STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675961	A. Building B. Wing	04/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Village	409 W Green Webster, TX 77598

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 39977 Based on observation, interviews, and record reviews the facility failed to immediately inform the resident's physician of a significant change in a resident's physical condition for one of five residents (Resident #1) reviewed for notification of change. -The facility failed to ensure Resident #1 received podiatry services on 3/29/24 and failed to ensure staff accurately and thoroughly reported Resident #1's change in condition to his third toe on his right foot, to his physician on 04/01/24. NP A was asked by Resident #1 to assess his right foot when he reported pain on 04/04/24. Resident #1 was sent to the hospital on 04/04/25 and had the third toe of his right foot amputated on 04/07/24 and the remaining toes on his right foot amputated on 5/12/24. Resident #1 no longer walked independently and used a wheelchair for mobility since 4/7/24. His right foot remained unhealed on 04/10/25 and he continued to receive n-going wound care and treatments related to repeated infections and other complications. An IJ was identified on 04/16/25 at 5:36pm. While the IJ was lowered on 04/19/25, the facility remained out of compliance at a scope of isolated and a severity level of actual harm that was not immediate jeopardy. These failures resulted in Resident #1 losing all of the toes on his right foot, significantly impacted his activities of daily living/mobility and placed residents at risk for infections, unwanted hospitalization s, amputation/s, and decreased quality of life. Finding included: Record review of Resident #1's Admission Record revealed he was a [AGE] year old male who admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of intellectual disabilities, Down syndrome, (a genetic chromosome 21 disorder causing developmental and intellectual delays), Type II diabetes mellitus with other circulatory complications (a long-term chronic condition in which the body has trouble controlling high levels of sugar in the blood), peripheral vascular disease, (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs/extremities) and acute osteomyelitis, right ankle and foot (a bone infection characterized by recent onset and can affect one or more parts of a bone). (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's admission MDS dated [DATE] revealed he had a BIMS score of 11 out of 15 indicating he had moderate cognitive impairment. He was coded as having no wounds, wound infections or pressure injuries and was set-up assistance with all of his ADL's including ambulating without an assistive device. Record review of Resident #1's undated care plan revealed the following: Resident #1 is prone to skin tears, rashes and bruising of unknown origin related to fragile skin .Resident #1 will remain free from serious injury or complications from minor injury .All injuries will sic me monitored until they are resolved .Notify MD and sic RR of any abnormal findings .and was dated as initiated on 10/17/2024 and revised on 4/15/25 with a target date of 7/3/2025. Continued record review of undated care plan also revealed, the following care area initiated on 9/26/2014, Resident #1 has potential for impaired peripheral blood flow to lower extremities r/t Peripheral Vascular Disease (PVD) .Resident #1 will remain free of complications related to PVD through review date .Resident #1's extremities will be pain, pallor, rubor, coldness, edema and skin lesions through the review date . Educate the resident on the importance of proper foot care including: proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks . Monitor the extremities for /sx of injury, infection or ulcers .Monitor/document/report PRN and s/sx of complications of extremities: coldness of extremity, pallor, rubor, cyanosis and pain .Monitor/document/report PRN any s/sx of skin problems related to PVD: Redness, Edema, Blistering, Itching, Burning, Cuts, Other skin lesions. The following intervention was dated as initiated on 10/15/24, Clean right stump surgical with NS, apply dry dressing. Record review of Resident #1's Physician Orders for the month of March 2024, revealed there were no wound care orders. Record review of facility undated podiatry list for Resident #1 revealed he had been seen by podiatry on 12/29/23 and was scheduled to see podiatry on 3/29/24 (3 months later) but did not. There were no records, despite repeated attempts with facility staff and podiatry company to retrieve records on why Resident #1 was never seen by podiatry on 3/29/24. Surveyor team did not receive any explanatory documentation or interviews prior to facility exit on 04/19/25. Record review of Resident #1's Physician Orders for the month of April 2024, revealed there were no wound care orders. Record review of Resident #1's Physician Orders for the month of May 2024 revealed the following physician orders dated 4/23/24 and listed as active: - Notify NP A for PCP A if any increased drainage, redness, odor or s/s infection in right foot surgical wound. - Cleanse with NS, apply iodosorb (antimicrobial gel that can be used to treat skin wounds and ulcers), cover with absorptive dressing using 4x4's and kerlix as needed for surgical wound right dorsal foot. - Cleanse with NS, apply iodosorb, cover with absorptive dressing using 4x4's and kerlix, everyday shift for surgical wound R dorsal foot (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- Bactrim DS Oral Tablet 800-160 MG 1 tablet by mouth two times a day for cellulitis right lower leg and foot for 10 days. - Doxycycline Hyclate Oral Tablet 100 MG Give 1 tablet by mouth two times a day for cellulitis right lower leg and foot for 10 days. Record review of Resident #1's Health Status Note dated 4/1/24 at 5:46pm revealed the following documentation by LVN A: Resident c/o pain to toes on right foot. This nurse took off resident's sock and small opening to the third toe noted with swelling. Resident stated that he thinks his new shoes are too tight. Toe cleansed, applied TAO and bandage. Continued record review of nursing progress notes revealed there were no other progress notes, or physician orders regarding Resident #1's toe. There was no documentation of LVN A notifying Resident #1's MD, NP, or RP. Record review of Resident #1's weekly skin assessment dated [DATE] revealed No new skin issues observed. Continued record review revealed LVN A completed a weekly skin assessment dated [DATE] and read in part: Right toe Pressure .third toe on right foot with edema. Record review of Resident #1's Skin/Wound Note by Wound Care Nurse B dated 4/4/24 at 9:55 am revealed 3rd toe on right foot ischemic (not receiving enough blood flow), macerated (when skin softens and breaks down due to prolonged exposure to moisture). Bandaid removed that resident had previously placed around toe. NP at bedside evaluating resident, orders will be given to charge nurse. Record review of NP A progress note dated 4/4/24 revealed in part: Patient stopped this provider during rounds and asked that I evaluate his foot. He reports pain to right foot. Right third toe with soft black eschar (dead tissue) to entire toe, significant maceration (softened skin caused by prolonged exposure to moisture), foul odor, full thickness wound (one that extends beyond the skin's superficial layers and penetrates into the fat, muscle, bone or tendon) with exposed bone to lateral third toe between third and fourth toe .Patient sent to Hospital A. Called RP discussed wound infection with bone involvement. Wound will be difficult to heal secondary to patients' diagnoses .patient will need aggressive management, evaluation by ID (Infectious Disease), Vascular, Podiatry. Need eval for amputation of digit. Record review of Resident #1's hospital records with an admitted : 4/04/2024 discharge date : 4/10/2024 revealed in part: Primary Discharge Diagnosis: Gangrene of right third toe. Diabetic foot infection. Assessment Plan . Principal Problem: Fungal infection .Gangrene right 3rd toe .4/7/24 amputation of right 3rd toe. Continued record review revealed Resident #1 returned to the facility on [DATE]. Record review of Resident #1's EMR revealed one wound care consultant note dated 4/23/24 by Wound Care MD A, which read in part: Wound Status .Wound Number: 2 .Wound Location: Right, Dorsal (back) foot (other distal) .Wound Type: Surgical Wound .Date Acquired: 04/23/2024. There was no other documentation from 4/10/24 when Resident #1 was discharged from the hospital until 4/23/24 from a Wound Care MD and documentation on 4/23/24 did not mention the amputation of the right foot third toe, located at the top anterior (front) of Resident #1's foot. Attempted to contact Wound Care MD A on 4/16/25 at 3:41pm and again on 4/17/24 at 12:02 pm. Did not receive a return call from Wound Care MD A prior to facility exit. