STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 1 of 9 residents (Residents #1) reviewed for resident rights in that: The facility failed to ensure Residents #1's call light was answered in a timely manner. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #1's admission record dated 06/13/2025 documented a [AGE] year-old female admitted on [DATE]. Resident #1 had diagnoses which included: epilepsy (abnormal electricity activity in the brain), chronic obstructive pulmonary disease (group of lung disease that clock airflow and make it difficult to breathe), major depressive disorder(serious mental illness characterized by persistent sadness, loss of interest in activities and significant impairment in daily functioning), anxiety(intense, excessive, and persistent worry and fear about everyday situation), and need for assistance with personal care. Record review of Resident #1's Quarterly MDS assessment, dated 04/30/2025, revealed the resident had a BIMS score of 14 indicating the resident was cognitively intact. The MDS also revealed Resident #1 required substantial/maximal assistance in the areas of toileting hygiene, shower/bathe, lower body dressing, and putting on /taking off footwear. Record review of Resident #1's care plan, dated 05/06/2025, revealed Resident #1 was care planned for urinary incontinence and had an intervention of: Ensure call light is in reach on the left side and encourage resident to request for assistance for safety. Observation on 06/13/2025 at 12:41 p.m.-12:59 p.m. , revealed Resident #1 used the call light for assistance and CNA A did not come into the room until 18 minutes after the call light was placed for Resident #1 to be assisted. Resident #1 wanted the surveyor to observe the slow response time of being assisted. (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
	675587	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/2025 at 1:00 p.m. , Resident # 1 stated that she was safe and had a concern about call lights not being answered for long periods of times. Resident #1 did not elaborate on the exact time it was taking to receive assistance but stated she would just wait around until someone came in to assist her. Resident #1 stated the slow response time on assistance being received was not a good thing for the residents. Resident # 1 stated that the slow response times of receiving assistance had been happening for months and nothing had been done about it . During an interview on 06/13/2025 at 3:20 p.m., CNA A stated CNAs should be answering call lights no later than 2 minutes. CNA A said he was assisting with dining room duties when Resident #1's call light went off. CNA B would have been responsible for answering Resident #1's call light. CNA A stated he came back on D hall after assisting in the dining room and seen Resident #1's call light was on and came in to assist. CNA A could not tell a reason to why CNA B was not able to answer Resident #1's call light. CNA A stated it was protocol to answer call lights timely and it was expected for CNA B to have answered Resident #1's call light promptly. CNA A stated if Resident #1's call light was not answered promptly, then Resident #1's needs would not have been met. During an interview on 06/13/2025 at 4:07 p.m., CNA B stated around 12:40 p.m., she was assisting with care on D hall. CNA B stated the door was shut and she did not know that Resident #1's call light had gone off. CNA B stated she would have been responsible for answering Resident #1's call light. CNA B stated when call lights was not answered promptly the resident's needs would not have been met. CNA B stated it was expected for Resident # 1's call light to be answered promptly and it took a little longer than usual to assist. During an interview on 06/16/2025 at 4:28 p.m., the DON stated it was everyone's responsibility to make sure call lights were answered as soon as possible. The DON stated the expectations was to make sure Resident #1's call light was answered as soon as possible to see what Resident #1's needs was. The DON stated depending on the situation on what could happen if the call lights was not answered as soon as possible. The DON stated it was hard to answer if what could happen because it depended on the situation . The DON was not able to elaborate on the possible outcome if a resident's call light was not answered timely as she kept stating it depended on the situation. During an interview on 06/16/2025 at 5:05 p.m., the ADM stated all staff can and was expected to answer call lights as soon as possible. The ADM stated it was expected for Resident #1's call light to be answered as soon as possible. The ADM stated not answering a call light as soon as possible can cause poor quality in care. Review of the facility's Answering the Call Light policy, revised March 2021, reflected, Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines 1. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. 2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ask the resident to return the demonstration. 3. Explain to the resident that a call system is also located in his/her bathroom. 4. Be sure that the call light is pulled in and functioning at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.es 6. Some residents may not be able to use their call light. Be sure to check these residents frequently. 