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	12/18/2025

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

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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** Based on observations, interviews and record reviews the facility failed to develop a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment which were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 20 residents (Resident #5, Resident #41, Resident #76) reviewed for care plans.The facility failed to implement a comprehensive person-centered care plan for Resident #5's diagnosis of bilateral presbycusis (hearing loss, in both ears, related to damage of the inner ear that develops gradually as you get older).The facility failed to implement a comprehensive person-centered care plan for Resident #41's scalp cancer.The facility failed to implement a comprehensive person-centered care plan for Resident #76's range of motion impairments.This failure could result in residents not receiving needed care and treatments. Findings included: Resident #5Record review of Resident #5's admission Record dated 12/17/2025, revealed an initial admission on [DATE] and a re-admission on [DATE]. Resident #5's admission Record revealed diagnoses of vascular dementia (decreased blood flow to areas of the brain), repeated falls, major depressive disorder, and bilateral presbycusis. She was [AGE] years old. Record review of Resident #5's MDS dated [DATE], revealed cognitive skills for daily decision-making score of 4 (severely impaired - never/rarely made decisions). Resident #5 was coded for difficulty hearing. Record review of Resident #5's care plan reviewed on 12/16/2025 revealed: Problem - The resident has impaired visual function related to diagnosis of Cataracts and Bilateral Presbycusis upon admit. Goal - The resident will have no indications of acute eye problems through the review date. Interventions - Identify/record factors affecting visual function including Physiological (glaucoma-a term for diseases that cause increased eye pressure, Crohn's-a bowel disease that causes chronic inflammation of the gastrointestinal tract, macular degeneration-a disease that damages the part of the eye responsible for sharp, central vision, cataracts-a condition in which the lens of the eye becomes progressively opaque resulting in blurred vision, color discrimination, light sensitivity, and dry eyes); Environmental (poor lighting, monochromatic color scheme), Choice (refuses to wear glasses, use mag glass, turn on lights) etc., Monitor/document/report as needed any signs/symptoms of acute eye problems, change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision. Record Review of Resident #5's care plan revealed there was not a focus area or interventions documented for hearing loss/difficulty hearing. During an interview on 12/18/2025 at 2:25 PM with the MDS/Care Plan Coordinator revealed the MDS/Care Plan Coordinator and the DON were responsible for the care plans and ensuring they were accurate and complete. The MDS/Care Plan Coordinator said she was not sure what presbycusis was, but it sounded like it was related to the eyes. She said she would have to look it up to be sure. The MDS/Care Plan Coordinator said a possible negative outcome of the inaccurate care plan would be inaccurate care provided to the resident.During an interview on (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/18/2025 at 2:31 PM with the DON revealed she confirmed the MDS/Care Plan Coordinator and the DON were responsible for the care plans and ensuring they were accurate and complete. The DON said she performed random reviews on care plans. The DON said she had not reviewed Resident #5's Care Plan. The DON said she did not feel like the resident would have a negative outcome because the resident did not speak English anyway. Resident #41Review of Resident #41's admission Record dated 12/17/25 revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included stroke, difficulty speaking, glaucoma and anxiety. Resident #41 was on hospice. Review of Resident #41's quarterly MDS assessment, dated 12/2/25, revealed:He had a blank BIMS score but showed memory problems with both long and short term memory. He had severely impaired cognitive skills for daily decision making.He was totally dependent on staff for ADLs.Cancer was not checked.He had mild pain symptoms and received scheduled and as-needed pain medication.He had a life expectancy of less than six months.Review of Resident #41's Order Summary Report, dated 12/17/25, revealed orders:Enhanced Barrier Precautions every shift for chronic cancer wound to scalp, dated 12/16/25.Fluocinonide 0.05% ointment apply to affected areas on scalp twice a day on weekends only, as needed every 12 hours as needed for scalp issues family to provide ointment/weekends only dated 1/28/25.Review of Resident #41's Care Plan, last updated 8/20/25 did not reveal a care plan for the cancer and associated wound care. Observation on 12/16/25 at 11:15 AM revealed Resident #41 was in bed with an approximately half an inch of skin growth in a circle on his head.Observation and interview on 12/17/25 at 9:00 AM the Treatment Nurse stated Resident #41's cancer lesion cracked open and was leaking fluid. The Treatment Nurse completed wound care on Resident #41's lesion correctly. Resident #76Review of Resident #76's admission Record, dated 12/17/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis affecting the body from the neck down) and history of traumatic brain injury.Review of Resident #76's admission MDS Assessment, dated 11/23/25, revealed:She was sometimes able to make herself understood. She had a BIMS score of 11, indicating she was moderately cognitively impaired. She used a wheelchair and a mechanical lift. She had range of motion impairments of the lower and upper extremities on both sides. She was dependent on staff for all ADLs.She had no falls.She received occupational, physical, and speech therapy.Observation of the lunch meal on 12/16/2025 at 12:23 PM revealed staff helped feed Resident #76 by holding her head up, there was a u-pillow on floor. Resident #76 did not lift her hands up to help. Interview on 12/16/2025 at 2:38 PM Resident #76's Responsible Party stated the staff kept moving the head rest on Resident #76's head rest causing it to break. The Responsible Party stated the staff did not use Resident #76's u-pillow. The Responsible Party was observed attaching a strap to the head rest to go around Resident #76's head and hold it up. Observation on 12/16/25 at 5:12 revealed Resident #76 was up in the dining room. Resident #76 was up in her wheelchair with the strap across head that had fallen into her eyes. Resident #76 moved her head back and forth trying to get the strap out of her eyes. Resident #76 did not lift her arms and push the strap up or off. Interview on 12/18/2025 at 3:32 PM the MDS nurse stated she was responsible for care plans. The MDS nurse said Resident #76 was full care for everything. The MDS nurse reviewed Resident #76's care plan and said there was no care plan for range of motion. The MDS nurse stated the care plan needed to be there so the staff knew what they could do with Resident #76 and what Resident #76 could and could not do. Record review of the facility's Care Plans, Comprehensive Person-Centered Policy dated 03/2022 read in part, 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.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observation, interview, and record review the facility failed to ensure each room was designed or equipped to assure full visual privacy for 46 (Rooms 2, 3, 4, 5, 6, 7, 9, 10, 12, 14, 15, 16, 17, 20, 21, 23, 25, 26, 28, 30, 31, 32, 33, 34, 35, 36, 37, 39, 40, 41, 42, 43, 44, 45, 46, 49, 50, 51, 52, 53, 54, 55, 56, 58, 59 and 60) of 60 dual occupancy rooms reviewed for privacy in the facility. The facility failed to ensure that dual occupancy rooms were provided with ceiling suspended curtains, which extended around the bed, to provide total visual privacy. This failure could lead to a lack of privacy for residents, allow residents' private medical treatment to be observed by roommates or others, and lead to a decline in psychosocial well-being. Findings included: During an observation on 12/18/2025 at 11:05 AM of resident rooms 2, 3, 4, 5, 6, 7, 9, 10, 12, 14 and 15 on A hall revealed that each room had dual occupancy with an A and B bed in each. During an observation on 12/18/2025 at 11:34 AM of resident rooms 16, 17, 20, 21, 23, 25, 26, 28 and 30 on B hall revealed that each room had dual occupancy with an A and B bed in each. The rooms had a single ceiling to floor curtain that divided the center of the room but stopped approximately 18 inches from the wall. Both A and B beds had a side curtain each but they each had a gap of 18 inches and 30 inches and were unable to allow for beds to have total visual privacy. During an observation on 12/18/2025 at 2:28 PM of resident rooms 31, 32, 33, 34, 35, 36, 37, 39, 40, 41, 42, 43, 44 and 45 on C hall revealed that each room had dual occupancy with an A and B bed in each. During an observation on 12/18/2025 at 3:05 PM of resident rooms 46, 49, 50, 51, 52, 53, 54, 55, 56, 58, 59 and 60 on D hall revealed that each room had dual occupancy with an A and B bed in each. During an interview on 12/18/2025 at 2:54 PM the Administrator was made aware of the observation of the resident rooms that had curtains that did not provide full visual privacy. The Administrator said he understood how that was an issue and they were in the process of fixing it. During record review of the facility's policy titled Bedrooms and dated January 2025 revealed in part: All residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. Policy interpretation and implementation. Each room is designed to provide full visual privacy for each resident (in the form of ceiling suspended curtains that extend around the bed) and equipped for adequate nursing care

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment for 1 of 5 residents reviewed for physician notification. (Residents #76) 1. The facility failed to notify the physician of Resident #76's family's demand to use a head strap for her wheelchair. This failure could place residents at risk of not receiving appropriate medical treatments, which could result in a decline in health. Findings included:Review of Resident #76's admission Record, dated 12/17/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis affecting the body from the neck down) and history of traumatic brain injury. Review of Resident #76's admission MDS Assessment, dated 11/23/25, revealed:She was sometimes able to make herself understood. She had a BIMS score of 11, indicating she was moderately cognitively impaired. She used a wheelchair and a mechanical lift (device used to move the full weight of a person from one surface to another). She had range of motion impairments of the lower and upper extremities on both sides. She was dependent on staff for all ADLs.She had no falls.She received occupational, physical, and speech therapy.No restraints were