STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675767	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency House	3745 Summer Crest Dr San Angelo, TX 76901

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 2 residents (Residents #1 and #3) reviewed for dialysis services. The facility failed to ensure the dialysis communication forms were completed to include the pre and post dialysis assessment for Resident #1 and Resident #3. The facility failed to ensure residents had a physician order for dialysis treatment and to inspect vascular access sites for Resident #1 and Resident #3. The facility failed to develop a person-centered care plan for Resident #1 and Resident #3 to address their dialysis needs. These failures could place residents at risk for complications and not receiving proper care and treatment to meet their needs.The findings included: Record review of Resident #1's face sheet revealed Resident #1 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses which included end stage renal disease (occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state) dependence on renal dialysis (artificial filtering of blood by a machine to remove waste and fluid) lobar pneumonia (bacterial infection that causes inflammation and consolidation of an entire lobe or large segment of the lung). Record review of the PPS 5-day MDS assessment, dated 12/22/2025, revealed Resident #1 had unclear speech and was usually understood by staff. The MDS revealed Resident #1 was usually able to understand others. The MDS revealed Resident #1 had a BIMS score of 3, which indicated severely impaired cognition. The MDS revealed Resident #1 had no behavior or refusal of care. Record review of the baseline care plan, last revised on 12/19/2025, revealed Resident #1 had no care plan for hemodialysis or end stage renal disease. Care Plan revealed Resident #1 had an acute infection with no other specifications. Record review of the Pre/Post Dialysis Communication Report forms for Resident #1, from December 2025, revealed Resident #1 had missing post dialysis assessment (completed by the facility staff) for the following dates: 12/22/2025, 12/24/2025. Record review of the order summary report, dated 01/27/2026, revealed Resident #1 had no orders for hemodialysis or to inspect vascular access sites. Record review of Resident #3's face sheet revealed Resident #3 was a [AGE] year-old male admitted on [DATE]. , Resident #3 had diagnoses which included end stage renal disease (occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state) dependence on renal dialysis (artificial filtering of blood by a machine to remove waste and fluid), type 2 diabetes mellitus (chronic condition causing high blood sugar due to insufficient insulin). Record review of Resident #3's quarterly MDS, dated [DATE], revealed Resident #3 had unclear speech, was usually understood by others and usually understands others. The MDS revealed Resident #3 had a BIMS of 12, which indicated moderately impaired cognition. The MDS revealed Resident #3 had no behavior or refusal of care. Record review of Resident #3's care plan revealed a care plan for hemodialysis with no specific frequency, location, or access site. Record review of the Pre/Post Dialysis (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Communication Report for Resident #3 for December 2025 revealed only 3 forms on 12/12/2025, 12/17/2025, 12/19/2025. Review for January 2026 revealed 5 forms on 1/9/2026, 1/12/2026, 1/16/2026, 1/21/2026, 1/23/2026. Record review of the order summary report, dated 1/27/2026, revealed Resident #3 had no orders for hemodialysis or to inspect vascular access sites. Interview on 1/26/2026 at 11:00 AM, the ADON revealed the facility had no dialysis policy they were expected to follow the standards of care. The ADON stated Resident #1 and Resident #3 had dialysis 3 times weekly on Monday, Wednesday, and Friday. The ADON stated staff were aware of dialysis days because the transportation schedule was posted at the nurse's station and if adjustments needed to be made the dialysis center would call the nurses. The ADON stated it was the nurse's responsibility to fill out the dialysis assessment form prior to and after dialysis. She stated at this current time the dialysis assessment process was not monitored. The ADON stated they were all new and had just assumed someone was responsible for the dialysis assessment forms. The ADON stated a risk of not doing the dialysis assessment and having physician orders could be inadequate care. Interview on 1/26/2026 at 12:00 PM, RN A said the admission check list did not include dialysis. RN A stated, Hopefully the nurses are monitoring the access and doing pre and post communication forms. RN A stated with staff turnover recently, the nurses were still completing orientation and learning who was responsible for the dialysis assessment forms. RN A stated care plans were the responsibility of the Interdisciplinary team. RN A stated a risk of not MD orders for dialysis could cause a decline in condition. Interview on 1/26/2026 at 1:00 PM, LVN B stated she was not aware that orders were not in the compute for residents with dialysis. She stated physician orders were usually put in at admission. LVN B stated nurses filled out the pre and post dialysis forms. LVN B stated if the form was not received back from dialysis, they would notify them. LVN B stated she was not aware who monitored this process. LVN B stated she had not noted a decline in condition related to not following these processes with Resident #1. Interview on 1/27/2026 at 2:30 PM, with Resident #1 and Resident #3's physician, The MD stated the risk of not following the standards of care for dialysis recipients could eventually lead to complications. Interview on 01/27/2026 at 4:31 PM, the Administrator stated he expected nursing staff to ensure dialysis orders were updated, care plans were resident centered, the post dialysis assessments were completed and documented on the dialysis communication form. The Administrator stated nursing management was responsible for monitoring to ensure orders were updated and the post dialysis assessment was completed and documented on the communication form. The Administrator stated they did not have a dialysis policy and just followed federal and state guidelines for dialysis residents. The Administrator stated it was important to ensure the post dialysis assessment was completed to monitor a change in the resident's condition. The Administrator stated it was important to ensure dialysis orders were updated to ensure compliance with the regulations.