempted to contact Family member emergency contact #1. She left a voice message and awaiting response from the family member (first emergency contact). LVN M will continue to monitor. Record review of Resident #6's Nurses Notes, dated 03/09/2026 at 10:04 a.m., reflected LVN M noted Resident #6 had a redness on top of the right 4th digit. Resident #6 reported discomfort. LVN M notified wound care nurse to reassess the area. Resident #6 was given pain medication and will continue to monitor. Record review of Resident #6's Nurses Notes, dated 03/09/2026 at 2:51 p.m., reflected LVN M noted Resident #6 received corona ointment to right foot 4th digit every two hours or as needed for redness/irritation and may leave at bedside. Resident #6's initial dose was at 10:04 a.m. on 03/09/2026.Record review of Resident #6's Nurses Notes, dated 03/09/2026 at 2:55 p.m., reflected LVN M noted Resident #6 pain medication was effective and Resident #6's pain was a zero.Record review of Resident # 6's Nurses Notes, dated 03/09/2026, at 4:14 p.m., reflected Treatment Nurse LVN N noted LVN M notified her of Resident #6 had redness and discomfort to the right foot, 4th toe. LVN M reported contacted the PCP, who provided new orders per Resident #6's request for as needed corona ointment as a barrier. Treatment Nurse LVN N documented upon assessment, Resident #6 was noted to have an open area to right 4th toe with 100 percent red granulation tissue (new, highly connective tissue that forms at the base of a wound during the phase of healing)noted with scant serous drainage. Resident #6's peri wound area was noted to have redness without warmth and was tender to touch. Resident #6 wound measuring 0.4 cm x 0.5 cm x 0.1 cm. Resident #6 wound left open to air at this time. Resident #6 noted with moisture associated skin damage to right buttock measuring 3 cm x 1.2 cm x 0.2 cm. Her wound bed noted with 100 percent red granulation tissue with moderate serous drainage noted. Resident #6 treatment initiated to cleanse with wound cleanser, apply calcium alginate, and cover with border foam dressing three times per week. Resident #6 was noted with moisture associated skin damage to left posterior thigh measuring 0.7 cm x 2.3 cm x 0.2 cm. The wound bed was noted with 100 percent dermis (the thick, middle layer of skin situated between the outer epidermis and inner tissue, often called the true skin) with moderate serous. Resident #6 peri wound noted with normal skin tones and treatment initiated to cleanse with wound cleanser, apply calcium alginate, and cover with border foam three times per week. Resident #6 notified Treatment Nurse LVN N she became aware of open areas to her buttocks and thigh on Sunday 03/08/2026 when a nurse (did not specify what nurse) informed her that a dressing would be applied due to the presence of open areas. Resident #6 reported she had not previously noticed the areas prior to the nurse (did not specify nurse name). Resident #6 voiced understanding the need for treatment and dressing application. The Physician Assistant verbalized she will notify Primary Care Physician and will follow up with Treatment Nurse LVN N regarding further instructions and wound care orders. Treatment (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse LVN N awaiting further guidance at this time. Record review of Resident #6's nurses notes dated 03/09/2026 at 4:26 p.m. reflected Treatment Nurse LVN N documented new skin issue located on rear left thigh. Additional location information: left thigh issue type : Moisture Associated Skin Damage. Progress: new wound. Wound acquired in house. The date acquired was on 03/09/2026. There was no signs or symptoms of infection. The area was not painful. It was staged in house by Treatment Nurse LVN N. The measurements : 0.74 width cm, 2.32 depth cm, 0.2 cm area. There was no tunneling(a complication where narrow, channel-like pathways or passageways extend from the main wound bed into surrounding tissue or muscle). Exudate (the liquid that seeps from a wound, containing water, proteins, nutrients, and white blood cells that facilitate healing by keeping the wound bed moist) amount was moderate, and type was serous with clear watery fluid, which is separated from solid elements. There was no odor. Other wound bed information: 100 percent dermis. Peri wound attached. Surrounding tissue: normal in color. No induration (the hardening or thickening of soft tissue, most commonly the skin, caused by inflammation, infection, or disease present. There was no swelling or edema. Peri wound temperature : normal. Dressing appearance: intact. Dressing saturation: Moderate 26- 75 percent. Cleansing solution: Normal saline. Primary dressing: Calcium Alginate. Secondary dressing: foam. Modalities: none. Treatment will be three times per week.Record review of Resident #6's nurses notes dated 03/09/2026 at 4:26 p.m. reflected Treatment Nurse LVN N documented new skin issue on right gluteus (located outer side of right hip). The issue type was Moisture Associated Skin Damage. This is a new wound associated with incontinence- associated with dermatitis (moisture associated skin damage). The wound was acquired at the facility. The date the wound was acquired was on 03/08/2026. There