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	01/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to report and investigate an incident for 1 resident of 5 residents (Resident #1) reviewed for abuse/neglect in that: The facility failed to report an allegation of staff abuse made by Resident #1 of an incident that occurred on 11/8/25 at an unknown time, to the State Agency. This failure could place residents at risk of abuse of residents.Record review of the admission record dated 1/12/26, revealed that Resident #1 was a [AGE] year-old male who was originally admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included Amyotrophic Lateral Sclerosis (also known as ALS, is a nervous system disease that affects nerve cells in the brain and spinal cord. ALS causes loss of muscle control. The disease gets worse over time), muscle wasting atrophy on the right lower leg (the presence of both low muscle mass and low muscle function (strength or performance), and need for assistance with personal care (anything that a client needs to maintain hygiene, well-being, self-esteem, and dignity). Record review of Resident #1's Significant Change MDS assessment dated [DATE] reflected a BIMS score of 15 out of 15 indicating his cognition was intact. He had upper limited range of motion on one side and lower extremity impairment on both sides. Resident #1 required total to substantial to maximal assistance with bathing/showering, toileting, lower body dressing. Record review of Resident #1's care plan, date Initiated: 09/3/2025 revealed the following: A care plan to address: ADL Self Care Performance Deficit r/t Musculoskeletal impairment R/T ALS Date Initiated: 09/03/2025. Revision on 09/03/2025, which included goals and interventions. Read in part. [Resident #1] will maintain current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Date Initiated: 09/03/2025. Revision on: 1/2/26. Target Date: 3/5/26 BATHING: the resident is EXTENSIVE PER 1 STAFF Date Initiated: 9/3/.25 Revision on: 9/3/25. BED MOBILITY: The resident is EXTENSIVE PER 1 STAFF, Date Initiated: 9/3/2025.Revision on: 9/3/25. PERSONAL HYGIENE/ORAL CARE: The resident is EXTENSIVE PER 1 STAFF, Date Initiated: 9/3/25. Revision on: 9/3/25. DRESSING: Resident is EXTENSIVE PER 1 STAFF. Date Initiated: 9/3/25. Revision on: 9/3/25. EATING: The resident is able to FEED SELF WITH ASSIST AS NEEDED. Date Initiated: 9/3/25. Revision on: 9/3/25. Transfers: The resident is TOTAL PER 2 STAFF. Date Initiated: 9/3/25. Revision on: 9/3/25. TOILET USE: The resident is EXTENSIVE PER 1 STAFF. Date Initiated: 9/3/25. Revision on: 9/3/25. Record review of the facility's incident/accident reports between 11/1/25 and 1/14/26 revealed there was no incident documented for Resident #1. Record review of the complaint intake #: 1053184 read in part. perpetrator was changing [Resident #1], unable to get the resident's arm to go through his sleeve. So, she had wrenched the resident's left arm behind him like the cops do to suspects, per the resident. The resident further reported that his arm had been hurting since the incident. The resident also reported that the incident was reported to the facility. Record review of Resident #1's pain assessment dated [DATE] revealed that Resident #1 complained of pain on the left shoulder at a pain level of 10 out 10 . Verbally complaining that he felt that his arm was being pulled out of its socket. Interventions that were attempted were pain medication which was denied. Signed by LVN S Record review of Resident #1's Radiology Reports (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 11/8/25 read in part. PROCEDURE: SHOULDER LT 2V Status: Final LEFT SHOULDER LT 2V: Findings: There is no shoulder separation, fracture or dislocation. Record review of a statement dated 11/8/25 written by CNA A revealed no issues with Resident #1 complaining of pain or injury. Record review of a statement dated 11/8/25 written by CNA B A revealed no issues with Resident #1 complaining of pain or injury. (Attempted to reach via telephone/number disconnected or no longer in services Record review of a statement dated 11/8/25 written by LVN S revealed that her statement described Resident #1's care received by CNA A and CNA B, per Resident #1, he, described his treatment received by CNA A, Resident #1and said he felt like a Rag Doll. An observation and interview on 1/14/26 at 10:00 AM of Resident #1 revealed he was sitting up in his bed, with the call-light within reach. He said that in November 2025, CNA A handled him like a rag doll while providing care, attempting to remove his shirt. He added that he had pain in his left shoulder after the incident. He said that he shared the information with (former) Administrator B. He stated the information was also shared during his most recent care plan meeting (date unknown). He said that this was never addressed and was swept under the rug. In an observation and interview on 1/14/25 at 10:19 AM with CNA A, regarding Resident #1, she said that she remembered the incident and the allegation made by Resident #1, but she could not remember the exact date. She stated she did not hear about the allegation until the next day, after the allegation was made and when she and other staff were required to write witness statements by the DON. She said that former Administrator B and the DON were aware, and her statement was provided, she said that she denied the allegation of handling Resident #1 rough. CNA A demonstrated with her arm how she removed the resident's shirt (holding her arm straight out). She denied pinning the resident's arm behind his back. She said she received training on Abuse/Neglect and Exploitation. An interview was conducted on 1/14/26 at 10:31 AM with the DON, she said that in reviewing her records, she vaguely remembered an issue with Resident #1 because in her records he had an X-Ray on 11/8/26. She said that former Administrator B, may have reported the incident, but she was not sure. When the surveyor shared the concern of an allegation of resident abuse from Resident #1 and asked the DON in the case where a resident alleged that he felt a staff member handled him like a rag doll would be considered abuse.? She said she would have to have additional information. When asked about a possible negative outcome for the resident if the allegation of abuse was not reported, she said that the abuse could continue, and no one would know anything about it. She said that the reason she felt that former Administrator B would not have reported the allegation would be that there were witnesses, abuse was not alleged, and there were no injuries. In an interview on 1/14/26 at 10:44 AM with Administrator A, he said that he was not the Administrator in November of 2025 but would begin an investigation into Resident #1's allegations of resident abuse. When asked in the case where a resident alleged that he felt a staff member handled him like a rag doll would be considered abuse? He said he would like to gather more information. On 1/15/26 at 10:00 AM attempted phone interview with CNA B, message that said phone is disconnected or is no lone=ger in service. On 1/15/26 at 12:26 PM, a telephone interview with LVN S regarding Resident #1, she said that she was not present in the room when Resident #1 received care by CNA A and CNA B, she came to assess and interview Resident #1 and said that Resident #1 said used the word Rag Doll to describe his treatment received by CNA A. She said that she did not see any injuries. She said that she documented her assessment in the electronic medical record and wrote her statement. A telephone interview was conducted on 1/15/26 at 12:38 PM with an anonymous complainant. The complainant said they were not present and did not witness the incident but called the complaint in when the resident said that a CNA was rough. During a telephone interview on 1/15/26 at 2:05 PM with former Administrator B, he said he did not recall an incident or allegation made by Resident #1 on 11/8/25. He said there were a lot of complaints, but he could not remember and no longer worked at the facility. Record review of the facility's policy and procedure entitled Abuse, Neglect and Exploitation and Misappropriation Prevention Program, dated revised April 2021 read in part.Residents have the right to be free from abuse, neglect, misappropriation and exploitation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This includes but is not limited to.verbal, mental, physical abuse.The resident abuse, neglect.prevention program consist of a facility-wide commitment and resource allocation to support the following objectives.protect residents from abuse including but not necessarily limited to facility staff, other residents, consultants .develop and implement policies and protocols to prevent and identify abuse and mistreatment of residents.