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's EMR revealed Resident #1 received wound care from Wound Care MD A and Wound Care Company A from 4/23/2024 through 6/25/2024. There were no Wound Care MD A notes from 6/25/24 through 7/30/24. Continued record reviews revealed Resident #1 was seen by Wound Care MD B from 9/12/24 through facility exit on 4/9/25. Attempted on 4/15/25 at 2:12 pm to contact Wound Care Nurse A for interview and was advised by facility DON and HR they had no contact information for Wound Care Nurse A. DON and HR both said that Wound Care Nurse A and Wound Care MD A no longer worked for the facility. Record review of NP A Progress Note dated 5/6/24 revealed the following: Evaluated patient rapid progression of ischemia and eschar noted, orders given to transfer to Hospital A for inpatient management, patient requires urgent vascular eval, will likely need additional debridement, possible further amputation . Skin: Right third toe digit status post amputation, increased light yellow slough/brown eschar to base of amputation site, gangrenous changes to right fourth toe, dry eschar to anterior second toe, unable to separate first and second toes, fourth and fifth toes for evaluation due to eschar (thick crusty layer of dead tissue that forms over a wound or burn) and slough (dead tissue separated from living tissue often seen in wounds or ulcers) DTI to anterior foot .Site is clinically worsening now with new ischemic areas/gangrenous changes to second and fourth toes .unable to palpate pedal pulses (inability to feel pulses in the feet). Record review of Resident #1's hospital records with a Surgery Date: 5/12/24 .Procedure Transmetatarsal (bones in the foot between the toes and the ankle) amputation right foot .gangrene noted to right 4th and 2nd toe with malodor and drainage noted. Fungal infection noted to bilateral feet. Incision site dehisced (burst open; split). Record review of NP A History and Physical note dated 5/16/24 revealed in part: Patient was transferred to Hospital A on 5/6/24 due to worsening necrotic changes/ischemia at surgical site and to multiple toes of right foot. He was seen by ID, noted to have weight gangrene with osteomyelitis to the second metatarsal head, third metatarsal, fourth proximal phalanx with right foot cellulitis .Patient is now status post right TMA on 5/12/2024 .Gangrene associated with type 2 diabetes mellitus status post right TMA status post IV antibiotics as per ID. discharged on course of oral antibiotic through 5/19/2024 .NWB RLE until surgical site healed . Osteomyelitis right foot .Status post amputation of right foot through metatarsal bone. Telephone interview with LVN A on 4/15/2025 at 2:04 pm they said they no longer worked at the facility but remembered working with Resident #. LVN A said they remembered the issue with Resident #1's foot or toe but did not recall specifics. LVN A said they could not recall if they notified Resident #1's MD, NP, or RP about Resident #1's toe. LVN A said they could not recall if they got an order for the TAO and Band-Aid, they applied to Resident #1's toe. LVN A said they did not recall if they notified the facility wound care nurse but said the facility had a wound care nurse at the time but could not recall their name. LVN A said they did not complete any type of SBAR/change in condition form or incident/accident report. LVN A said they only completed a progress note and most likely put the information on the facility 24-hour nurse report LVN A said they did not recall notifying the DON, ADON or Administrator about Resident #1's toe. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 4/15/25 at 2:15 pm with DON who said they began working at the facility as the DON in January 2025 and was unaware of anything that happened at the facility in 2024 and was unaware of the origin of right foot issues for Resident #1. Requested copy of nursing 24-hour report from 4/1/24. DON said they did not have access to that report. Interview and observation of Resident #1 on 4/15/25 at 3:55pm who was seated in his wheelchair in his room. He was wearing fingerless gloves and propelling himself around his room using his left leg and both arms. His right foot was completely bandaged in clean white gauze wrap up to and above his ankle. None of the right foot was visible underneath the dressing. He was wearing loose sweatpants and a white velcro sneaker on his left foot. Resident #1 said he had surgery on his right foot 2 times and said he used to walk before I lost my toes. When asked how many toes he had lost on his right foot, he replied, all of them. Resident #1 said he wished he could walk again because he did not walk now and could only use his wheelchair. Resident #1 said he liked his wheelchair, but it was not the same as walking. Resident #1 said he had no pain at the time or whenever his dressings were changed. Resident #1 said it only hurt when they cut my toes and after. Resident #1 refused at this interview for surveyor to observe the wound on his right foot. Interview with CNA C on 4/26/25 at 9:41am who said they worked at the facility since 2009 and was familiar with Resident #1. CNA C said they were rarely assigned to provide direct care for Resident #1 but would sometimes help him shower and did not recall observing any issues with his feet or toes. CNA C said Resident #1 was very nice and used to be independent for ADL's and used to walk around the facility with no walker, cane, or wheelchair. CNA C said he was saddened, and it was a sad circumstance that Resident #1 no longer walked around and had to use a wheelchair because Resident #1 used to love to go on facility outings and on outings with his family, but it seemed like Resident #1 could no longer do as much because of being in a wheelchair. Interview with CNA A on 4/16/25 at 9:50 am who said they worked with Resident #1 in the past and present and had worked at the facility for 4 years. CNA A said Resident #1 used to walk and was independent with mostly all of his ADL's but can now only use a wheelchair after his toes were amputated on his right foot. CNA A said they did not know any specific details about Resident #1's toes because he never complained to her about anything, and she never saw anything when she provided care. CNA C said that whatever happened, it started around the same time last year. CNA C said that if Resident #1 had complained to her she would have documented in her CNA notes and immediately reported it to the charge nurse at the time. Interview with CNA B on 4/16/25 at 10:00 am who said they worked the same unit that Resident #1 resided on but did not regularly provide direct care to Resident #1. CNA B said they worked at the facility since 2017 and was never aware of any issues with Resident #1's feet or toes until after the amputation. CNA B said they remembered Resident #1 as independent and used to walk freely but was now confined to a wheelchair. Attempted telephone interview with NP A on 4/16/25 at 12:09pm. Surveyor notified by DON that NP A declined to have contact information shared with surveyor and NP A refused to speak with any state surveyor or representative without legal representation present. DON provided surveyor with administrative office number to schedule an appointment. Surveyor left messages twice on administrative office voicemail with surveyor contact information and purpose of call and never received a return call prior to exit. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Attempted interview with Wound Care Nurse A on 4/16/25 at 1:33pm but advised by DON and HR there were no contact numbers or information for Wound Care Nurse A after company change in September of 2024 and they did not know when Wound Care Nurse A's last date of employment was because they had no access to a lot of records after the company change in September of 2024. Telephone interview with Wound Care Nurse B on 4/16/25 at 3:48 pm who confirmed that they were the current facility wound care nurse and provided care and treatments as ordered to Resident #1. Wound Care Nurse B said they had only been working as the facility wound care nurse for 1 month and did not know who the previous wound care nurse was. Wound Care Nurse B said Wound Care MD B, saw and evaluating Resident #1 weekly. Wound Care Nurse B said they were responsible for completing the weekly skin assessments for Resident #1. Wound Care Nurse B said Resident #1 had 2 areas on his right foot currently and no issue or wound on his heel. Wound Care Nurse B said that Resident #1 had a small opening on the lateral side of his right foot and an opening in the area were his big toe used to be that will not close. Wound Care Nurse B said that neither area had any signs or symptoms of infection and Resident #1 tolerated and was compliant with the dressing changes and treatments well and did not complain of pain much. Wound Care Nurse B said they were not familiar with Resident #1 prior to amputation. Interview on 4/17/25 at 12:31 pm with Wound Care MD B who said they had been seeing Resident #1 since the fall of 2024. When asked if they knew the origin of Resident #1's wound, Wound Care MD B said they did not know what the wound looked like when it first started. Wound Care MD B said Resident #1's was not healing since the first amputation, due to the residents' history and issues with poor circulation and peripheral vascular disease. When asked if Wound Care MD B felt in their professional medical opinion if a 3-day delay in communication between the nurse identifying Resident #1's third right toe change in condition and when NP A evaluated Resident #1 three days later, because Resident #1 requested an evaluation, could have caused a wound that serious, Wound Care MD B could not say. Wound Care MD B said it would be hard to say if the 3-day delay in communication caused Resident #1's toe wound to deteriorate that quickly because he did not know what the toe looked like at the time it started but due to Resident #1's underlying vascular issues/PVD and diabetes history, it was possible that a wound like his could have developed in that short period of time. Attempted telephone interview on 4/17/25 at 12:37 pm with facility Medical Director and advised by facility ADON that Medical Director was off and with family and would return surveyor call if possible. Surveyor left voicemail message with contact information and purpose for call and never received a return call prior to exit. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with Administrator and DON on 4/17/25 at 1:44pm they both said they had no additional records for Resident #1. They both said they started working at the facility in their current roles after Resident #1 had his toes amputated. Administrator said they started working at the end of December 2024 and the DON said she started working at the facility in January 2025. They both said there had been a change in the company that owns the facility in 2024 and not all of the previous resident or staff records were available or accessible. They said they did not have information for Wound Care Nurse A, the former facility Social Worker and did not have any information from Podiatry Company A on why Resident #1 was not seen or treated on 3/29/24. They said they had no information on why LVN A documented on Resident #1's change in condition of right third toe but did not document the appropriate notifications to MD and RP. They said that was not their current practice, policy or procedure but had no control over what happened in the past. They said they had not completed any recent staff training on wound care, physician notifications or change in condition but staff completed whatever topic was on the monthly CBT's. Record review of Resident #1's current Wound Assessment Report created by Wound Care MD B dated 4/10/25 revealed in part: Location: Right Lateral Forefoot .Arterial Ulcer .Stage/Severity: Full Thickness . Location: Right Medial TMA .Surgical Wound .Stage/Severity: Full Thickness. Indicating Resident #1 had 2 areas on his right foot that remained unhealed from April 2024. Record review of LVN A's personnel file revealed there were no completed trainings listed and no competency checks in the file provided. Record review of at least 4 current facility nursing staff personnel files, ADON, Wound Care Nurse B, DON and LVN B on 4/15/25 at 4:48 pm revealed no specific documented training/curriculum for change in condition, wound care/skin, or physician notification. Record review of facility policy and procedure titled: Change in a Resident's Condition or Status Revised September 2017 read in part, .The facility shall notify the resident, his or her attending physician and representative (sponsor) of changes in the resident's condition and/or status.3. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in a resident's condition or status. Record review of the facility policy and procedure titled: Guidelines for Notifying Physicians of Clinical Problems Revised January 2017 read in part under the heading Overview, .These guidelines are intended to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient and effective manner . The policy did not include information on wounds, skin, or foot problems. On 04/16/25 at 5:36 pm an IJ and Substandard Quality of Care (SQC) in area of Quality of Care were called with the Administrator, DON, ADON and RCO. They were informed that the IJ had been identified due to the above failures, the IJ template was provided, and they were asked to provide a plan of removal at that time. The plan of removal was accepted on 4/17/25 at 1:10 pm after revisions. The POR read in part: Plan of Removal for Immediate Jeopardy (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Actions that the facility will take to prevent serious harm from occurring or recurring for treatment and services to prevent complications for a resident who received foot care. 1. Facility in-serviced nurses regarding physician notification for changes of condition in resident skin integrity was initiated with licensed clinical staff on 4/16/25 by the DON and ADON. Scheduled staff will be completed before allowing patient assignment care. 2. The Medical Director was initially made aware of the Immediate Jeopardy 4/16/25 at 6:15 pm and had been involved in the development of the plan of removal. 3. All Nurses had an in-service regarding skin integrity and assessment protocol with a specific focus on lower extremity, foot and diabetic wounds from policy and procedure was initiated by the DON on 4/16/25. Scheduled staff will be completed by designee continuation before allowing patient assignment care. 4. The facility will identify skin conditions by completing skin assessments performed on each active resident in the facility by the ADON/DON/Designee starting 4/16/25. The update will be documented on the weekly skin in PCC-electronic medical record and any abnormal findings will be immediately communicated to the physician and or medical director for orders. This was with all licensed clinical staff and any scheduled staff will have the in-service completed prior to allowing patient care. 5. RNC (regional nurse-corporate) completed an in-service with DON and ADON regarding physician notification of changes in condition of skin and order implementation per policy and procedure. This was completed 4/16/25. 6. An in-service with nursing staff regarding POC ADL documentation including skin monitoring and reporting changes in skin from policy and procedure was initiated by the DON on 4/15/25 and continues, showers including skin assessment and reporting changes in skin or refusals to the nurse from policy and procedure was initiated by the DON on 4/14/25 and continues. Scheduled staff will be completed by designee continuation before allowing patient assignment care. Nursing administration monitors compliance and will review weekly skin documents for 2 weeks and follow up accordingly on MD notifications and orders. All CNA's had in-services on 4/14/2025 and were trained on making observations and reporting any resident changes in condition, how to report any changes, who to report any changes to, and what changes to look for, in residents while performing any care. Any CNA unable to attend would be individually trained before the start of their next shift. Monitoring: Observations on 4/17/25 of random and sample residents revealed call lights in place. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interviews on 4/17/25 with 2 CNA's, 1 LVN and 1 RN on all halls to verify in-service training on recognizing Change in condition and the procedure/s for reporting changes in condition, physician notifications and skin assessments and documentation. Questions asked of the staff included what the steps were to take when a resident had a change of condition in skin/wounds. Answers were to notify the charge nurse of any changes in a residents' condition and to document in POC and shower sheets. Charge nurses said they would assess the resident and complete a progress note, notify the physician, transcribe orders, and implement orders. The charge nurses also said they would notify the residents responsible party and the DON and then complete a skin assessment form as needed. Record review of nursing staffing sheets provided for the week of April 15, 2025, through April 17, 2025, provided signed in-service sheets for all current licensed nurses, certified CNAs and MAs on the POC ADL documentation including skin monitoring and reporting changes in skin from policies and procedures revealed compliance. Record review also revealed all staff work 12-hour shifts from either 6 am-6 pm or 6 pm -6 am. Observation of Resident #1 on 4/17/25 at 1:15 pm who declined to have wound or wound care observation conducted by surveyor at that time. Observation rounds on 4/17/25 at 10:22 am and 2:55 pm of staff members making rounds and checking on the status of residents including those dependent for ADL's, bathing/showers and with type II diabetes mellitus, current wounds, PU and NPU. Call lights were observed in place and staff observed responding to call lights in a timely manner. Record review on 4/17/25 at 5:08 pm confirmed training and in-services initiated on all facility shifts. RNC in-service training with DON and ADON had been completed. Copy of change in condition and physician notification policy and procedures were received, reviewed, and attached to the staff trainings. 100 % Audit of the facility census 73 of skin assessments had been completed. Audit of all physician notifications, as a result of facility wide skin audit had been completed. Audit on 4/18/25 of new hire nursing staff revealed no new staff hired that required new trainings. Audit on 4/18/25 of facility wide skin assessments revealed 15 residents identified with skin concerns with new orders received and implemented as prescribed. Interviews on 4/18/25 with 4 CNA's, 3 LVN's and 2 MA's on all halls to verify in-service training on recognizing Change in condition and the procedure/s for reporting changes in condition, physician notifications and skin assessments and documentation. Questions asked of the staff included what the steps were to take when a resident had a change of condition in skin/wounds. Answers were to notify the charge nurse of any changes in a residents' condition and to document in POC and shower sheets. Charge nurses said they would assess the resident and complete a progress note, notify the physician, transcribe orders, and implement orders. The charge nurses also said they would notify the residents responsible party and the DON and then complete a skin assessment form as needed. Interview with RNC/RCO on 4/18/25 at 4:47 pm who said skin audit was completed for facility. Audit of 5 of 15 residents identified with skin concerns and new orders revealed they had weekly skin assessments, progress notes that included documentation of MD and RP notifications and orders had been transcribed and implemented as ordered. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interviews on 4/19/25 at what time with 11 staff on all halls and spanning all shifts confirmed training on recognizing Change in condition and the procedure/s for reporting changes in condition, physician notifications and skin assessments and documentation. Questions asked of the staff included what the steps were to take when a resident had a change of condition in skin/wounds. Answers were to notify the charge nurse of any changes in a residents' condition and to document in POC and shower sheets. Charge nurses said they would assess the resident and complete a progress note, notify the physician, transcribe orders, and implement orders. The charge nurses also said they would notify the residents responsible party and the DON and then complete a skin assessment form as needed. Record review on 4/19/25 of training documents and nursing competencies of staff scheduled to work had been completed. On 4/19/25 at 1:10 pm the Administrator, RCO, and RDO were notified that the immediacy had been lowered, however, the facility remained out of compliance at a scope of isolated and a severity level of actual harm that was not immediate jeopardy. The facility was continuing to monitor their plan.