is not signs or symptoms of infection. Resident #6 was not exhibiting any pain from the new wound. Treatment Nurse LVN N staged the wound as the following: length - does not give the length of the wound, 2.97 cm width, 1/18 cm depth and 0.2 cm2 (square centimeter) 2.08. There was no undermining (tissue destruction occurs under the skin at the wound edge, separating it from the underlying tissue and creating a pocket) or tunneling. Granulation was 100 percent . The Exudate amount was moderate. The exudate type was serous: clear watery fluid, which was separated from solid elements. There was no odor to the area after cleansing. The peri wound was attached. The surround tissue was maceration (softening, whitening, and breakdown of the skin caused by prolonged exposure to moisture, such as sweat, urine, or wound fluid). The following was not present: induration, edema, peri wound temperature. Resident #6's dressing was intact, and dressing saturation was moderate 26-75 percent. Cleansing solution : normal saline. Primary dressing: calcium alginate. Secondary dressing was foam and three times per week. Record review of Resident #6's nurses notes dated 03/09/2026 at 4:26 p.m., reflected Treatment Nurse LVN N documented Resident #6 had new skin issue located on the right dorsum (the top or upper surface, extending from the ankle to the toes) 4th toe. Issue type: Diabetic foot ulcer. Progress: new wound. Wound acquired in-house on 03/05/2026. Resident #6 did not have any signs or symptoms of infection. She was not in pain. Treatment Nurse LVN N stated the wound was as follows: Length 0.4 cm, 0.45 cm depth, and area cm2 0.15. There was no tunneling. Granulation was 100 percent. Exudate amount was light. Exudate type; serous with clear watery fluid, which was separated from the solid elements. There was no odor after cleansing. There was no induration or edema. Peri wound was attached, and the surrounding tissue was erythema(a common skin characterized by redness of inflammation, caused by increased blood flow in the dilated capillaries of the skin's lower layers) Dressing saturation was zero percent. Cleansing solution was normal saline and no dressing. There was no modalities (specialized, non-surgical techniques, tools, or technologies used to address specific skin concerns). The frequency of treatment was to leave open to air per Physician Assistant. The Physician Assistant will give further wound care orders when rounding in facility today. Record review of Resident #6's nurses note dated 03/09/2026 at 5:12 p.m. reflected Treatment Nurse LVN N received call from Physician Assistant regarding new open areas on Resident #6. Physician Assistant will see Resident #6 for evaluation of new areas tomorrow (03/10/2026). The Physician Assistant (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in agreement with applying calcium alginate and border foam to Resident #6's right buttocks and left posterior thigh. The Physician Assistant ordered for the 4th toe on right foot leave to open air for today and will reevaluate tomorrow (03/10/2026) when she is in facility making her rounds on the residents. Resident #6 was made aware of the new orders. Record review of Resident #6's nurses notes dated 03/10/2026 at 8:04 a.m. reflected Resident #6 was out of the facility for an appointment. Record review of Resident #6's Physician Assistant Progress Note, dated 03/10/2026 reflected Resident #6 had a right foot 4th digit diabetic wound.Interview and Observation of Resident #6 on 03/09/2026 at 12:00 p.m. revealed Resident #6 was in her room lying in bed. She stated her toe did hurt whenever it was touched or she moved her leg, and her toe touched another one of her toes. She stated at this time she was not in pain. The area on her toe was swollen very red and had brownish color draining. Surveyor did obtain a picture of her toe. Resident #6 stated the area on her toe began last Thursday 03/05/2026. She stated it was a red and pinkish color. Resident #6 stated she was getting a shower from the best CNA in the facility (CNA O). She stated CNA O was giving her a shower and when she began to wash her feet the small red /pinkish area began to bleed , however, you could barely see any blood. Resident #6 stated a person could barely see the red/ pinkish area on her toe. Resident #6 stated when CNA O finished her shower she reported to LVN M. She heard CNA O report this information to LVN Min the hallway and she was in her room. Resident #6 stated she heard LVN M state she would assess the toe on Resident #6 sometime today (03/05/2026). Resident #6 stated LVN M came to her room and put some ointment on her toe. She stated her toe was not red or pinkish when the nurse (LVN M) came to her room. Resident #6 stated on Thursday (03/5/2026) the toe on her right foot was fine there was not any pain, no open area, it was a little pink at first and she said by end of day on Thursday (03/05/2026) it looked normal. She stated she did not voice any concerns about her toe from Thursday 03/05/2026 until Sunday 03/08/2026 when the nurse came to her room to complete her skin assessment. She stated a nurse came in her room on Sunday (03/08/2026) and looked at her skin. Resident #6 stated this is when the nurse found the area