identified. Review of Resident #76's Care Plan, initiated 12/3/25, revealed no care plan for Resident #76's range of motion impairment. Review of Resident #76's Nurse's Notes dated 12/16/25 at 3:11 p.m. revealed the resident's family in facility. The family was working on the resident's wheelchair. Getting new head gear to keep head in place. Review of Resident #76's Order summary, dated 12/17/25, revealed:No orders for a head strap.Observation on 12/16/25 between 12:18 p.m. - 12:23 p.m. revealed Resident #76 was up in her wheelchair with her head braced on a u-shaped pillow. Therapy was overheard telling Resident #76 that staff would come to feed her. Resident #76 was unable to hold her head up independently. Observation on 12/16/25 at 5:12 p.m. revealed Resident #76 was up in her wheelchair in the dining room with the head strap attached to the wheelchair head piece going across her forehead. The strap fell into her eyes and she was moving her head trying to get the strap up. Observation on 12/17/25 at 8:21 a.m. revealed Resident #76 was up in her wheelchair in the lobby of the facility. Resident #76 had the head strap on. The strap was across Resident #76's forehead and not in her eyes. Interview on 12/17/25 at 4:53 p.m. Resident #76's Physician stated he was not made aware of the family's demand for a head strap and did not give an order for it. The Physician stated the head strap was not like the 5 or more falls he got notified of in a day and it was different enough he would remember that. Resident #76's Physician stated the last time was in the building was 12/12/25 and Resident #76 did not have the strap. The Physician stated he would expect to be notified, and the strap was a restraint. Interview on 12/18/25 at 1:21 PM the DON stated she talked to the doctor before using the strap. The DON said she did not put the order for the strap until 12/18/25 because the facility was trying to come up with a plan for what to do with the strap. Review of the facility policy and procedure on change in a residence condition or status, revised February 2021, revealed Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.Nurse will notify the resident's attending physician or physician on call when there has been a need to alter the resident's medical treatment significantly or specific instruction to notify the physician of changes in the resident's condition.A significant change of condition is a major decline or improvement in the resident status in that: requires interdisciplinary review and/or revision to the care plan.The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the use of the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints for 1 of 3 (Resident #76) residents reviewed for restraints. The facility failed to provide assessment, care planning, and a physician's order for the use of a head strap (Velcro strap permanently affixed to the head rest of the wheelchair) restraint for Resident #76. This failure could result in residents having physical restraints used that limited their movement without being evaluated for medical need. Findings included: Review of Resident #76's admission Record, dated 12/17/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis affecting the body from the neck down) and history of traumatic brain injury. Review of Resident #76's admission MDS Assessment, dated 11/23/25, revealed:She was sometimes able to make herself understood. She had a BIMS score of 11, indicating she was moderately cognitively impaired. She used a wheelchair and a mechanical lift (Device used to hold the entire weight of the body while moving from one surface to another). She had range of motion impairments of the lower and upper extremities on both sides. She was dependent on staff for all ADLs.She had no falls.She received occupational, physical, and speech therapy.No restraints were identified. Review of Resident #76's Care Plan, initiated 12/3/25, revealed no care plan for Resident #76's range of motion impairment. Review of Resident #76's Order summary, dated 12/17/25, revealed:No orders for the head strap. Review of Resident #76's Nurse's Notes dated 12/16/25 at 3:11 p.m. revealed: Resident's family in facility. Family working on resident's wheelchair. Getting new head gear to keep head in place. Review of Resident #76's Occupational Therapy Notes dated 12/15/25 revealed: no change in function since last visit and was compliant with skilled interventions and compliant with trained techniques. Review of Resident #76's Occupational Therapy Notes dated 12/17/25 revealed: no change in function or condition since last visit, compliant with skilled interventions and compliant with trained techniques. Review of Resident #76's Speech Therapy Notes dated 12/15/25 (completed 12/16/25), revealed: skilled interventions to address dysarthria (muscle weakness of vocal chords/muscles) focused on development of/instruction in cuing hierarch, rate control techniques to increase respiratory support and phonation (speaking) techniques to elicit carryover with increased volume and oversaturation of speech with increased speech intelligibility to 75 % intelligible in simple conversational tasks and with 50% verbal cues and with 50% visual cues and with 50% tactile cues without the need for cues/instruction. Review of Resident #76's Speech Therapy Notes for service 12/16/25 (written 12/18/25) revealed, subjective: updated supportive positioning strap, reported to interdisciplinary team (Inservice provided with updated MDS care plan). Patient's family provided new device for position and patient voiced compliance for her support. Patient's family provided new neck positioning with physical therapy provided intervention clarity with patient/caregivers. Response to therapy patient was able to voice all understanding that her positioning is important for her swallowing safety and conveyed knowledge that she was not restrained, nor did she feel like she was. Complexities: please do not adjust the hardware of the headrest, only adjust the head strap for stabilization while patient is in upright position. Please remove the strap and position patient in a reclining manner with the soft moon collar. 