7. Report all defective call lights to the nurse supervisor promptly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 of 9 residents (Resident #2) reviewed for discharge requirements. The facility failed to ensure Resident #2 was readmitted to the facility, after being sent to the hospital for behaviors. This failure could place discharged residents and residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services. Findings included: A record review of Resident #2's face sheet dated 06/13/2025 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2's diagnosis was Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Unspecified asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen making it difficult to breath), Vascular dementia (brain damage caused by multiple strokes), and adjustment disorder with mixed anxiety and depressed mood. A record review of Resident #2's Initial MDS assessment, dated 06/11/2025, reflected the resident had a BIMS score of 99, which indicated Resident # 2 was unable to complete the interview. A record review of Resident #2's care plan, dated 06/06/2025, reflected Resident #2 had a diagnosis of Alzheimer's disease and resides in the secured unit due to his wandering and poor safety awareness. The approach consent for placement in the secured unit will be obtained from the guardian or responsible party. Review of Resident #2's medical records history reviewed through Matrix, revealed a 30 -day discharge letter was not provided to Resident #2's RP, or the local ombudsman when he was sent out to the hospital for behaviors on 06/11/2025 and was not allowed to return back to the facility. Review of Resident #2's progress note dated 06/11/2025 at 5:49 p.m., written by LVN C revealed Local Police arrived at facility and calmed resident down. Resident explained to police he didn't know why he was here, and he was being held here like a hostage. Police called supervisor which advised them to call EMS for transport to hospital to be evaluated. Resident agreed and willingly sat on gurney for EMS transport to hospital with no issues. MD, and RP notified and aware. Attempted an interview on 06/13/2025 at 10:50 p.m., 2:02 p.m., and 06/16/2025 at 10:37 a.m. left message for the local ombudsman to return call. The Local ombudsman did not return call by the exit 06/16/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/2025 at 11:30 p.m., the HSW stated Resident #2 had been medically cleared to come back to the facility. The HSW stated she had spoken with the ADM and he stated he was not accepting Resident # 2 back to the facility. The HSW stated the hospital just could not hold Resident #2 there and he had been medically, and psych cleared to return back to the facility. The HSW stated he had made contact with the ADM on three different attempts and kept being told Resident #2 was not allowed back due to his behaviors. The HSW stated Resident #2 was still at the hospital waiting to be able to return to the facility and she was working on getting Resident #2 placed at the VA hospital. During an interview on 06/16/2025 at 10:48 a.m., the RP stated on 06/11/2025 she received a text message from the ADM that evening, time not recalled, that Resident #2 was being transferred to the hospital for behaviors. The RP stated the DON called her by phone on 06/11/2025 time not recalled and stated that Resident #2 would not be allowed to come back to the facility due to his behaviors. The RP stated she had spoken with the ADM on 06/11/2025 by phone and he stated that Resident #2 could not come back to the facility because he had broken the door to the secured unit. The RP stated she was not given a 30-day discharge notice prior to Resident #2 being sent out to the hospital for behaviors. The RP stated the ADM was adamant about not allowing Resident #2 back to the facility due to his behaviors. The RP stated Resident #2 was not able to make any decisions and she was not able to participate in finding Resident #2 placement at another facility. The RP stated she spoke with the HSW on 06/11/2025,time not recalled and was told Resident #2 was medically cleared to return to the facility and the ADM refused Resident #2 to return. The RP stated Resident #2 was discharged from the hospital to the VA hospital on [DATE] and the time was not recalled. During an interview on 06/16/2025 at 2:20 p.m., the BOM stated she did know or partake in the immediate discharge of Resident #2. The BOM stated the SW would have been involved with the immediate discharge, but she was out of the facility on vacation out of the state. The BOM stated it was expected for Resident #2 to have received a 30-day discharge to have enough time to be placed at another facility. Attempted an interview on 06/16/2025 at 3:45 p.m., Left message for the SW to return call. The SW did not return call by the exit date 06/16/2025. During an interview on 06/16/2025 at 3:46 p.m., LVN C stated on the evening of 06/11/2025, Resident #2 was upset and did not know why he was at the facility. LVN C stated Resident #2 took a chair and hit at the door because he was unable to get out the secured unit. LVN C stated she assessed the resident and called 911. LVN C stated Resident # 2 had calmed down while talking with the police. LVN C stated the ADM gave word to send Resident # 2 out to the hospital for his behaviors. LVN C did not know when the resident was sent out to the facility for behaviors that he was not able to return to the facility. During an interview on 06/16/2025 at 4:28 p.m., the DON stated Resident #2 had been sent out to the hospital on [DATE] for behaviors. The DON stated the resident was hitting and kicking the door of the secured door. The DON stated the police came and resident was transported to the hospital. The DON stated Resident #2 was sent out to be treated and was able to return once treatment was received. The DON stated she was unaware that Resident #2 was not able to return back to the facility when he was sent out. The DON stated the ADM and the SW would have handled the immediate discharge for Resident #2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/16/2025 at 5:05 p.m., the ADM stated he followed the policy for immediate discharge. The ADM stated he wanted to make sure all his residents was safe. The ADM stated that Resident #2 had broken the door to the secured unit trying to get out. The ADM stated he had failed to provide a 30-day discharge notice to Resident #2, RP, and the local ombudsman. The ADM stated it was expected for a 30-day discharge notice to be given. The ADM stated if a 30-day discharge were not given Resident #2, or the RP would not have the provisions they would need for Resident #2 to be successful. Review of nursing policy and procedure manual titled facility-initiated discharge date d 07/2024 reflected It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge of the resident from the facility, except in limited circumstances.