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39977 Based on observation, interview and record review, the facility failed to coordinate with Pre-Admission and Resident Review program (PASRR) under Medicaid and initiate services within 20 days after the date that the services are agreed upon in the IDT meeting, to ensure that individuals with intellectual developmental disabilities receive the care and services they need in the most appropriate setting for 1 of 31 residents (Resident#1) reviewed for PASRR. The facility failed to complete and submit therapy evaluations for Habilitative services for PT, OT and ST services agreed upon in an IDT meeting on 10/17/24 addressing Resident #1's needs. This failure could affect residents with intellectual and developmental disabilities requiring PASRR services at risk of a delay in or not receiving specialized services that would enhance their highest level of functioning. Finding included: Record review of Resident #1's Admission Record revealed he was a [AGE] year old male who admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of intellectual disabilities, Down syndrome, (a genetic chromosome 21 disorder causing developmental and intellectual delays), Type II diabetes mellitus with other circulatory complications (a long-term chronic condition in which the body has trouble controlling high levels of sugar in the blood), peripheral vascular disease, (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs/extremities) and acute osteomyelitis, right ankle and foot (a bone infection characterized by recent onset and can affect one or more parts of a bone). Record review of Resident #1's admission MDS dated [DATE] revealed he had a BIMS score of 11 out of 15 indicating he had moderate cognitive impairment. He was coded as having no wounds, wound infections or pressure injuries and was set-up assistance with all of his ADL's including ambulating without an assistive device. Record review on 4/15/25 of an interdisciplinary team conference meeting conducted on 10/17/24 page 4 of 8 revealed the following: A2700. Nursing Facility Specialized Services Indication .A. I certify that the need for all habilitation therapies (not habilitative therapies) were discussed .A2800. Nursing Facility Specialized Services .D. Specialized Assessment Occupational Therapy (OT) .E. Specialized Assessment Physical Therapy (PT) .F. Specialized Assessment Speech Therapy (ST) .G. Specialized Occupational Therapy (OT) .H. Specialized Physical Therapy (PT) .I. Specialized Speech Therapy (ST). All were coded in the second column as the number 2=New. A3000. IDD Specialized Services .F. Habilitation Coordination was coded as the number 3=on-going. IDT meeting held with attendees above. Services agreed upon as noted above. Resident wishes to start therapy PT/OT/ST. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	3500 LA-IDD Specialized Services and Participation Confirmation .A. I am confirmed the IDD section .B. All IDD Specialized Services selected were agreed to by the IDT. And was coded as 1=Yes. Annual SPT was held. Individual will get new assessments for OT, PT and ST to start services and will continue with HAB Coordination for monthly monitoring . Record review of NFSS form dated 12/2/24 read in part: ST .Status: Denied .1. HHSC did not receive information previously requested from the nursing facility necessary to establish eligibility for the service . 12/12/24 .Status: Denied .12/12/24 .TMHP: This therapy service cannot be processed because the individual does not have a valid assessment on file .Request type: Habilitative Therapies OT PT .OT .12/9/24 TMHP: NFSS form for Occupational Therapy was not submitted within 30 calendar days of IDT meeting .PT .12/9/24 TMHP: NFSS form for Physical Therapy was not submitted within 30 calendar days of IDT meeting. Interview on 4/15/25 at 1:43 pm with DOR/DOT they said they started working at the facility in September of 2024. They said they had some records from the previous company but not many records from before 9/1/24 when the current company took over. The DOR/DOT said Resident #1 most recently received habilitative services per the PASRR service plan from 1/3/25 through 3/21/25. The DOR/DOT said Resident #1 was on Medicare part A services from 4/10/24 through 5/6/24 and again from 5/15/24 through 7/27/24 and then Medicare B services from 9/23/24 through 10/17/24. Interview on 4/15/25 at 1:55 pm with HR they could not find any contact information on MDS Nurse A. Interview with MDS Nurse B on 4/15/25 at 2:08 pm who said they had only worked at the facility as the MDS Coordinator since February of 2025. MDS Nurse A said Resident #1 was receiving habilitative services for PT/OT/ST services since they had been in the MDS Coordinator role. MDS Nurse B said they did not know what happened regarding Resident #1's habilitative therapy services for PT/OT/ST prior to February 2025. Observation and interview with Resident #1 on 4/15/25 at 3:55 pm who was seated in his wheelchair in his room. He was wearing fingerless gloves and propelling himself around his room using his left leg and both arms. His right foot was completely bandaged in clean white gauze wrap up to and above the ankle. None of his right foot was visible underneath the dressing. He was wearing loose sweatpants and a white Velcro sneaker on his left foot. Resident #1 said he had surgery on his right foot 2 times and said he used to walk before I lost my toes. When asked how many toes he had lost on his right foot, he replied, all of them. Resident #1 said he wished he could walk again because he did not walk now and could only use his wheelchair. Interview with DON and Administrator on 4/17/25 at 1:44pm they both said there had been a change in the company that owns the facility in 2024 and not all of the previous resident or staff records were available or accessible. They said they did not have information for MDS Nurse A and did not know when they stopped working at the facility. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of facility policy and procedure titled Policy and Procedure for PL1/PASRR/NFSS//1012/PCSP/ Revised 1/16/2019 revealed in part: The facility will ensure compliance with all Phase I and II guidelines of the PASRR process for Long Term Care .All specialized services identified by the Local Authority must be added to the Comprehensive care plan and initiated within 25 days of the meeting date where the recommendations are ordered .If it is determined that the PE positive resident requires any additional services such as PT, OT, ST .complete the PCSP form marking recommended items . Notify physicians and obtain orders for recommended items, write orders in PCC, notify therapy of new orders, and submit NFSS forms for specific recommendations. Remember the recommendations must be completed within 25 days of the submission of the IDT form .Check the alerts tab daily .to see the progress of all NFSS forms and ensure everything is processed/complete.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39977 Based on observation, interviews, and record reviews the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one of five residents (Resident #1), reviewed for Quality of Care. -The facility failed to ensure Resident #1 received podiatry services on 3/29/24 and failed to ensure staff accurately and thoroughly reported Resident #1's change in condition to his third toe on his right foot, to his physician on 04/01/24. NP A was asked by Resident #1 to assess his right foot when he reported pain on 04/04/24. Resident #1 was sent to the hospital on 04/04/25 and had the third toe of his right foot amputated on 04/07/24 and the remaining toes on his right foot amputated on 5/12/24. Resident #1 no longer walked independently and used a wheelchair for mobility since 4/7/24. His right foot remained unhealed on 04/10/25 and he continued to receive n-going wound care and treatments related to repeated infections and other complications. An IJ was identified on 04/16/25 at 5:36pm. While the IJ was lowered on 04/19/25, the facility remained out of compliance at a scope of isolated and a severity level of actual harm that was not immediate jeopardy. These failures resulted in Resident #1 losing all of the toes on his right foot, significantly impacted his activities of daily living/mobility and placed residents at risk for infections, unwanted hospitalization s, amputation/s, and decreased quality of life. Finding included: Record review of Resident #1's Admission Record revealed he was a [AGE] year old male who admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of intellectual disabilities, Down syndrome, (a genetic chromosome 21 disorder causing developmental and intellectual delays), Type II diabetes mellitus with other circulatory complications (a long-term chronic condition in which the body has trouble controlling high levels of sugar in the blood), peripheral vascular disease, (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs/extremities) and acute osteomyelitis, right ankle and foot (a bone infection characterized by recent onset and can affect one or more parts of a bone). Record review of Resident #1's admission MDS dated [DATE] revealed he had a BIMS score of 11 out of 15 indicating he had moderate cognitive impairment. He was coded as having no wounds, wound infections or pressure injuries and was set-up assistance with all of his ADL's including ambulating without an assistive device. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's undated care plan revealed the following: Resident #1 is prone to skin tears, rashes and bruising of unknown origin related to fragile skin .Resident #1 will remain free from serious injury or complications from minor injury .All injuries will sic me monitored until they are resolved .Notify MD and sic RR of any abnormal findings .and was dated as initiated on 10/17/2024 and revised on 4/15/25 with a target date of 7/3/2025. Continued record review of undated care plan also revealed, the following care area initiated on 9/26/2014, Resident #1 has potential for impaired peripheral blood flow to lower extremities r/t Peripheral Vascular Disease (PVD) .Resident #1 will remain free of complications related to PVD through review date .Resident #1's extremities will be pain, pallor, rubor, coldness, edema and skin lesions through the review date . Educate the resident on the importance of proper foot care including: proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks . Monitor the extremities for /sx of injury, infection or ulcers .Monitor/document/report PRN and s/sx of complications of extremities: coldness of extremity, pallor, rubor, cyanosis and pain .Monitor/document/report PRN any s/sx of skin problems related to PVD: Redness, Edema, Blistering, Itching, Burning, Cuts, Other skin lesions. The following intervention was dated as initiated on 10/15/24, Clean right stump surgical with NS, apply dry dressing. Record review of Resident #1's Physician Orders for the month of March 2024, revealed there were no wound care orders. Record review of facility undated podiatry list for Resident #1 revealed he had been seen by podiatry on 12/29/23 and was scheduled to see podiatry on 3/29/24 (3 months later) but did not. There were no records, despite repeated attempts with facility staff and podiatry company to retrieve records on why Resident #1 was never seen by podiatry on 3/29/24. Surveyor team did not receive any explanatory documentation or interviews prior to facility exit on 04/19/25. Record review of Resident #1's Physician Orders for the month of April 2024, revealed there were no wound care orders. Record review of Resident #1's Physician Orders for the month of May 2024 revealed the following physician orders dated 4/23/24 and listed as active: - Notify NP A for PCP A if any increased drainage, redness, odor or s/s infection in right foot surgical wound. - Cleanse with NS, apply iodosorb (antimicrobial gel that can be used to treat skin wounds and ulcers), cover with absorptive dressing using 4x4's and kerlix as needed for surgical wound right dorsal foot. - Cleanse with NS, apply iodosorb, cover with absorptive dressing using 4x4's and kerlix, everyday shift for surgical wound R dorsal foot - Bactrim DS Oral Tablet 800-160 MG 1 tablet by mouth two times a day for cellulitis right lower leg and foot for 10 days. - Doxycycline Hyclate Oral Tablet 100 MG Give 1 tablet by mouth two times a day for cellulitis right lower leg and foot for 10 days. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's Health Status Note dated 4/1/24 at 5:46pm revealed the following documentation by LVN A: Resident c/o pain to toes on right foot. This nurse took off resident's sock and small opening to the third toe noted with swelling. Resident stated that he thinks his new shoes are too tight. Toe cleansed, applied TAO and bandage. Continued record review of nursing progress notes revealed there were no other progress notes, or physician orders regarding Resident #1's toe. There was no documentation of LVN A notifying Resident #1's MD, NP, or RP. Record review of Resident #1's weekly skin assessment dated [DATE] revealed No new skin issues observed. Continued record review revealed LVN A completed a weekly skin assessment dated [DATE] and read in part: Right toe Pressure .third toe on right foot with edema. Record review of Resident #1's Skin/Wound Note by Wound Care Nurse B dated 4/4/24 at 9:55 am revealed 3rd toe on right foot ischemic (not receiving enough blood flow), macerated (when skin softens and breaks down due to prolonged exposure to moisture). Bandaid removed that resident had previously placed around toe. NP at bedside evaluating resident, orders will be given to charge nurse. Record review of NP A progress note dated 4/4/24 revealed in part: Patient stopped this provider during rounds and asked that I evaluate his foot. He reports pain to right foot. Right third toe with soft black eschar (dead tissue) to entire toe, significant maceration (softened skin caused by prolonged exposure to moisture), foul odor, full thickness wound (one that extends beyond the skin's superficial layers and penetrates into the fat, muscle, bone or tendon) with exposed bone to lateral third toe between third and fourth toe .Patient sent to Hospital A. Called RP discussed wound infection with bone involvement. Wound will be difficult to heal secondary to patients' diagnoses .patient will need aggressive management, evaluation by ID (Infectious Disease), Vascular, Podiatry. Need eval for amputation of digit. Record review of Resident #1's hospital records with an admitted : 4/04/2024 discharge date : 4/10/2024 revealed in part: Primary Discharge Diagnosis: Gangrene of right third toe. Diabetic foot infection. Assessment Plan . Principal Problem: Fungal infection .Gangrene right 3rd toe .4/7/24 amputation of right 3rd toe. Continued record review revealed Resident #1 returned to the facility on [DATE]. Record review of Resident #1's EMR revealed one wound care consultant note dated 4/23/24 by Wound Care MD A, which read in part: Wound Status .Wound Number: 2 .Wound Location: Right, Dorsal (back) foot (other distal) .Wound Type: Surgical Wound .Date Acquired: 04/23/2024. There was no other documentation from 4/10/24 when Resident #1 was discharged from the hospital until 4/23/24 from a Wound Care MD and documentation on 4/23/24 did not mention the amputation of the right foot third toe, located at the top anterior (front) of Resident #1's foot. Attempted to contact Wound Care MD A on 4/16/25 at 3:41pm and again on 4/17/24 at 12:02 pm. Did not receive a return call from Wound Care MD A prior to facility exit. Record review of Resident #1's EMR revealed Resident #1 received wound care from Wound Care MD A and Wound Care Company A from 4/23/2024 through 6/25/2024. There were no Wound Care MD A notes from 6/25/24 through 7/30/24. Continued record reviews revealed Resident #1 was seen by Wound Care MD B from 9/12/24 through facility exit on 4/9/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Attempted on 4/15/25 at 2:12 pm to contact Wound Care Nurse A for interview and was advised by facility DON and HR they had no contact information for Wound Care Nurse A. DON and HR both said that Wound Care Nurse A and Wound Care MD A no longer worked for the facility. Record review of NP A Progress Note dated 5/6/24 revealed the following: Evaluated patient rapid progression of ischemia and eschar noted, orders given to transfer to Hospital A for inpatient management, patient requires urgent vascular eval, will likely need additional debridement, possible further amputation . Skin: Right third toe digit status post amputation, increased light yellow slough/brown eschar to base of amputation site, gangrenous changes to right fourth toe, dry eschar to anterior second toe, unable to separate first and second toes, fourth and fifth toes for evaluation due to eschar (thick crusty layer of dead tissue that forms over a wound or burn) and slough (dead tissue separated from living tissue often seen in wounds or ulcers) DTI to anterior foot .Site is clinically worsening now with new ischemic areas/gangrenous changes to second and fourth toes .unable to palpate pedal pulses (inability to feel pulses in the feet). Record review of Resident #1's hospital records with a Surgery Date: 5/12/24 .Procedure Transmetatarsal (bones in the foot between the toes and the ankle) amputation right foot .gangrene noted to right 4th and 2nd toe with malodor and drainage noted. Fungal infection noted to bilateral feet. Incision site dehisced (burst open; split). Record review of NP A History and Physical note dated 5/16/24 revealed in part: Patient was transferred to Hospital A on 5/6/24 due to worsening necrotic changes/ischemia at surgical site and to multiple toes of right foot. He was seen by ID, noted to have weight gangrene with osteomyelitis to the second metatarsal head, third metatarsal, fourth proximal phalanx with right foot cellulitis .Patient is now status post right TMA on 5/12/2024 .Gangrene associated with type 2 diabetes mellitus status post right TMA status post IV antibiotics as per ID. discharged on course of oral antibiotic through 5/19/2024 .NWB RLE until surgical site healed . Osteomyelitis right foot .Status post amputation of right foot through metatarsal bone. Telephone interview with LVN A on 4/15/2025 at 2:04 pm they said they no longer worked at the facility but remembered working with Resident #. LVN A said they remembered the issue with Resident #1's foot or toe but did not recall specifics. LVN A said they could not recall if they notified Resident #1's MD, NP, or RP about Resident #1's toe. LVN A said they could not recall if they got an order for the TAO and Band-Aid, they applied to Resident #1's toe. LVN A said they did not recall if they notified the facility wound care nurse but said the facility had a wound care nurse at the time but could not recall their name. LVN A said they did not complete any type of SBAR/change in condition form or incident/accident report. LVN A said they only completed a progress note and most likely put the information on the facility 24-hour nurse report LVN A said they did not recall notifying the DON, ADON or Administrator about Resident #1's toe. Interview on 4/15/25 at 2:15 pm with DON who said they began working at the facility as the DON in January 2025 and was unaware of anything that happened at the facility in 2024 and was unaware of the origin of right foot issues for Resident #1. Requested copy of nursing 24-hour report from 4/1/24. DON said they did not have access to that report. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and observation of Resident #1 on 4/15/25 at 3:55pm who was seated in his wheelchair in his room. He was wearing fingerless gloves and propelling himself around his room using his left leg and both arms. His right foot was completely bandaged in clean white gauze wrap up to and above his ankle. None of the right foot was visible underneath the dressing. He was wearing loose sweatpants and a white velcro sneaker on his left foot. Resident #1 said he had surgery on his right foot 2 times and said he used to walk before I lost my toes. When asked how many toes he had lost on his right foot, he replied, all of them. Resident #1 said he wished he could walk again because he did not walk now and could only use his wheelchair. Resident #1 said he liked his wheelchair, but it was not the same as walking. Resident #1 said he had no pain at the time or whenever his dressings were changed. Resident #1 said it only hurt when they cut my toes and after. Resident #1 refused at this interview for surveyor to observe the wound on his right foot. Interview with CNA C on 4/26/25 at 9:41am who said they worked at the facility since 2009 and was familiar with Resident #1. CNA C said they were rarely assigned to provide direct care for Resident #1 but would sometimes help him shower and did not recall observing any issues with his feet or toes. CNA C said Resident #1 was very nice and used to be independent for ADL's and used to walk around the facility with no walker, cane, or wheelchair. CNA C said he was saddened, and it was a sad circumstance that Resident #1 no longer walked around and had to use a wheelchair because Resident #1 used to love to go on facility outings and on outings with his family, but it seemed like Resident #1 could no longer do as much because of being in a wheelchair. Interview with CNA A on 4/16/25 at 9:50 am who said they worked with Resident #1 in the past and present and had worked at the facility for 4 years. CNA A said Resident #1 used to walk and was independent with mostly all of his ADL's but can now only use a wheelchair after his toes were amputated on his right foot. CNA A said they did not know any specific details about Resident #1's toes because he never complained to her about anything, and she never saw anything when she provided care. CNA C said that whatever happened, it started around the same time last year. CNA C said that if Resident #1 had complained to her she would have documented in her CNA notes and immediately reported it to the charge nurse at the time. Interview with CNA B on 4/16/25 at 10:00 am who said they worked the same unit that Resident #1 resided on but did not regularly provide direct care to Resident #1. CNA B said they worked at the facility since 2017 and was never aware of any issues with Resident #1's feet or toes until after the amputation. CNA B said they remembered Resident #1 as independent and used to walk freely but was now confined to a wheelchair. Attempted telephone interview with NP A on 4/16/25 at 12:09pm. Surveyor notified by DON that NP A declined to have contact information shared with surveyor and NP A refused to speak with any state surveyor or representative without legal representation present. DON provided surveyor with administrative office number to schedule an appointment. Surveyor left messages twice on administrative office voicemail with surveyor contact information and purpose of call and never received a return call prior to exit. Attempted interview with Wound Care Nurse A on 4/16/25 at 1:33pm but advised by DON and HR there were no contact numbers or information for Wound Care Nurse A after company change in September of 2024 and they did not know when Wound Care Nurse A's last date of employment was because they had no access to a lot of records after the company change in September of 2024. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Telephone interview with Wound Care Nurse B on 4/16/25 at 3:48 pm who confirmed that they were the current facility wound care nurse and provided care and treatments as ordered to Resident #1. Wound Care Nurse B said they had only been working as the facility wound care nurse for 1 month and did not know who the previous wound care nurse was. Wound Care Nurse B said Wound Care MD B, saw and evaluating Resident #1 weekly. Wound Care Nurse B said they were responsible for completing the weekly skin assessments for Resident #1. Wound Care Nurse B said Resident #1 had 2 areas on his right foot currently and no issue or wound on his heel. Wound Care Nurse B said that Resident #1 had a small opening on the lateral side of his right foot and an opening in the area were his big toe used to be that will not close. Wound Care Nurse B said that neither area had any signs or symptoms of infection and Resident #1 tolerated and was compliant with the dressing changes and treatments well and did not complain of pain much. Wound Care Nurse B said they were not familiar with Resident #1 prior to amputation. Interview on 4/17/25 at 12:31 pm with Wound Care MD B who said they had been seeing Resident #1 since the fall of 2024. When asked if they knew the origin of Resident #1's wound, Wound Care MD B said they did not know what the wound looked like when it first started. Wound Care MD B said Resident #1's was not healing since the first amputation, due to the residents' history and issues with poor circulation and peripheral vascular disease. When asked if Wound Care MD B felt in their professional medical opinion if a 3-day delay in communication between the nurse identifying Resident #1's third right toe change in condition and when NP A evaluated Resident #1 three days later, because Resident #1 requested an evaluation, could have caused a wound that serious, Wound Care MD B could not say. Wound Care MD B said it would be hard to say if the 3-day delay in communication caused Resident #1's toe wound to deteriorate that quickly because he did not know what the toe looked like at the time it started but due to Resident #1's underlying vascular issues/PVD and diabetes history, it was possible that a wound like his could have developed in that short period of time. Attempted telephone interview on 4/17/25 at 12:37 pm with facility Medical Director and advised by facility ADON that Medical Director was off and with family and would return surveyor call if possible. Surveyor left voicemail message with contact information and purpose for call and never received a return call prior to exit. Interview with Administrator and DON on 4/17/25 at 1:44pm they both said they had no additional records for Resident #1. They both said they started working at the facility in their current roles after Resident #1 had his toes amputated. Administrator said they started working at the end of December 2024 and the DON said she started working at the facility in January 2025. They both said there had been a change in the company that owns the facility in 2024 and not all of the previous resident or staff records were available or accessible. They said they did not have information for Wound Care Nurse A, the former facility Social Worker and did not have any information from Podiatry Company A on why Resident #1 was not seen or treated on 3/29/24. They said they had no information on why LVN A documented on Resident #1's change in condition of right third toe but did not document the appropriate notifications to MD and RP. They said that was not their current practice, policy or procedure but had no control over what happened in the past. They said they had not completed any recent staff training on wound care, physician notifications or change in condition but staff completed whatever topic was on the monthly CBT's. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's current Wound Assessment Report created by Wound Care MD B dated 4/10/25 revealed in part: Location: Right Lateral Forefoot .Arterial Ulcer .Stage/Severity: Full Thickness . Location: Right Medial TMA .Surgical Wound .Stage/Severity: Full Thickness. Indicating Resident #1 had 2 areas on his right foot that remained unhealed from April 2024. Record review of LVN A's personnel file revealed there were no completed trainings listed and no competency checks in the file provided. Record review of at least 4 current facility nursing staff personnel files, ADON, Wound Care Nurse B, DON and LVN B on 4/15/25 at 4:48 pm revealed no specific documented training/curriculum for change in condition, wound care/skin, or physician notification. Record review of facility policy and procedure titled: Change in a Resident's Condition or Status Revised September 2017 read in part, .The facility shall notify the resident, his or her attending physician and representative (sponsor) of changes in the resident's condition and/or status.3. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in a resident's condition or status. Record review of the facility policy and procedure titled: Guidelines for Notifying Physicians of Clinical Problems Revised January 2017 read in part under the heading Overview, .These guidelines are intended to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient and effective manner . The policy did not include information on wounds, skin, or foot problems. On 04/16/25 at 5:36 pm an IJ and Substandard Quality of Care (SQC) in area of Quality of Care were called with the Administrator, DON, ADON and RCO. They were informed that the IJ had been identified due to the above failures, the IJ template was provided, and they were asked to provide a plan of removal at that time. The plan of removal was accepted on 4/17/25 at 1:10 pm after revisions. The POR read in part: Plan of Removal for Immediate Jeopardy Actions that the facility will take to prevent serious harm from occurring or recurring for treatment and services to prevent complications for a resident who received foot care. 1. Facility in-serviced nurses regarding physician notification for changes of condition in resident skin integrity was initiated with licensed clinical staff on 4/16/25 by the DON and ADON. Scheduled staff will be completed before allowing patient assignment care. 2. The Medical Director was initially made aware of the Immediate Jeopardy 4/16/25 at 6:15 pm and had been involved in the development of the plan of removal. 