45-90 degrees use head strap. Review of Resident #76's Physical Therapy notes for 12/16/25 revealed, change in function: no. Proper positioning while seated in the wheelchair with emphasis on proper neck position to facilitate comfort. Speech therapist consulted therapist about the temporary positioning device/equipment brought/provided by the patient's family which is attached on the patient's wheelchair to facilitate proper positioning. Therapist educated family about proper positioning. Observation on 12/16/25 at 12:18 p.m. - 12:23 p.m. revealed Resident #76 was up in her wheelchair with her head braced on a u-shaped pillow. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Therapy was overheard telling Resident #76 that staff would come to feed her. She was unable to hold her head up. Interview and observation on 12/16/2025 at 2:38 PM Resident #76's family said the staff kept moving the head rest and it would break. The family began attaching a strap to the wheelchair head piece. The family said they did not care about getting therapy or the nursing staff involved in the use of the strap and they wanted Resident #76's head up. The family said the facility did not use the u-pillow. Observation on 12/16/25 at 5:12 p.m. revealed Resident #76 was up in her wheelchair in the dining room with the head strap across her forehead. The strap fell into her eyes and she was moving her head trying to get the strap up. Observation on 12/17/25 at 8:21 a.m. revealed Resident #76 was up in her wheelchair in the lobby of the facility reclined. Resident #76 had the head strap on. The strap was across Resident #76's forehead and not in her eyes. Interview on 12/17/25 at 4:53 p.m. Resident #76's physician stated he was not informed of the use of the head strap, would expect to be notified of the use of the head strap, did not give the order for the head strap, and that it was a restraint. Interview on 12/18/25 at 10:27 AM LVN B stated Resident #76 did have the head strap on that morning. Interview on 12/18/25 at 1:21 p.m. the DON stated Resident #76's head strap was only as needed when Resident #76 was at a 90-degree angle to support her head. The DON stated there was a struggle with the staff and the wheelchair. The DON stated the facility had tried a u-pillow that helped. The DON stated Resident #76 was no able to take it off, but the head piece was a positioning device and Resident #76's head would fall no matter what the facility did. The DON stated getting the device needed a doctor's order. When asked about an assessment the DON stated the order for the strap was as-needed and to monitor for skin breakdown, and she wrote the physician's order 12/18/25. The DON stated the head piece had not been used. Interview on 12/18/25 at 1:37 p.m. the DOR stated Resident #76 had a specialized wheelchair and she was on occupational and physical therapy for repositioning. The DOR stated she saw Resident #76 for speech therapy. The DOR stated Resident #76 had impulsive, spastic, or jerky movements. Resident #76's PT, also present, stated the strap was only to be used when eating and feeding. The PT stated the strap was a positioning tool and did not restrict Resident #76's movement. The PT stated Resident #76 did not have the fine motor skills to be able to remove it but could get her arm up to communicate with the staff if she wanted it off. The DOR stated the device was used during a trial and did not need an order initially. The DOR said the strap was there so they could get Resident #76's head in the right position for swallowing. The DOR said the strap was on trial and would not have an order until the recommendation was made. The DOR stated she was not in the building during the evening meal to see if the device was effective. Interview on 12/18/25 at 1:57 p.m. the Administrator stated Resident #76's strap met the definition of a restraint. Observation on 12/18/25 at 3:56 - 4:54 p.m. revealed Resident #76 was up in the dining room in front of the television with the head strap on. She was not eating nor were there any staff around her consistently. Review of the facility's policy and procedure on Assistive Devices and Equipment, revised January 2020 documented: our facility maintains and supervises the use of assistive devices and equipment for residents.Recommendations for the use of devices and equipment are based on comprehensive assessment and documented in the resident's care plan. The following factors are addressed to the extent possible to decrease the risk of avoidable accidents and associated with devices and equipment. Appropriateness for resident condition - the resident is assessed for lower extremity strength, range of motion, balance and cognitive abilities when determining the safest use of devices and equipment. Staff practices - staff are required to demonstrate competency on the use of devices and equipment and are available to assist and supervise residents as needed. No policy for restraints was provided.

