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	11/20/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to be free from abuse for 1 of 7 residents (Resident #2) reviewed for abuse in that:The facility failed to ensure Resident #2 was free from abuse by Resident #1 on 07/25/2025 when Resident #1 hit Resident #2 in the face. This failure could place residents at risk of abuse and psychosocial harm. Findings included:Resident #1Record review of Resident #1's admission record, dated 11/20/2025, revealed a [AGE] year-old male who admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included unspecified dementia (loss of memory), schizoaffective disorder, bipolar type (a mental illness that combines symptoms of schizophrenia [chronic mental disorder affecting thoughts, perceptions, emotions, and social interactions] and a mood disorder but does not meet the criteria for either alone), and personal history of traumatic brain injury (damage to the brain caused by a head injury). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 14, indicating intact cognition. Further review of the MDS revealed no behavior exhibited for physical behavioral symptoms directed towards others; the resident's verbal behavior towards others and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) were coded 2 (Behavior of this type occurred 4 to 6days, but less than daily).Record review of Resident #1's care plan revealed the following:- Resident #1 requires psychotropic medications and antiseizure for Behavior management DX Schizoaffective and Bipolar and History of Traumatic Brain Injury. Date initiated 06/20/2025. - Resident #1 has potential to demonstrate physical behaviors hit another resident r/t Anger, Dementia. Date initiated 07/28/2025.Record review of Resident #1's nursing note, dated 07/25/2025 at 5:39 pm, revealed Received a phone call from [Name], NP with Dr. [name], requesting clarification regarding a recent incident involving the resident. Explained that this nurse was informed by staff that the resident was witnessed by dietary personnel physically assaulting another resident. According to the report, the resident appeared upset that the other resident was looking at him while he ate. He was initially seated one table away, then rolled over in his wheelchair and punched the other resident on the right side of the face without any verbal exchange. [Name], NP gave verbal orders to initiate a 1:1 sitter with 15-minute safety checks, to obtain an X-ray of the face if the resident complains of pain or discomfort, and to proceed with referral and transfer to an inpatient psychiatric facility as needed. Informed NP that [Facility Name] may have a potential bed available, and nursing staff will send documentation for possible admission. NP verbalized understanding and agreement. Also updated NP that the facility has been actively working on discharge placement, but efforts have been complicated by the resident's ongoing wound care needs. The assigned nurse was instructed to notify the resident's family regarding the incident and plan of care.Record review of Resident #1's nursing note, dated 07/25/2025 at 7:45 pm, revealed Resident physically assaulted another resident. He stated the other resident was taking food from a female in the dining room and he hit him. The two were immediately separated and all parties were notified of the assault.Record review of Resident #1's nursing note, dated 07/25/2025 at 9:40 pm, revealed pt. was relocated to the 500 hall currently has a 1:1 sitter. pt calm with no outward s/s of aggression or agitation.Record review of Resident #1's nursing note, dated 07/26/2025 at 8:16 am, revealed Patient continues to remains on 1:1 observation with dedicated staff per physician order and safety protocol. Throughout the shift, the patient has presented as calm, cooperative, and emotionally stable. No episodes of verbal or physical aggression have been observed or reported to writer. Patient is engaging appropriately with staff and peers and displays a mood congruent with affect. Notably, the patient has exhibited intermittent forgetfulness, including repeated questioning about whether pain medication was administered. Writer provided reassurance and clarification, and patient was redirected without resistance. No signs of distress, confusion, or agitation were noted following redirection.Record review of Resident #1's telehealth progress note, dated 07/28/2025 revealed .Other Symptoms: Highly irritable. Physical aggression towards others. Verbal aggression. [Name], LVN called to reported the patient is becoming verbally and physically aggressive. The nurse reported the patient assaulted another resident. No injuries reported. The facility attempted to send out the patient to an inpatient psych hospital but he was denied due to his wounds. The patient is currently on 1:1 observation with checks every 15 minutes. Plan: Continue 1 on 1 monitoring. Increase Depakote DR 1250mg QAM &QPM Continue 1000mg noon dose. Obtain CBC/VPA on 1 week