3. All Nurses had an in-service regarding skin integrity and assessment protocol with a specific focus on lower extremity, foot and diabetic wounds from policy and procedure was initiated by the DON on 4/16/25. Scheduled staff will be completed by designee continuation before allowing patient assignment care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation rounds on 4/17/25 at 10:22 am and 2:55 pm of staff members making rounds and checking on the status of residents including those dependent for ADL's, bathing/showers and with type II diabetes mellitus, current wounds, PU and NPU. Call lights were observed in place and staff observed responding to call lights in a timely manner. Record review on 4/17/25 at 5:08 pm confirmed training and in-services initiated on all facility shifts. RNC in-service training with DON and ADON had been completed. Copy of change in condition and physician notification policy and procedures were received, reviewed, and attached to the staff trainings. 100 % Audit of the facility census 73 of skin assessments had been completed. Audit of all physician notifications, as a result of facility wide skin audit had been completed. Audit on 4/18/25 of new hire nursing staff revealed no new staff hired that required new trainings. Audit on 4/18/25 of facility wide skin assessments revealed 15 residents identified with skin concerns with new orders received and implemented as prescribed. Interviews on 4/18/25 with 4 CNA's, 3 LVN's and 2 MA's on all halls to verify in-service training on recognizing Change in condition and the procedure/s for reporting changes in condition, physician notifications and skin assessments and documentation. Questions asked of the staff included what the steps were to take when a resident had a change of condition in skin/wounds. Answers were to notify the charge nurse of any changes in a residents' condition and to document in POC and shower sheets. Charge nurses said they would assess the resident and complete a progress note, notify the physician, transcribe orders, and implement orders. The charge nurses also said they would notify the residents responsible party and the DON and then complete a skin assessment form as needed. Interview with RNC/RCO on 4/18/25 at 4:47 pm who said skin audit was completed for facility. Audit of 5 of 15 residents identified with skin concerns and new orders revealed they had weekly skin assessments, progress notes that included documentation of MD and RP notifications and orders had been transcribed and implemented as ordered. Interviews on 4/19/25 at what time with 11 staff on all halls and spanning all shifts confirmed training on recognizing Change in condition and the procedure/s for reporting changes in condition, physician notifications and skin assessments and documentation. Questions asked of the staff included what the steps were to take when a resident had a change of condition in skin/wounds. Answers were to notify the charge nurse of any changes in a residents' condition and to document in POC and shower sheets. Charge nurses said they would assess the resident and complete a progress note, notify the physician, transcribe orders, and implement orders. The charge nurses also said they would notify the residents responsible party and the DON and then complete a skin assessment form as needed. Record review on 4/19/25 of training documents and nursing competencies of staff scheduled to work had been completed. On 4/19/25 at 1:10 pm the Administrator, RCO, and RDO were notified that the immediacy had been lowered, however, the facility remained out of compliance at a scope of isolated and a severity level of actual harm that was not immediate jeopardy. The facility was continuing to monitor their plan.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244 Based on observation, interviews, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident # 2) reviewed for adequate supervision. --The facility failed to provide adequate supervision and put measures in place to prevent residents from eloping. Resident #2 had a history of exit seeking behaviors and wandering and eloped from the facility on 3/15/25. He was found walking on the street in front of the facility. The resident discharged to home 3/21/25. This noncompliance was identified as Past Non-Compliance. The IJ began on 3/15/25 and ended on 3/15/25. The facility corrected the noncompliance by conducting elopement assessments, updating care plans, providing in-servicing to staff, elopement drills, and ensuring all door locks were operating securely prior to surveyor entrance. This failure placed residents at risk of potential accidents, injuries, harm, or death. Findings included: Record review of Resident #2's face sheet revealed admitted [DATE] with diagnoses including: Dementia with behavioral disturbance (loss of cognitive functioning with disturbances to mood, behavior, and perception), depression (persistent sadness, loss of interest affecting sense of well-being), hypertension (high blood pressure), psychosis (disconnection from reality), schizoaffective disorder (mood disorder symptoms). Record review of resident #2's admission MDS dated [DATE] revealed a BIMS of 3, indicating severely impaired cognitive skills. Resident # 2 was independent in ambulation with no assistive devices and required supervision with ADLs, with partial/moderate assistance with bathing. Record review of the baseline care plan dated 2/28/25 revealed Resident # 2 was a fall/safety risk and safety measures included re-direct to use walker when walking. Behavior symptom measures included re-direct to go back to his room. Record review of Resident # 2's assessments revealed he had an admission elopement assessment dated [DATE], but it was not completed for safety measures. Record review of Resident # 2's care plan, initiated 3/21/25, revised 3/26/25, revealed he was an elopement risk, wanderer, wanders aimlessly. Interventions were to distract by offering pleasant diversions, structural activities, food, conversation, television, books, and provide a wander guard bracelet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of progress notes dated 3/2/25 revealed Resident #2 attempted to elope from the facility multiple times: 6:08 am-attempted to elope, re-directed back to his room, re-educated on safety, resident expressed understanding; 7:22 am-attempted to elope by pushing the back door in cafeteria, was re-directed back to his room, re-educated on safety, resident expressed understanding; 7:50 am-attempted to elope at end of 300 hall, was re-directed back to his room, re-educated on safety, resident expressed understanding; 8:30am- attempted to elope tried to push open the front doors, was re-directed back to his room, re-educated on safety, resident expressed understanding; 8:50 am- attempted to elope through back door of 500 hall, was re-directed back to his room, re-educated on safety, resident expressed understanding; 9:15 am- attempted to force open the door leading out of cafeteria, was re-directed back to his room, re-educated on safety, resident expressed understanding; 11:22 am- attempted to force the front doors open, became combative when re-directed back to his room; 12:21 pm- attempted to elope from back door by cafeteria, became combative when re-directed back to his room; 1:54 pm - attempt to elope out front door, became combative when re-directed back to his room. MD, RP were notified. A telephone message was left with LVN E on 4/18/25 at 4:00pm, the call was returned on 4/23/25 at 2:30 pm. In telephone interview, LVN E confirmed the events in the progress note on 3/2/25 occurred, and Resident # 2 was confused and wandered in the facility. Record review of the Incident report dated 3/15/25 at 2:30 pm revealed: at approximately 2:15 the resident was escorted to his room, at apprx. 2:30 resident was then seen being escorted back into facility by staff. It was explained to nurse on duty that resident was seen walking down the street on the same side of the street as the facility going towards the gas station. The staff member explained the resident was confused and was not complaining of pain or discomfort at the time. Resident has clean clothes on and rubber sole shoes. Resident was alert and stable at time of return to facility. Resident stated he was going by a friend when asked where he was going. Resident could not explain which friend he was attempting to go by. Resident had skin assessment performed and no skin issues were found. v/s were taken and found to be WNL. MD and RP were notified. Resident was placed on 1 on 1 monitoring. Record review of the 24-hour report dated 3/15/2025 at 7:50 pm revealed the nursing progress note: approximately 2:15 pm resident was escorted to his room and at approximately 2:30 pm, resident was seen being escorted back to the facility by staff. It was explained the resident was seen walking down the street on same side as the facility going toward the gas station. The staff member explained the resident was confused, and there were no complaints of pain or discomfort at the time. The resident had clean clothes on and rubber soled shoes. Resident was alert, stable at time of return to facility. Resident had skin assessment performed, no skin issues found. Vital signs WNL. Resident was placed on 1:1 monitoring. MD and RP notified. Record review of Resident # 2's progress notes dated 3/15/ 25 revealed at approximately 2:15 pm resident was escorted to his room and at approximately 2:30 pm, resident was seen being escorted back to the facility by staff. It was explained the resident was seen walking down the street on same side as the facility going toward the gas station. The staff member explained the resident was confused, and there were no complaints of pain or discomfort at the time. The resident had clean clothes on and rubber soled shoes. Resident was alert, stable at time of return to facility. Resident had skin assessment performed, no skin issues found. Vital signs WNL. Resident was placed on 1:1 monitoring. MD and RP notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Provider Investigation Report dated 3/15/25 revealed nursing was doing rounds on the 500 hall and noticed the resident was not in his room, the resident was a wanderer, search party was started. He was located outside the facility 15 minutes later, was assessed with no injuries or adverse effects, elopement