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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** 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 3 residents (Resident #30) reviewed for catheter care. Resident #30's urine collection bag was observed hanging on the armrest of his wheelchair and above the bladder. This failure could place residents at risk for catheter associated urinary tract infections. The findings included: Record review of Resident #30's admission record dated 12/17/2025 revealed he was admitted to the facility on [DATE] with diagnosis of benign prostatic hyperplasia (an enlarged prostate that can cause urinary problems). He was [AGE] years of age. Record review of Resident #30's MDS dated [DATE] revealed: BIMS - 11 indicating he was moderately impaired. Bladder and bowel appliances = indwelling catheter. Record review of the current care plan for Resident #30, last reviewed/revised: 10/01/2025, revealed in part: The resident has an indwelling catheter. The resident will show no s/sx (signs or symptoms) of urinary infection through review date. Position catheter bag and tubing below the level of the bladder and away from entrance room door. During an observation on 12/16/2025 at 10:02 AM revealed Resident #30 was sitting up in his wheelchair in the hallway right outside the shower room. The resident had his catheter bag hanging on the armrest of his wheelchair and higher than his urinary bladder area. During an observation and interview on 12/16/2025 at 10:34 AM CNA A said she had not assisted Resident #30 out of bed this morning. CNA A said as far as she knew someone else had assisted Resident #30 out of bed and perhaps they had placed the urinary catheter on the resident's wheelchair arm rest. CNA A said whenever she assisted Resident #30 into his wheelchair she would place his catheter bag on the frame under his wheelchair. CNA A said the reason she placed the catheter bag on the lower area was to maintain the bag lower than the resident's bladder and prevent back flow of urine. The CNA then proceeded to do other tasks and then later took the resident into the shower room but the catheter bag continued to be left on the armrest. During an interview on 12/18/2025 at 2:37 PM the DON said the catheter bag was supposed to be placed below the bladder to prevent urine back flow. The DON was made aware of the observation of Resident #30 sitting up in his wheelchair with the catheter bag hanging on the wheelchair's armrest. The DON said at times the resident would place the bag on the armrest whenever he transferred himself out of bed. The DON was made aware that CNA A had been made aware of the catheter hanging on the armrest but did not remove it and continued to leave it on the arm rest. During an interview on 12/18/2025 at 2:52 PM the Administrator was made aware of the observation of Resident #30 sitting up in his wheelchair with the catheter bag hanging on the wheelchair's armrest. The Administrator was also made aware about the staff being made aware of the catheter bag hanging on the armrest but they did not place the catheter lower and continued to perform other tasks. The Administrator said he was not a clinician so was not able to say if there were any possibilities of infections. During a record review of the Centers for Disease and Controls website: https://www.cdc.gov/uti/about/cauti-basics.htmltitled Catheter Associated Urinary Tract Infections CAUTI basics accessed 12/16/2025, revealed, .Reducing risks . Check the position of the urine bag; it should always be below the level of the bladder During a record review of the facility's policy titled Catheter care, urinary dated September 2014 revealed in part: Purpose: The purpose of this procedures is to prevent catheter-associated urinary tract infections. 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.