on her bottom. She stated she was not in pain with the area on her bottom and did not realize it was there until Sunday. She stated it was not there when she received a shower on Thursday 03/05/2026 and when staff had changed her prior to Sunday (03/08/2026). Resident #6 stated the nurse on Sunday (03/08/2026) never mentioned an area on her thigh. She stated the nurse told her the treatment nurse would be in her room on Monday (03/09/2026) morning to reassess her toe and the area on her buttocks. Resident #6 stated she agreed with the plan. She stated she did receive pain medications as needed. She stated she woke up on Sunday morning (03/08/2026) and moved her right leg and noticed her toe was red and swollen. Resident #6 repeated on Sunday (03/08/2026) was when the toe began to swell and have some drainage. Resident #6 stated she had not experienced any pain with her bottom and she had received a shower in the past few days, and it was not there when she had her shower and when staff changed her clothes. In an interview on 03/09/2026 at 1:55 p.m. Treatment Nurse LVN N stated she received a message from LVN M close to lunch time about Resident #6 having a new area on the 4th toe on her right foot. She stated she was going to assess the area on the 4th toe on her right foot today (03/09/2026). She stated Resident #6 did not have any other skin concerns. Treatment Nurse LVN N and surveyor reviewed Resident #6's skin assessment together dated 03/08/2026. Resident #6's skin assessment revealed Resident #6 had 2 skin tears (did not specify location), red open areas to buttocks (did not specify measurements or how many open areas) and 1 open area to right toe (did not specify measurements, location of the open area). The Treatment Nurse LVN N stated she was not notified of the new skin concerns on Resident #6 except for the area on Resident #6's toe. She stated LVN M had notified her today about the open area on the toe but did not mention anything of other skin concerns. Treatment Nurse LVN N stated the nurse completed the skin assessment on Sunday 03/08/2026 and was expected to contact her, contact the physician and the family. She stated anytime there is a new skin concern she was to be notified. Treatment Nurse LVN N viewed the facility phone in her possession and stated there was no message (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schulenburg Regency Nursing Center	111 College St Schulenburg, TX 78956

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the nurse on Sunday 03/08/2026 about Resident #6's new skin concerns. She reviewed the nurses notes and stated there were no nurses notes from the nurse who worked on Sunday. Treatment Nurse LVN N stated LVN L was the nurse who completed the skin assessment on 03/08/2026. She stated there was no other documentation in the electronic medical record related to Resident #6's new skin concerns. She stated she would be going to Resident #6's room and would complete a skin assessment. She stated LVN L did not follow the expectations of communicating and following reporting new skin concerns at the facility. Treatment Nurse LVN N stated when there was a new skin condition this was considered a change of condition. In an interview on 03/09/2026 at 2:40 p.m. The Director of Nurses stated anytime there was a new skin concern the physician and treatment nurse were to be notified immediately the day the new skin concern was discovered. She stated the nurse on duty Sunday 03/08/2026 who completed Resident #6's weekly skin assessment needed to measure the new skin concerns and if there was any existing skin concerns, observe any discoloration of the skin, if Resident #6 was in pain, take pictures if needed, document any drainage, and document where the skin concerns were located on Resident #6's body. The Director of Nurses stated she expected a nurses note to be completed with full assessment information in the nurses note and to document on the communication board for the next shift to know about new concerns with Resident #6. She stated if the area was on Resident #6 toe on 03/05/2026 and a nurse knew about the area, the nurse was expected to report it to the treatment nurse and call the physician. The Director of Nurses stated the Treatment Nurse LVN N was informed today about the area on Resident #6's toe from the nurse working with Resident #6 (LVN M). She stated she would need to do some investigation with this incident with Resident #6 before responding to any further questions.In an interview on 03/09/2026 at 3:15 p.m. LVN M stated last Thursday (03/05/2026) CNA O reported to her of Resident #6 had a small red/ pinkish area and could barely see it on her toe on her right foot. She stated CNA O reported when she was giving Resident #6 a shower and she was washing her feet she noticed after she washed her right foot there was a little blood coming from the reddish/pinkish area on her toe. LVN M stated she did observe Resident #6's toe and put some zinc ointment on the toe but she did not see any open areas, and it was not discolored. LVN M stated she did not document anything about the toe in nurses notes. She stated today was her first day back to work and she reported to the treatment nurse this morning (03/09/2026) to