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	12/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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 interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 (Resident #1) of 5 residents reviewed for dignity.LVN S failed to change and/or irrigate Resident #1's foley catheter on 11/28/25 when it was leaking, not flowing correctly, and there was an order to change it and irrigate it PRN, causing Resident #1 to sit in urine soaked bed linen and t-shirt.This failure could place residents at risk for embarrassment, decrease in dignity, and a decrease in quality of life. Findings included:Record review of Resident #1's undated face sheet revealed he was a [AGE] year old male originally admitted on [DATE], with diagnoses of neuromuscular dysfunction of the bladder (unable to control bladder), paraplegia (paralysis of lower half), osteomyelitis of thoracolumbar vertebra (infection of the vertebra in the mid back area), Type 2 diabetes (body does not produce insulin or resists it), and a right below the knee amputation.Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating normal cognition. The resident was dependent (helper does all of the effort and resident does none of the effort) with toileting hygiene. The MDS also revealed the resident had an indwelling catheter and was frequently incontinent of bowel. Resident #1 had a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer that he admitted with.Record review of Resident #1's Care Plan dated 9/29/25, revealed a Focus: Resident had a foley catheter for neurogenic bladder (Initiated: 4/1/25, Revised: 4/1/25). The goal was to remain free from catheter-related trauma through the review date (Initiated: 4/1/25, Revised: 4/1/25, Target: 6/27/25). The interventions included check tubing for kinks every shift and maintain the drainage bag off of the floor, monitor/document for pain/discomfort due to catheter, monitor/record/report to MD for s/sx UTI: no output.Record review of Resident #1's Physician Orders revealed the following orders from MD M:- Foley Catheter 16Fr Dx: Neuromuscular Dysfunction of Bladder. Ordered 9/29/25.- Flush foley with 60cc NS every day, every shift and PRN. Ordered on 10/20/25.- May change foley catheter PRN leakage, blockage, and sedimentation. Ordered 10/17/25.Record review of Resident #1's Progress Notes revealed a Nursing Note from 11/28/25 at 1:18pm from LVN S that read, Alerted by call light I entered patients room with patient advising me that he had notified EMS. Patient assessed A&O times 4 no pain, nonlabored respirations and able to verbalize. Patient stated that he would just like to be seen in the ER. Patient documentation was provided to EMS upon arrivale [arrival]. Patient transported to ER, facility supervisor notified.Record Review of Resident #1's hospital discharge paperwork from 11/28/25 revealed he was seen for a dislodged foley catheter and a UTI. He was prescribed Cefpodoxime (antibiotic) 200mg BID for 10 days, for UTI.In an interview on 11/30/25 at 11:35am, Resident #1 said on 11/28/25 his catheter was not draining, and he was soaked in urine. He said his shirt and his bed linen were soaked in urine. He said he asked LVN S to change his foley and she told him his catheter was fine. Resident #1 then told LVN S if you don't help me, I'm calling 911. He said LVN S said, That's fine, do whatever you want. Resident #1 said since LVN S was not helping him, he called 911. He said he did not want to be sitting in his urine.In an interview on 12/1/25 at 11:50am, LVN R said when Resident #1 came back from the hospital he was telling her about the problems he had with LVN S not helping him when he was leaking everywhere. She said if the catheter did not get changed it could cause a UTI, obstruction, or a full bladder. LVN R did not report the issue to anyone.In an interview on 12/1/25 at 12:10pm, EMS B said he observed Resident #1 covered in urine from his mid-chest down when he went to the facility to pick him up. EMS B said the resident told him that his catheter stopped working and he had told LVN S, and she told him not to worry about it. EMS B said the resident told LVN S if she did not help him he was going to call 911 and she told him to do whatever he wanted and walked out.In an interview on 12/1/25 at 1:15pm, the DON said Resident #1 filed a grievance yesterday (11/30/25) regarding LVN S not changing his catheter. The DON said that was the first time she heard about the incident. The DON said if a resident had a leaking foley and had an order for it to be flushed and/or changed, she expected the nurse to flush the foley first to see if that took care of the leaking, and if that did not work, she expected the nurse to change the catheter. She said if the catheter did not get changed it could cause a urinary tract infection or a burst bladder.In an interview on 12/1/25 at 1:20pm, LVN S said she saw Resident #1's foley catheter leaking and saw that he was covered in urine. She said he asked her to change his catheter, but she wanted to call the MD to see what he wanted to do, even though there were orders to change it. She said she did not clean up

