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	09/19/2024

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interviews and record reviews, the facility failed to ensure an encoded, accurate and complete MDS assessment was electronically transmitted to the CMS System within 14 days after completion for 4 of 5 residents (Resident #22, #46, #63, and #77) reviewed for MDS assessments. 1. The facility failed to ensure Resident #22's quarterly MDS assessment was completed and transmitted timely. 2. The facility failed to ensure Resident #46's quarterly MDS assessment was completed and transmitted timely. 3. The facility failed to ensure Resident #63's significant change MDS assessment was completed and transmitted timely. 4. The facility failed to ensure Resident #77's annual MDS assessment was completed and transmitted timely. This deficient practice placed residents at risk of not having assessments completed and submitted in a timely manner as required. The findings included: Review of Resident #22's Admission Record, dated, 9/19/24 documented she was [AGE] year-old female admitted to the facility on [DATE] with diagnoses including vascular dementia, high blood pressure, stroke with paralysis on one side, high cholesterol, osteoporosis (weak bones) without fracture, depression, and anxiety. Review of Resident #22's MDS assessment history revealed her last MDS was a Quarterly assessment Accepted on 5/17/24. She had an Annual MDS dated [DATE] that was export ready. Review of Resident #46's Admission Record, dated 9/18/24, documented she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including malnutrition, high blood pressure, high cholesterol, osteoporosis without fracture, transient cerebral ischemic attack (brief stroke-like symptoms usually resolving itself within 24-hours), difficulty speaking, disorientation, and arthritis. (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: 675767	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #46's MDS history revealed she had a 5-Day Medicare Stay MDS completed 5/18/24. She had a Quarterly MDS dated [DATE] that was export ready. Review of Resident #63's Admission Record dated 9/18/24 documented she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, diabetes, anxiety, arthritis, depression, high blood pressure, low thyroid, and high cholesterol. Review of Resident #63's MDS history revealed she had a Significant Change MDS assessment completed 5/16/24. She had a Discharge, return anticipated MDS dated [DATE] that was export ready and an entry MDS dated [DATE] that was export ready. Review of Resident #77's Admission Record, dated 9/19/24 documented, he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including heart disease, malnutrition, high blood pressure, high potassium, difficulty speaking, and cognitive decline. Review of Resident #77's MDS history revealed he had a Quarterly MDS assessment completed 5/16/24. He had an annual MDS Assessment completed and export ready dated 8/16/24. In an interview on 09/19/24 at 11:59 AM, the MDS Coordinator stated she sent the MDS Assessments to the Assessment regional boss and the regional boss was responsible for exporting the MDS Assessment from the facility's documentation program and importing it (transferring it) into LTC Simple (the CMS program used for MDS Assessments). The MDS Coordinator stated she was capable of running reports of what MDS assessments were due that did not affect LTC Simple in any way. The MDS Coordinator stated Resident #22, #46, #63, and #77's due MDS were ready for export since 8/16/24 and had not been exported for a month until 9/11/24. The MDS Coordinator stated she was out sick for a week, and she was the only person in the building who completed MDS Assessments in the building. The MDS Coordinator stated the last MDS sent on Resident #63 was 5/26/24. The MDS Coordinator stated Resident #77's last MDS Assessment was an Annual Assessment due on 8/16/24 and was completed and transmitted on 9/12/24. The MDS Coordinator stated Resident #22 had an Annual MDS on 8/15/24 and it was completed on 9/10/24 but it had not been transmitted yet. The MDS Coordinator stated the outcome to not transmitting MDS on time would be that the LTC-Simple would not be on time. The MDS Coordinator stated the MDS was just the assessment the facility did for all of the residents, and she did not know what the outcome would be other than they would loose points on the quality measures for their star rating for not transmitting on time. Record review of the CMS RAI Version 3.0 Manual, last revised October 2023, reflected: For a Quarterly, Significant Correction to Prior Quarterly, Discharge or PPS assessment, encoding must occur within 7 days after the MDS completion Date . Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 26221 48593 Based on interviews and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 8 residents (Resident #65, Resident #17) reviewed for care plans. 1. The facility failed to have a care plan addressing Resident #17's Enhanced Barrier Protection with her Pressure Ulcer. 2. The facility failed to have a care plan in place to accurately address Resident #65's behavioral problems. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Resident #17 Record review of Resident #17's admission record dated 09/19/2024 indicated she was admitted to the facility on [DATE]. Diagnoses included dementia, and muscle wasting and atrophy. She was [AGE] years of age. Record review of Resident #17's MDS assessment dated [DATE] indicated her BIMS score was a 3 indicating the resident's cognition was severely impairment. In Section M - Skin conditions, Resident had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Record review of Resident #17's care plan dated 07/04/2024 indicated in part: Problem: The resident has actual impairment to skin integrity of the r/t (related to) pressure area noted to coccyx (commonly referred to as the tailbone). Goal: The resident will have no complications through the review date. Interventions: Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Follow facility protocols for treatment of injury. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal. In an interview on 9/19/24 at 10:26 a.m., the MDS Coordinator stated she was sure Resident #17's Pressure Ulcer needed an intervention or care plan addressing Enhanced Barrier Protection but she needed to learn more about it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/19/24 at 10:26 p.m., the MDS Coordinator stated her process for identifying what needed to be care planned and not care planned started with printing out the Care Area Assessments from the MDS Assessments and anything she observed in the resident's room. The MDS Coordinator stated the DON reviewed the care plan for accuracy at the time it was written and the regional person also checked but she did not know how often. Resident #65 Observations from 09/17/24 through 09/19/24 of resident in the facility revealed the resident appeared to be upset through the during of the survey. The resident only offered short answers to the surveyor and did not want to have a full interview. Interview with the DON on 09/18/2024 at 12:31 pm revealed the staff were aware of Resident #65's behavioral issues. DON stated that the resident often had emotional outbursts and would yell at staff. DON stated the resident has not ever been aggressive with other residents. Interview with MDS coordinator on 09/19/24 at 1:34 PM revealed she was aware of the behavioral issues the resident had and believed it to be care planned. She stated this is something that needed to be care planned to ensure he is receiving the appropriate interventions. MDS v stated that she had it care planned but for some reason it was resolved when he left for the hospital a few months back. MDS coordinator stated she will reinstate the care plan. Review of the facility's policy and procedure for Comprehensive Person-Centered Care Plans, revised December 2016, revealed: 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 The Interdisciplinary Team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will: incorporate identified problem areas. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plans. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. b. When possible, interventions address the underlying source(s) of the problem area(s), not just the addressing only symptoms or triggers. c. Care planning individual symptoms in isolation may have little, if any benefit for the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observations, interviews, and record reviews, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 4 residents (Resident #43) reviewed for quality of care. The facility failed to ensure CNA A did not lift Resident #43's urine collection bag above his bladder while she transferred the resident with the use of a mechanical lift. This failure could place residents at risk for catheter associated urinary tract infections (CAUTI). The findings included: Record review of Resident #43's admission record dated 09/17/2024 indicated he was admitted to the facility on [DATE]. Diagnoses included benign prostatic hyperplasia (BPH) (Age-associated prostate gland enlargement that can cause urination difficulty) and diabetes. He was [AGE] years of age. Record review of Resident #43's MDS assessment dated [DATE] indicated Cognitive Skills for Daily Decision Making = Modified independence - some difficulty in new situations only. Bladder and bowel: Appliances = Indwelling catheter (including suprapubic catheter and nephrostomy tube) Record review of Resident #43's care plan dated 08/27/2024 indicated in part: Problem: Resident has a Foley catheter related to dx of BPH. Goal: Resident will be/remain free from catheter-related trauma through review date. Interventions: Monitor/document for pain/discomfort due to catheter. Secure catheter with securement device. During an observation on 09/17/24 at 10:32 AM, CNA A and CNA B transferred Resident #43 from his wheelchair to his bed with the use of the mechanical lift. Resident #43 had an indwelling urinary catheter and CNA A took the catheter drainage bag and hung it on one of the hooks of the mechanical lift. When the CNA's raised Resident #43 with the lift the catheter drainage bag was noted to go up as well approximately 12 inches above the resident's bladder. The urine in the drainage bag was seen flowing back in the direction of Resident #43's penis. During an interview on 09/17/24 at 02:15 PM, CNA A said the urinary catheter bag was supposed to be kept at the height of under the knee. CNA A said the catheter bag was supposed to be kept low so that the urine in the bag would not flow back into the resident's bladder. CNA A was made aware of the observation when she transferred Resident #43, and his catheter bag was about a foot above his waist. CNA A said she had missed that and had not noticed the bag had gone that high during the transfer. CNA A said if the catheter bag was elevated past the resident's waist, that could lead to infections such as UTIs due to the back flow of urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/24 at 02:20 PM, the DON said it was expected for nursing staff to maintain the height of the catheter bag below the urinary bladder. The DON said if the catheter bag was elevated higher than the resident's bladder that could lead the urine in the bag backing into the resident's bladder. The DON said if the urine in the catheter back flowed into the resident's bladder, it could lead to infections. The DON said they conducted training and in-services on transferring residents and how to maintain the catheter bag below the bladder during resident care. The DON said they monitored nursing staff by conducting proficiency training on an annual basis. During an interview on 09/19/24 at 02:42 PM, the Administrator said he was not a clinician and was not able to explain what the expectations were regarding the catheter bag. The Administrator said he was sure the DON knew the answer to that. Record review of the facility's policy titled Catheter care, urinary dated 09/2014 indicated in part: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining unobstructed urine flow. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48593 Based on observation, interview, and record review, the facility failed to ensure all controlled drugs and biologicals were stored in separately locked and permanently affixed compartments for 2 of 8 medication carts (Med Cart #1, Med Cart #2), reviewed for pharmacy services. The facility failed to ensure Med Cart #1, Med Cart #2 remain locked while unattended. This failure could place residents at risk of and unauthorized access to medications. Findings included: Observation of the facility Med Cart #1 on 09/17/2024 at 09:06 am showed the cart to be unlocked and unattended. Observation of the facility Med Cart #2 on 09/17/2024 at 09:08 am showed the cart to be unlocked and unattended. An interview with CMA C on 09/17/2024 at 11:44 am revealed he had walked away from the cart to administer medication to a resident. CMA C stated that the policy was to lock the cart if they are not getting medication out of it and especially if one walks away. CMA C stated he messed up leaving it unlocked and was just in a hurry. An interview with the DON on 09/19/2023 at 2:30 pm revealed medication carts should be locked when unattended . The DON stated that she educated staff on keeping the carts locked after the initial observation of the medication carts being unlocked and would continue to emphasize the importance. A review of the facility policy titled Medication Administration with a revision date of 12/1/21, provided by the DON, read in part, during administration of mediations, the medication cart is to be kept closed and locked when out of sight of the medication nurse or aid. The cart must be clearly visible to the personnel administering medications, and all outward sides be inaccessible to residents or other passing by.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30057 Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: The facility failed to ensure the Food Supervisor (FS) was wear a mustache guard while there was uncovered food in the kitchen. This deficient practice could place residents who consumed meals and/or snacks from the kitchen at risk for food borne illness. The findings were: During an observation and interview on 09/17/24 at 09:32 AM, the FS was noted to have a mustache and not covered with a hair restraint. The FS was leaning over some uncovered pots that contained food and were on the stove top. The FS was asked about his mustache and if he ever covered it,. The FS asked the surveyor if he was supposed to cover it. The FS said that honestly, he had not thought about covering his mustache and at that time, he took a face mask and put it on. During an interview on 09/19/24 at 02:38 PM, the Administrator was made aware of the observation of the FS not having his mustache covered with a hair restraint. The Administrator said if staff had a beard, then he could see that the policy applied. The Administrator said the policy indicated for staff to use beard coverings and not specifically mustache covering. Record review of the facility's policy titled Employee sanitation and dated 10/01/2018 indicated in part: The nutrition and food service employees of the facility will practice good sanitation practices in accordance with the state and US food codes in order to minimize the risk of infection and food borne illness. Employee cleanliness requirements - Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food contact surfaces.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Residents #17 and #43) reviewed for infection control. The facility failed to ensure CNAs A and B followed EBP procedures by not wearing a gown while transferring Resident #43 with the mechanical lift. (Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents). The facility failed to ensure the Treatment nurse followed EBP procedures by not wearing a gown while providing wound care for Resident #17. This failure could place residents at risk for cross contamination and infection. Findings: Record review of Resident #43's admission record dated 09/17/2024 indicated he was admitted to the facility on [DATE]. Diagnoses included benign prostatic hyperplasia (BPH) (Age-associated prostate gland enlargement that can cause urination difficulty) and diabetes. He was [AGE] years of age. Record review of Resident #43's MDS assessment dated [DATE] indicated in part: Cognitive Skills for Daily Decision Making = Modified independence - some difficulty in new situations only. Bladder and bowel: Appliances = Indwelling catheter (including suprapubic catheter and nephrostomy tube) Record review of Resident #43's care plan dated 08/27/2024 indicated in part: Problem: Resident has a Foley catheter related to dx of BPH. Goal: Resident will be/remain free from catheter-related trauma through review date. Interventions: Monitor/document for pain/discomfort due to catheter. Secure catheter with securement device. Record review of Resident #43's Order Summary Report dated 09/18/24 revealed in part: Foley catheter care Q shift and PRN. Effective 08/23/2024 Record review of Resident #17's admission record dated 09/19/2024 indicated she was admitted to the facility on [DATE]. Diagnoses included dementia, and muscle wasting and atrophy. She was [AGE] years of age. Record review of Resident #17's MDS dated [DATE] indicated in part: BIMS = 3 indicating resident had severe impairment. Section M - Skin conditions = Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's care plan dated 07/04/2024 indicated in part: Problem: The resident has actual impairment to skin integrity of the r/t pressure area noted to coccyx. Goal: The resident will have no complications through the review date. Interventions: Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Follow facility protocols for treatment of injury. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal. Record review of Resident #17's Order Summary Report dated 09/19/24 revealed in part: unstageable to sacrum cleanse with dwc (dermal wound cleanser), pat dry. Skin prep around wound, Santyl to wound bed, then calcium alginate and cover with bordered foam. Change daily and prn if dressing come off or becomes soiled. Effective 09/17/2024 During an observation on 09/17/24 at 10:32 AM, CNA A and CNA B transferred Resident #43 from his wheelchair to his bed with the use of the mechanical lift. Resident #43 had a urinary catheter and CNA A took the catheter drainage bag and hung it on one of the hooks of the mechanical lift. Both CNAs assisted with the transfer and neither of them wore PPE during the procedure. There were no EBP sings posted outside the resident's room. During an interview on 09/17/24 at 02:15 PM CNA A was asked if she was aware of what EBP was. CNA A said she had not heard of that nor been told that she had to use PPE when assisting a resident with a catheter. CNA A asked if she was to wear PPE then she would, but again she had not heard about it. During an interview on 09/17/24 at 02:34 PM, CNA B was asked if she was aware of what EBP was. CNA B said she had not heard of that and did not know what EBP stood for. CNA B said they had not received any training about using PPE with residents that had a catheter and of course no training regarding EBP. During an observation on 09/19/24 at 08:38 AM, the treatment nurse performed wound care on Resident #17. The treatment nurse entered Resident #17's room and performed the wound care to the resident's sacrum (coccyx area). During the entire process of the wound care, the treatment nurse did not put on PPE as the resident was on EBP precautions. During an interview on 09/19/24 at 08:50 AM, the treatment nurse said she had forgotten to don PPE during Resident #17's wound care. The treatment nurse said she could not believe she had forgotten as she had thought about making sure she would don PPE when she performed the wound care. The wound care nurse said she was supposed to don PPE to prevent the spread of infections. During an interview on 09/19/24 at 02:24 PM the DON said it was expected for staff to use PPE when assisting a resident on EBP precautions. The DON said if staff did not used PPE, then they could possibly expose residents to infections. The DON said part of the reason the failure occurred was because staff had not gotten used to using EBP procedure. The DON said staff had not placed the PPE and EBP precautions out yet and had not been trained on EBP as they had just recently when surveyor's made them aware of that requirement. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/19/24 at 02:47 PM the Administrator said it was expected for staff to use EBP equipment if they were going to assist a resident on EBP precaution. The Administrator said the reason to use PPE in EBP resident rooms was to prevent the spread of infections. The Administrator said they were in the process of training the staff on the use of EBP. Record review of the facility Enhanced Barrier Precautions policy dated August 2022 revealed in part: Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBP's employ targeted gown and glove use during high contact resident care activities and gloves and gown are applied prior to performing the high contact resident care activity. The policy further includes examples of high-contact activities including providing hygiene, transferring, and wound care. Record review of the facility's policy titled Policies and practices - infection control dated October 2018 indicated in part: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of our infection control policies and practices are to: Prevent, detect, investigate and control infections in the facility; Maintain a safe, sanitary and comfortable environment for personnel, residents, visitors and the general public; establish guidelines for implementing isolation precautions, including standard and transmission-based precautions. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. 48593

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	09/19/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 30057 Based on observation and interview the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for physical environment. The facility failed to ensure one of six stove top burners ignited automatically. This failure could place residents at risk of foodborne illnesses and potential for injury to residents and staff. Findings included: During an observation and interview on 09/17/24 at 09:30 AM, the stove in the kitchen was inspected. One of the six burners was noted to turn not turn on when the knob was turned to on by [NAME] D. [NAME] D said she had to use a lighter to turn that burner on as it did not turn on automatically like the other five burners. [NAME] D said she believed the burner had been like that for about two weeks at that time. During an interview on 09/17/24 at 09:32 AM, the FS said the burner on the stove top did not turn on automatically, but that it would turn on with the use of a lighter. During an observation and interview on 09/18/24 10:08 AM, [NAME] D was asked to show the surveyor how she turned on the stove top burner that did not turn on automatically. [NAME] D said they used that burner as well and she would use a lighter to turn it on. [NAME] D went to look for the lighter, but was unable to locate it. The cook asked the FS for the lighter and at this time the FS came with the lighter and turned on the stove top burner. The FS said he was not sure how long the stove top burner had not been working properly. The FS said if the burner was turned on, left on, and it did not light up, it could lead to an explosion. The FS said he had reported it to the maintenance department today and they were going to look at it. During an interview on 09/19/24 at 10:40 AM, the Maintenance Supervisor said he had not been made aware by the kitchen staff that one of the stove top burners was not working properly until after the state surveyors had entered. The Maintenance Supervisor said he had just been made aware yesterday and he had started working on it. During an interview on 09/19/24 at 02:46 PM, the Administrator said they did not have a specific policy regarding the kitchen equipment. The Administrator said it was expected for the kitchen equipment to work properly and if not that it should be reported promptly to be repaired.