look at Resident #6's toe on her right foot. LVN M stated she did observe it earlier today and she did apply ointment approved from Physician Assistant on Resident #6's toe. She stated there was some drainage coming from the area. LVN M stated there was no information reported to her in morning report from the night shift about any skin concerns of Resident #6. She stated CNA O reported to her today (03/09/2026) of Resident #6 having new areas on her buttocks. She stated she was not aware of the new skin concerns until today. LVN M stated there was not any information about Resident #6 documented on the communication board in the electronic medical records. She stated anytime there was a change of condition including new skin concerns the nurse was expected to document it on the communication board for all staff in the facility to view the changes of a resident. CNA O stated she did not report to the treatment nurse about the new areas on Resident #6's buttocks and when she contacted the Physician Assistant concerning Resident #6's area on her toe she did not report about the area on Resident #6's buttocks due to not knowing a lot of information about the area. She stated she did not assess Resident #6's buttocks. LVN M stated she was expected to report new concern to the Physician and ensure the resident's family was aware of new concern. Resident #6 is her own responsible party and she has a family takes care of finances and both was notified. She stated she did not report to anyone about the small red area and it had a small amount of bleeding when it was reported to her on Thursday 03/05/2026 and she was expected to report this to the treatment nurse and document it in the nurses notes.In an interview on 03/10/2026 at 9:05 a.m. CNA O stated she worked with Resident #6 on 03/05/2026 and was off work on 03/06/2026, 03/07/2026 , and 03/08/2026. She stated on 03/05/2026 Resident #6 had a small reddish pink area on her toe on her (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right foot. She stated she thought it was her fourth toe. CNA O stated she gave Resident #6 a shower and when they were in the shower she noticed a very small pinkish area on Resident #6's toe on her right foot. CNA O stated she was not able to leave Resident #6 alone and she was finished with the shower. She stated she assisted Resident #6 to her room and assisted her to bed. She stated LVN M was standing in the hall near Resident #6's room and she went in the hall and reported to LVN M about Resident # 6 having a very small pinkish spot on her toe on her right foot. She stated LVN M stated she would assess the area on Resident #6's toe sometime that day (03/05/2026). CNA O stated she did not discuss the area on Resident #6's toe anymore with LVN M. She stated once she reported the concern about Resident #6's toe to the nurse she did what she was supposed to do when there was a new condition with a resident. CNA O stated she was talking to Resident #6 yesterday (03/09/2026) about if she wanted to be assisted out of bed and Resident #6 stated I want to stay in bed a nurse is supposed to come and check my bottom and my toe. The nurse yesterday (03/08/2026) found a new skin problem on my bottom. CNA O stated there was not any skin concerns to Resident #6's thigh area or her buttocks on 03/05/2026 when she gave her a shower. CNA O reported Resident #6 stated I did not know I had any problems on my bottom until I was told yesterday (03/08/2026)- (this was the first time the staff noticed of skin condition on resident bottom was 03/08/2026 and Resident #6 was notified immediately when the nurse assessed her during weekly skin assessment). She stated I have not had any pain or issues on my bottom and there was not any issues I felt, and the nurse told me immediately what she found when she did my skin assessment on 03/08/2026 prior to this date I did not have any concerns on my bottom. I am not in pain except my toe hurts a little and the nurse already gave me some medicine for the pain, and it is a lot better. CNA O stated she reported the areas on Resident #6's bottom to LVN M yesterday (03/09/2026) right after breakfast around 9:00 a.m. She stated LVN M reported she would notify the treatment nurse.In an attempted interview on 03/10/2026 at 9:46 a.m. LVN M did not answer the phone and left voice message to return phone call and sent a text message with surveyor's phone number.In an interview on 03/10/2026 at 9:56 a.m. LVN L stated she worked at this facility on 03/08/2026 on the 600 hall. She stated she did complete skin assessment on Resident #6 on 03/08/2026. LVN L stated Resident #6 had 2 pressure areas on her buttocks and both of them were opened. She stated she did look at Resident #6's toe on her right foot. LVN L stated she documented on the skin assessment but was expected to complete a nurses note and to document more information. She stated I know I did not complete the skin assessment correctly and that is nursing 101 on how to assess a skin concern. She stated she needed to measure the areas on Resident #6's buttocks and her toe, note any discoloration of Resident #6's skin concerns, touch for any heat from the toe area, note any drainage from the skin concerns, and document the color