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 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 interview and record review, the facility failed to ensure that a resident who entered the facility with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #1) of 5 residents reviewed for catheters.LVN S failed to change and/or irrigate Resident #1's foley catheter on 11/28/25 when it was leaking, not flowing correctly, and there was an order to change it and irrigate it PRN, causing Resident #1 to call 911 and go to the ER.This failure could place residents at risk of urinary tract infections, the bladder to burst, skin break down, embarrassment, and possible hospitalization. Findings included:Record review of Resident #1's undated face sheet revealed he was a [AGE] year old male originally admitted on [DATE], with diagnoses of neuromuscular dysfunction of the bladder (unable to control bladder), paraplegia (paralysis of lower half), osteomyelitis of thoracolumbar vertebra (infection of the vertebra in the mid back area), Type 2 diabetes (body does not produce insulin or resists it), and a right below the knee amputation.Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating normal cognition. The resident was dependent (helper does all of the effort and resident does none of the effort) with toileting hygiene. The MDS also revealed the resident had an indwelling catheter and was frequently incontinent of bowel. Resident #1 had a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer that he admitted with.Record review of Resident #1's Care Plan dated 9/29/25, revealed a Focus: Resident had a foley catheter for neurogenic bladder (Initiated: 4/1/25, Revised: 4/1/25). The goal was to remain free from catheter-related trauma through the review date (Initiated: 4/1/25, Revised: 4/1/25, Target: 6/27/25). The interventions included check tubing for kinks every shift and maintain the drainage bag off of the floor, monitor/document for pain/discomfort due to catheter, monitor/record/report to MD for s/sx UTI: no output.Record review of Resident #1's Physician Orders revealed the following orders from MD M:- Foley Catheter 16Fr Dx: Neuromuscular Dysfunction of Bladder. Ordered 9/29/25.- Flush foley with 60cc NS every day, every shift and PRN. Ordered on 10/20/25.- May change foley catheter PRN leakage, blockage, and sedimentation. Ordered 10/17/25.- Cefpodoxime Proxetil Taoblet (antibiotic) 200mg, 1 PO BID for 10 days, for UTI. Ordered on 11/28/25.Record review of Resident #1's Progress Notes revealed a Nursing Note from 11/28/25 at 1:18pm from LVN S that read, Alerted by call light I entered patients room with patient advising me that he had notified EMS. Patient assessed A&O times 4 no pain, nonlabored respirations and able to verbalize. Patient stated that he would just like to be seen in the ER. Patient documentation was provided to EMS upon arrivale [arrival]. Patient transported to ER, facility supervisor notified. There was no documentation regarding the resident's catheter leaking or anything about the resident wanting to go to the ER for antibiotics. Record Review of Resident #1's hospital discharge paperwork from 11/28/25 revealed he was seen for a dislodged foley catheter and a UTI. He was prescribed Cefpodoxime (antibiotic) 200mg BID for 10 days, for UTI.In an interview on 11/30/25 at 11:35am, Resident #1 said on 11/28/25 his catheter was not draining, and he was soaked in urine. He said his shirt and his bed linen were soaked in urine. He said he had issues before with it not draining and the nurse would change out the catheter. Resident #1 said normally his foley bag was full in the morning and on 11/28/25 it was not. He said his pubic area was hard and tender, so he knew his bladder was full. He said he asked LVN S to change his foley and she told him his catheter was fine. Resident #1 then told LVN S if you don't help me, I'm calling 911. He said LVN S said, That's fine, do whatever you want. Resident #1 said since LVN S was not helping him, he called 911. He said once he got to the hospital they told him the foley catheter tube had a tear in it, the part that was in his urethra.In an interview on 12/1/25 at 11:50am, LVN R said the indications for changing a foley catheter were if it was occluded, leaking, or she could not irrigate it. She said she had changed Resident #1's catheter on 11/25/25 or 11/26/26 and that it had leaked before. She said if the catheter did not get changed it could cause a UTI, obstruction, or a full bladder. She said when Resident #1 came back from the hospital he was asking her if they were allowed to change and irrigate his foley, and he was telling her about his problems he had with LVN S not helping him when he was leaking everywhere. LVN R said Resident #1's foley catheter had to be changed in the ER when he went.In an interview on 12/1/25 at 12:10pm, EMS B said he observed Resident #1 covered in urine from his mid-chest down when he went to the facility to pick him up. EMS B said the resident told him that his catheter stopped working and he had told LVN S, and she told him not to worry about it. EMS B said the resident told LVN S if she did not help him he was going to call 911 and she told