assessment was completed, and resident was placed on 1:1 monitoring while the investigation was being completed. Resident was monitored closely after in-services were completed. All residents were counted, Maintenance Director checked all door alarms/wander guard systems, and a local fire and safety company was called to check the systems. In-services were initiated on Elopement protocols/Missing residents. The resident discharged to home 3/21/25. Record review of facility's in-service on Elopement, Missing Residents, and Wandering and Elopements was conducted with all staff 3/16/25 to 3/22/25, to allow for training of all disciplines on all shifts. Staff received training on the Elopement policy, including what to do in case a resident was seen leaving the premises, when a resident was missing, and when a missing resident returned to the premises. Record review of additional in-person in-services with all staff revealed Elopement/Missing Resident training on 12/30/24, including training on the Elopement and Missing Resident policies and procedures. In addition, the facility has online training available to staff at any time, including preventing, recognizing, reporting Abuse/Neglect, Managing behaviors, Resident Rights. Record review of facility Incident/Accident report dated 4/15/25 revealed no other elopements occured since 3/15/25. Interview with the DON on 4/16/25 at 11:20 am stated she was notified when Resident # 2 was missing on 3/15/25. She said Resident # 2 had a habit of wandering in the facility, and often had to be re-directed. She said she did not remember who found him, but he was found walking on the street outside the facility and was brought back into the facility. She said an assessment was done, and he had no injuries and did not complain of pain. He was placed on 1:1 monitoring. She said the staff knew to notify her of any incidents that occurred. Interview with MA A on 4/16/25 at 3:15 pm stated she works 6am to 6pm, and she had an in-service on elopement, the last one was about 3 weeks ago, after a resident eloped. She said she was the one who found him on 3/15/25 at around 2 pm, she was sitting in her car and saw him walking in the parking lot. She said she recognized him and went to re-direct him and bring him back into the facility. She said he was confused, and he cooperated when she brought him back inside. MA A said Resident #2 walked around a lot and she would see staff taking him back to his room, but she had never heard of him eloping until the time she found him and re-directed him back inside on 3/15/25. Interviews with LVN B and LVN C on 4/16/25 from 3:25 pm to 3:30 pm stated they had training on elopement about a month ago, including alert staff, inform the authorities and start searching for the resident. They said some residents are wanderers and would have to be monitored more closely and re-direct if they attempted to open a door or elope. The LVNs said they were not working on the day Resident # 2 eloped. Interview with the Receptionist on 4/16/25 at 3:40 pm stated if she saw any resident trying to get out the door, she said she would call the Administrator, make sure the code was set, and tell them they could not go out the door. She said at that point, they would usually turn around and return to their room or the hallway. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the Administrator on 4/16/25 at 5:15 pm, stated Resident #2 would sometimes be seen standing by the front door looking at the code, like he was trying to get the door code. He said he was not seen trying to follow anyone out the door. Interviews with CNA D, CNA E, and CNA F on 4/17/25 from 12:15 pm to 12:30 pm stated they work the day shift, 6am to 6pm, and had training on elopement about a month ago, with instructions on what to do if a resident tried to get out or had gone outside the doors. They said the first thing would be to notify the nurse and Administrator and start searching for the missing resident. They said they had to watch some residents more closely since they tended to wander and had to re-direct them if they attempted to elope. The CNAs said they were not working when Resident # 2 eloped. Interview with MA B on 4/17/25 at 12:35 pm stated she works the day shift, 6am to 6pm, and had training on elopement about 3 weeks ago and had instructions on what to do if a resident was missing. She said the first thing would be to let the nurse know, and then start trying to find the resident. She said there is an Elopement Binder at the nurse's station with pictures of residents who are an elopement risk, so staff would be aware of residents who might try to elope. She said she was not working when Resident # 2 eloped. Interview with the Activity Director on 4/17/25 at 12:45 pm stated they had elopement training about 3 weeks ago, on what to do if a resident eloped and was missing. She said call the DON and Administrator and start searching for the resident. She said she was not working when Resident # 2 eloped and heard about it later. She remembered him., and said he was confused often and would sometimes come in her activity room. Interview with OT A and OT B on 4/17/25 at 1:55 pm stated they had elopement training about a month ago, with instructions on what to do if a resident attempted to elope, or if they eloped. They said to alert the nurses, Administrator, DON and try to keep the resident in the facility after they return. They said they were not working with Resident # 2 when he eloped, but he was on therapy service for a short time, and had PT, OT and ST. Interview with MA C on 4/18/25 at 9:40 am stated she works the day shift, 6am to 6pm, and had elopement training about 3 weeks ago, and it went over what to do if a resident eloped or tried to elope. She said if a resident was trying to elope, you would re-direct them, distract them by talking about family or other things. She said she was not working when Resident # 2 eloped but heard about it after it happened. She remembered him, and said he was easy to re-direct if he was wandering, but she did not see him trying to open the doors. Interview with MA D on 4/18/25 at 9:55 am revealed he works 6am to 6pm. He said he has had elopement training, with instructions on what to do if a resident eloped or tried to elope. He said he was not working when Resident # 2 eloped, but he did remember him. He said Resident # 2 was confused but easily re-directed. MA D said he would take Resident # 2 outside in the enclosed patio area and sit in the sun sometimes and he seemed to like that. Observations of the door locks with the Administrator on 4/18/25 at 10:40 am revealed 3 of the egress doors have added keypads for exit, along with magnetic locks and wander guard alarms. He said there are work orders in process, valid until 5/18/25, to have delayed egress hardware installed on the other egress doors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675961	A. Building B. Wing	04/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Village	409 W Green Webster, TX 77598

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interviews with CNA L, CNA M, CNA P, CNA R on 4/19/25 revealed they work the night shift, 6pm to 6am, and work weekends if needed. They said they have elopement training, and the last one was about 3 weeks ago. They said the training goes over the elopement policy, and what to do if a resident elopes or tries to elope. The main thing would be to let the nurse know and try to find the resident by searching inside and outside the facility. On 4/16/25 at 5:41 pm, the Administrator was provided the past noncompliance IJ template. A plan of removal was not requested. An IJ template was provided to the administrator via email. The noncompliance began on 3/15/25 and ended on 3/15/25. The facility had corrected the noncompliance before the investigation began. The following interventions were implemented prior to survey entry and surveyor confirmed Past Non-Compliance: Resident #2 was immediately assessed. Resident #2 was placed on 1:1 level of supervision. Resident #2's care plan was updated to reflect elopement risk. Facility notification of abuse incident to responsible party, MD, Ombudsman and HHSC. Completion of in-services on abuse and elopements. Staff and management recognizing the steps to report abuse and neglect and interventions for elopement. Record review of facility policy Elopements, revised April 2006, revealed: it is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical. Should an employee observe a resident leaving the premises, he/she should attempt to prevent the departure, obtain assistance from other staff members, be courteous in preventing the departure; upon return to the facility: examine the resident for injuries, contact the physician, contact the resident's representative, complete an incident report, make notation in the medical record; should an employee discover a resident is missing from the facility, thoroughly search the building and premises, notify Administrator and DON, notify resident's representative, notify physician, notify law enforcement, provide search teams, make extensive search of surrounding areas. Record review of facility policy Wandering and Elopements, revised March 2019, revealed: the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. (continued on next page)

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	675961	A. Building B. Wing	04/19/2025

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Regency Village	409 W Green Webster, TX 77598

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of facility policy Emergency Procedures - Missing Resident, revised August 2018, revealed instructions including: alert department heads and pertinent staff of missing resident; note the time the resident was discovered missing; notify Administrator, Director of Maintenance, DON; initiate a thorough search by staff members to locate the resident; if search is unsuccessful, notify the police to report the resident missing; notify the responsible party and physician if resident not found in the facility or on the grounds.