of the drainage. She stated I was to document a nurses notes, take pictures to send to the treatment nurse on 03/08/2026 , contact the physician and family. She stated she did not do any of this and did not report the new skin concerns on Resident #6 to anyone in the facility or document it on the communication board in the electronic medical record to alert all staff of change of condition with Resident #6. She stated she was expected to document all the information she was expected to gather when assessing skin concerns and document it in a nurses note and she stated she did not complete a nurses note. LVN L stated I did not do anything correct when assessing Resident #6's new skin concerns. She stated she did not notice any areas on Resident #6 thighs only on her buttocks and toe on right foot. She stated she forgot to report to the oncoming nurses of the changes with Resident #6 skin concerns.In an interview on 03/10/2026 at 10:15 a.m. RN P stated she worked on Friday 03/06/2026 from 6:00 a.m. to 6:00 p.m. She stated she was assigned on the hall where Resident #6 resides. She stated she had checked Resident #6's catheter and Resident #6 did not report any concerns to her (RN P). She stated Resident #6 does not hesitate to report any health concerns or any concerns to anyone. RN P stated Resident #6 had her TED hose (specialized medical compression stockings designed for non-ambulatory residents to prevent blood clots on both feet. She did not see her feet. RN P stated Resident #6 did not complain about being in pain when she was in (continued on next page)

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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 observations, interviews and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for one of two kitchens reviewed for kitchen sanitation. The facility failed to ensure Dietary Assistant [NAME] D used proper hand hygiene during food preparation. These failures could place residents who ate food from the kitchen at risk for foodborne illness.Findings included: Observation and interview on 03/09/2026 at 12:15 p.m. revealed Dietary Assistant [NAME] D was holding the top of a clip board with both of her bare hands. There was a hard black substance covering the top of the clip board where Dietary Assistant [NAME] D had her fingers on her right and left hand touching the substance. Dietary Assistant [NAME] D placed the clip board on top of a shelf and she touched the right side of her scrub top with fingers on her right and left hand. Dietary Assistant [NAME] D walked to the steam table and picked up a divided plate with her left hand. Her fingers on her left hand were located inside the plate, and she placed food on the area where her fingers had touched the plate. She did this twice on two different plates. Dietary Assistant [NAME] D pulled the aluminum foil away from the chicken spaghetti and her fingers on both hands touched inside of the aluminum foil. Her fingers on her right hand touched the chicken spaghetti in the pan on the steam table. She never washed or sanitized her hands. She was interrupted from serving food and was asked if she washed her hands prior to serving food. Dietary Assistant [NAME] D stated she did not wash or sanitize prior to serving food. She immediately stopped serving food and sanitized her hands. Interview on 03/09/2026 at 12:40 p.m. Dietary Assistant [NAME] D stated the clip board did have black dirty stuff all over it. She stated she did touch the black substance and she did not wash her hands after she placed the clip board on top of the shelf. She stated she did touch her scrub top. She stated it was expected to wash her hands prior to serving food. Dietary Assistant [NAME] D stated the clip board and her scrub top was considered contaminated. She stated there was a possibility a resident may have bacteria on their plate or in their food transferred from her hands. Dietary Assistant [NAME] D stated if a resident swallowed food with bacteria on the food there was a possibility the resident may become physically sick with stomach issues such as vomiting and may need to be hospitalized . She stated she had been in-serviced on hand hygiene in February 2026, but she did not recall the exact date. Interview on 03/11/2026 at 12:05 p.m. The Dietary Supervisor stated all staff were required to wash hands between tasks and whenever they touched anything contaminated. She stated the clip board and clothes were considered contaminated. She stated there was a possibility bacteria moved from Dietary Assistant [NAME] D's hands onto residents' plates and food. She stated she did not recall the date of the in-service. She stated if a resident ingested some type of bacteria the resident may develop a food borne illness and may need to be transferred to the emergency room for evaluation if the resident became severely ill. She stated she in-serviced all staff in February 2026 on hand hygiene when preparing food. Record review of the Facility's Policy on Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, not dated, reflected Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. All employees must wash their hands: during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks and/or after engaging in other activities that contaminate the hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #21 and Resident #87) of four residents reviewed for infection control practices, in that: The facility failed to ensure Med Aide C sanitized the blood pressure monitor before Resident #21, in between Resident #21 and Resident #87 and after Resident # 87 while obtaining blood pressure.This failure could place residents at risk for healthcare associated with cross-contamination and infections.Findings included:Review of Resident #21's face sheet dated 03/09/26 reflected an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses including unsteadiness on feet, muscle weakness, muscle wasting, lack of coordination , history of falling, and hypertension (high blood pressure).Review of Resident #21's quarterly MDS assessment, dated 01/15/26 revealed her BIMS was 15 indicating that her cognition was intact.Review of Resident #21's care plan dated 08/21/25 reflected she had altered cardiovascular status r/t: HTN and risk for Dehydration. The relevant intervention was evaluating blood pressure and monitoring other vital signs.Review of Resident # 21's medication order revealed: Nebivolol HCl Oral Tablet 5 MG (Nebivolol HCl): Give 1 tablet by mouth one time a day related toessential (primary) hypertension. Hold for Pulse under 50. Record pulse even when held and notify MD. -Start Date-01/13/2026.Review of Resident #87's face sheet dated 03/09/26 reflected an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses including unsteadiness on feet, muscle weakness, muscle wasting, lack of coordination, cognitive communication deficit, and hypertension.Review of Resident #87's initial MDS assessment, dated 12/22/25 revealed his BIMS was 11 indicating that his cognition was moderately impaired. Review of Resident #87's care plan dated 12/31/25 reflected he had hypertension. The relevant intervention was taking blood pressure except after physical activity or emotional distress and administering blood pressure medications as directed by the physician.Review of Resident # 87's medication order revealed: Norvasc Tablet 10 MG (amlodipine Besylate): Give 1 tablet by mouth one time a day related toessential (primary) hypertension . Hold if SBP is less than 100 or DBP is less than 60.Document B/P even if med is held and notify charge nurse -Start Date-12/17/2025.During an observation conducted on 03/09/26 at 9:45 a.m., Med Aide C did not sanitize the wrist blood pressure monitor before using it on Resident #21, between Resident #21 and Resident #87, and after Resident #87. Med Aide C measured Resident #21's blood pressure with the wrist monitor without prior sanitization. After administering medications to Resident #21, she proceeded to Resident #87 and used the same monitor without sanitizing it first. She did not sanitize the monitor after the completion of using it on Resident #87 until the investigator pointed out the omission.In an interview on 03/09/26 at 10:35 a.m., Med Aide C stated that she had been employed at the facility for approximately five years and had received in-service training on hand sanitization between residents. However, she indicated that she had not received any training on the importance of sanitizing medical equipment between patients. She said that she had not previously considered the significance of sanitizing medical equipment concurrently with hand sanitization. She stated that, following her current mistake, she had come to recognize the importance of sanitizing blood pressure cuffs between residents, as it helps reduce the risk of transmitting infectious diseases through contamination.During an interview on 03/11/26 at 2:25 p.m., ADON A stated that she also serves as the facility's infection preventionist. She confirmed that her expectation was for all staff to sanitize medical equipment, including blood pressure cuffs, between residents. ADON A reported that she observed deficiencies in infection control practices during routine rounds in the facility. She explained that when deficiencies are identified, staff members are retrained and re-educated accordingly. ADON A further stated on Med Aide C's remark that she had never received training on sanitizing medical (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment during her five years of employment at the facility that sanitizing medical equipment was part of the standard precautions for infection control. She said the facility conducted in-service training on standard precautions at least once a month and Med Aide C attended them most of the time. She indicated she would discuss this matter with the DON, who was on leave that week, and plans to include additional topic of sanitizing medical equipment in the in-service sessions.Review of the in-service records from 10/01/25 to 03/10/26 revealed there were no in-services on cleaning medical equipment .There was one in service on 02/03/26 on ?infection control, universal precautions , hand washing and the review of the sign in sheet revealed Med Aide C had not participated in it.Record review of facility's policy Cleaning and Disinfection of Resident-Care Items and Equipment revised in September 2022 reflected : Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment).