

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675961	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2025
NAME OF PROVIDER OR SUPPLIER  Regency Village		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26867</p> <p>Based on interviews and record review, the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System, within 14 days, upon a resident's transfer, reentry, discharge, and death, for 1 of 18 residents (Resident #35) reviewed for transmitted MDS data to the CMS System.</p> <p>The facility failed to complete Resident #35's Admission MDS assessment within 14 days of admission.</p> <p>This failure could place residents at risk of not having their assessments transmitted timely which could cause a delay in treatment.</p> <p>The findings included:</p> <p>Record review of Resident #35's face sheet dated 05/13/25 revealed a -[AGE] year-old female admitted to the facility on [DATE].</p> <p>Record review of Resident #35's admission MDS assessment, dated 12/18/2024, revealed the signature page indicated it was signed as completed on 12/30/24, 18 days after admission.</p> <p>During an interview with the DON on 5/13/25 at 2:00pm the DON said the MDS staff signed a few days ago. She said the MDS were being done remotely and the facility was in the process of hiring an MDS nurse.</p> <p>During interview on 5/14/25 at 1:33 p.m., the Director of Reimbursement said the former MDS Coordinator was a no call/no show yesterday 5/13/25 and they were in the process of hiring an MDS nurse. The Director of Reimbursement said that herself and the MDS Consultant would fill in the gap till the facility hired an MDS coordinator. The Director of Reimbursement said if the MDS was not completed timely, could result in delay in services.</p> <p>(continued on next page)</p>

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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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/14/25 at 1:54 p.m., the MDS Consultant said she had provided oversight to the facility since September of 2024. The MDS Consultant said it was a team effort between her and the Director or Reimbursement to cover the facility regarding MDS. The MDS Consultant said they would have someone soon to cover MDS remotely. The MDS Consultant said she trained staff at the facility in person regarding MDS by going over the policy and procedures, coding of the MDS, RAI manual and guidelines. The MDS Consultant said the previous MDS Coordinator had started at the facility in February of 2025 and had 2-3 years of prior experience.</p> <p>During an interview with the Facility's Administrator on 05/13/25 at 3:30PM, he said the facility had gone through several MDS staff for the past few months. He said late MDS may result in delay in providing needed services to resident.</p> <p>Policy on MDS completion was requested on 05/13/25 at 3:30pm and the Administrator said the facility followed the RAI manual.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26867</p> <p>Based on interview and record review, the facility failed to ensure that assessments accurately reflected residents' status for 3 (Resident #7, #16, #22) of 10 residents reviewed for accuracy of assessments.</p> <p>-The facility failed to ensure that Resident #7's falls that occurred on 4/20/25 were documented on their annual MDS assessment dated [DATE].</p> <p>-The facility failed to ensure that Resident # 16 's falls were documented on her Annual MDS assessment dated [DATE], quarterly MDS dated [DATE] and 12/11/24.</p> <p>- The facility failed to ensure that Resident # 22 's falls were documented on her Annual MDS assessment dated [DATE], quarterly MDS dated [DATE] and 12/23/24.</p> <p>These failures could place residents at risk of receiving inadequate care and services based on inaccurate assessments.</p> <p>Findings included:</p> <p>Resident #7</p> <p>Record review of Resident #7's face sheet dated 5/13/2025, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Acute on Chronic Systolic (Congestive) Heart Failure (disorder where the heart does not pump blood as well as it should) and Muscle Weakness.</p> <p>Record review of Resident #7's care plan with last review 5/13/25 revealed she had two falls on 4/20/25.</p> <p>Record review of Resident #7's Fall Nurses' Note dated 4/20/25 at 5:36 a.m. revealed resident had an un-witnessed fall with no injury.</p> <p>Record review of Resident #7's Fall Nurses' Note dated 4/20/25 at 12:33 p.m. revealed resident had an un-witnessed fall with no injury.</p> <p>Record review of Resident #7's Progress Notes for date range 4/19-4/21/25 revealed on 4/20/25 at 5:25 a.m. Resident #7 was found on the floor and on 4/20/25 at 12:47 p.m. Resident #7 was found lying on her right side.</p> <p>Record review of Resident #7's annual MDS dated [DATE] and printed 5/12/24 revealed a BIMS score of 00 that indicated severe cognitive impairment. Record review also revealed no falls since admission/entry or reentry or the prior assessment in section J1800.</p> <p>During interview on 5/14/25 at 10:25 a.m., the DON said Resident #7's falls on 4/20/25 should have been claimed on the MDS dated [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 5/14/25 at 1:33 p.m., the Director of Reimbursement said a fall should be coded if it occurred on 4/20/25 and the MDS was on 5/1/25. The Director of Reimbursement said if the MDS was not coded correctly then that triggered on care plans which could prevent interventions that could prevent future falls.</p> <p>Resident #16</p> <p>Record review of Resident #16's face sheet dated 5/13/2025, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included lack of coordination, unsteady feet, difficulty in walking, chronic respiratory failure, chronic pain, Hypertension (high blood pressure), depression, generalized anxiety, and muscle weakness.</p> <p>Record review of facility's accidents and incident's log dated 05/12/25 indicated Resident #16 had un-witnessed fall on 11/14/24, and witnessed falls on 12/30/24, 01/08/25, and 03/17/25.</p> <p>Record review of Resident #16's Care plan dated 04/16/24 revealed Resident #16 was care-planned for falls: Resident #16 has had an actual fall 3/16/25 - unwitnessed fall no injury Date Initiated: 04/16/2025, Revision on: 04/16/2025.</p> <p>Record review of Resident #16's annual MDS dated [DATE], indicated the section on fall assessment were left blank section on falls since admission, re-admission was coded 0 which indicated no fall history.</p> <p>Record review of Resident #16's Quarterly MDS dated [DATE] indicated the section on fall assessment were left blank section on falls since admission, re-admission was coded 0 which indicated no fall history</p> <p>Record review of Resident #16's Quarterly MDS dated [DATE] indicated the section on fall assessment were left blank section on falls since admission, re-admission was coded 0 which indicated no fall history.</p> <p>Resident #22</p> <p>Record review of Resident #22's face sheet dated 5/13/2025, revealed a-72-year -old male resident admitted to the facility initially on 09/14/22 and readmitted on [DATE].</p> <p>Record review of facility's accidents and incident's log dated 05/12/25 indicated Resident #22 had multiple falls as followed witnessed Falls on-</p> <p>01/18/25</p> <p>01/23/25</p> <p>3/18/25</p> <p>Unwitnessed Falls on</p> <p>02/01/25</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>02/06/25</p> <p>Record review of Resident #22's care plan dated 09/23/22 with a revision date of 04/16/25 indicated Resident #22 was care planned for falls:</p> <p>Focus-Resident # 22 had a fall on 1/18/25 - Witnessed Fall, 1/23/25 - Witnessed Fall,2/1/25 - Unwitnessed Fall, 2/6/25 - Unwitnessed Fall, 3/18/25 - Witnessed fall, Date Initiated: 09/23/2022.</p> <p>Goal: Resident #22 will be free of minor injury through the target date 03/27/2025.</p> <p>Resident #22 will not sustain serious injury through the target date 03/27/2025 .</p> <p>Record review of Resident #22's Significant change MDS assessment dated [DATE] and quarterly MDS dated [DATE], revealed the sections on fall assessment were left blank, section on falls since admission/ re-admission was coded 0 which indicated no fall history.</p> <p>During interview on 05/12/25 at 10:15 am Resident #22's sitter said she sits with Resident #22 due to multiple falls. Resident #22 was unable to communicate.</p> <p>During interview on 5/14/25 at 1:20 p.m. the CDO said if the MDS was coded inaccurately then the resident could have adverse effects but did not elaborate.</p> <p>During interview on 5/14/25 at 1:54 p.m., the MDS Consultant said</p> <p>if a MDS was not coded correctly then the care provided or needed could be affected, the care planning process could be affected, and could affect everything all the way around.</p> <p>51036</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244</b></p> <p>Based on observations, interviews and record reviews, the facility failed to develop and implement comprehensive care plans with measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs identified in the comprehensive assessment for of 20 residents reviewed for care plan accuracy(Residents # 59, 123, 17)</p> <p>---there were no comprehensive care plans in Resident #'s 59, 123, and 17 electronic medical records.</p> <p>These failures placed residents at risk of receiving inadequate care due to incomplete care plans.</p> <p>Findings include:</p> <p>Resident # 59</p> <p>Record review of Resident # 59's face sheet revealed admitted [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (lung conditions causing airflow obstruction), hypertension (high blood pressure), heart failure (inability of heart to pump blood as it should), muscle weakness, lack of coordination (problems with balance).</p> <p>Record review of Resident # 59's Admission MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment, understands others and understood by others, frequently incontinent of bowel and bladder, partial/moderate assistance required for bathing and toileting, and supervision/set up for hygiene.</p> <p>Record review of Resident # 59's undated comprehensive care plan revealed it was blank: there were no focus areas, goals or interventions developed to assist direct care staff in providing care for Resident # 59.</p> <p>Resident # 123</p> <p>Record review of Resident # 123's face sheet revealed admitted [DATE] with diagnoses including Parkinson's (central nervous system disorder affecting movement), unqualified visual loss, both eyes, hypertension (high blood pressure), chronic obstructive pulmonary disease (lung conditions causing airflow obstruction), anxiety disorder (excessive worry, fear, nervousness), depression (loss of interest in activities).</p> <p>Record review of Resident # 123's Admission MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognitive functioning, severely impaired visual functioning, understood by others and understands others, always continent, Hospice while a resident, partial/moderate assistance required for eating, hygiene, toileting, dressing, and maximum assistance needed for bathing.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident # 123's undated comprehensive care plan revealed it was blank: there were no focus areas, goals or interventions developed to assist direct care staff in providing care for Resident # 123.</p> <p>Resident # 17</p> <p>Record review of Resident # 17's face sheet revealed admitted [DATE] with diagnoses including dementia (impairment in memory, thinking and social abilities), peripheral neuropathy (nerve damage causing pain and numbness in hands and/or feet), transient ischemic attack (temporary interruption of blood flow to the brain), heart failure (inability of heart to pump blood as it should), osteoarthritis (deterioration of tissue at the ends of bones), cervicgia (neck pain).</p> <p>Record review of Resident # 17's Admission MDS dated [DATE] revealed BIMS score of 14 indicating intact cognitive ability, understands others and understood by others, always incontinent of bowel and bladder, partial/moderate assistance required for hygiene, and maximum assistance needed for toileting and dressing.</p> <p>Record review of Resident # 17's undated comprehensive care plan revealed it was blank: there were no focus areas, goals or interventions developed to assist direct care staff in providing care for Resident # 17.</p> <p>In an interview on 5/14/25 at 12:30pm, the DON said the MDS coordinator did not put the care plan into the EMR. She said the triggered areas from the MDS would be used to build the care plan, but it was not done for Residents # 59, # 123, and # 17. She said there would need to be someone hired to complete the care plans.</p> <p>In an interview on 5/14/25 at 12:40pm, the ADON said the DON and MDS nurse would be responsible for care plans, and she looks at the baseline care plan to determine if anything needed to be addressed.</p> <p>In an interview on 5/14/25 at 3:30pm, the RDO, DON, and ADON said they did not know what happened and why there were so many care plans missing. They said there have been 3 MDS nurses working here since September 2024. The MDS nurse would develop the care plan from information from the IDT meeting and input from the nurses. The risk of having incomplete care plans would residents not receive correct care.</p> <p>Record review of facility policy Care Plans, Comprehensive Resident Centered, revised December 2016, revealed, in part: .the comprehensive person-centered care plan is developed within 7 days of the required comprehensive assessment (MDS) .assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51036</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out Activities of Daily Living received the necessary services to maintain grooming and personal hygiene for 1 (Resident #7) of 5 residents reviewed for Activities of Daily Living.</p> <p>The facility failed to provide Resident #7 with adequate oral care.</p> <p>This failure could place residents at risk of diminished quality of life or decreased self-esteem.</p> <p>Findings included:</p> <p>Record review of Resident #7's face sheet dated 5/13/2025, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Need for Assistance with Personal Care.</p> <p>Record review of Resident #7's annual MDS dated [DATE] revealed a BIMS score of 00 that indicated severe cognitive impairment. Record review also revealed score of 03 which was partial/moderate assistance for oral hygiene in Section GG0130.</p> <p>Record review of Resident #7's care plan printed 5/13/25 revealed the resident required extensive assistance by staff with personal hygiene and oral care</p> <p>Record review of Resident #7's POC Response History printed 5/12/25 with look back for 14 days showed documentation regarding personal hygiene (How resident maintains personal hygiene, including brushing teeth) from 4/29/25-5/4/25 and 5/6/25-5/8/25. Further review revealed there was no documentation on 5/5/25 and from 5/9/25-5/12/25.</p> <p>During interview on 5/12/25 at 11:31 a.m., Resident #7's family member stated she had previously put a sign above the resident's bed that said please help me brush my teeth. She stated Resident #7 was able to brush her teeth with set up assistance prior to recent decline. Resident #7 was no longer able to brush her teeth. Resident #7's family member said Resident #7's mouth was horrible, and she was disheartened when she saw the state of her mouth on 5/11/25. Resident #7's family member said she went to the nurse at that time and asked for mouth swabs and tried to do oral care but was not trained how to do oral care.</p> <p>Observation and interview on 5/12/25 at 2 p.m. of Resident #7 revealed dried brown crustiness to Resident #7's lips. LVN G removed the dried brown crusty substance from Resident #7's lips. There was a dry brown substance noted inside Resident #7's mouth coating her upper and lower teeth. LVN G and the DON then provided care to Resident #7. LVN G said she was not sure how often oral care should be completed. The DON said the aides were responsible for oral care and should provide oral care first thing in the morning and then as needed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/12/25 at 2:40 p.m., CNA K said they had not done oral care on Resident #7 as they had not worked with her in a while, and she had declined since they last worked with her, and they did not want to disturb her. CNA K said oral care was done once per shift. CNA K said they had oral care training during orientation and was checked off performing oral care on a resident. CNA K said if a resident was unable to brush their teeth, then they used a sponge to provide oral care.</p> <p>Observation on 5/13/25 at 10:42 a.m. of Resident #7 revealed no buildup noted on Resident #7's teeth or lips.</p> <p>During interview on 5/14/25 at 9:02 a.m., LVN H said she normally worked the hallways where Resident #7 resided. LVN H said the nurse was responsible for overseeing oral care, but the aides could perform oral care. LVN H said if a resident was unable to brush their teeth, then staff could use swabs which should be done after meals. LVN H said if a resident did not receive oral care, then the resident could get ulcers in the mouth or cavities or possible gum breakdown or infections.</p> <p>During interview on 5/14/25 at 9:32 a.m., CNA L said they should do oral care every day on the residents. CNA L said they used a sponge for oral care if the resident was unable to brush their teeth and would also do oral care after every meal. CNA L said they recently started at the facility and had not had any ongoing trainings regarding oral care and maybe had oral care training during orientation. CNA L said they worked on the hallway where Resident #7 resided.</p> <p>During interview on 5/14/25 10:25 a.m., the DON said if oral care was not completed then the resident could get oral decay, dental issues, dry tongue or could be hard for them to take anything in. The DON said they would do an in-serve regarding oral hygiene.</p> <p>During interview on 5/14/25 at 12:04 a.m., the ADON said if oral care was not completed then a resident could have dehydrated or parched mouth, cavities, or infection.</p> <p>During interview on 5/14/25 at 3:06 p.m., the Administrator said they did not have any previous trainings to provide regarding oral care this year.</p> <p>Record review of facility's procedure Oral Care revealed The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection.</p> <p>Record review of facility's policy Activities of Daily Living (ADLs), Supporting revealed Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036</b></p> <p>Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care was provided such care, consistent with professional standards of practice for 2 (Residents #27 and #32) of 4 residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #27's oxygen humidifier was not empty and Resident #32's oxygen concentrator was working appropriately by not beeping.</p> <p>The failure could place residents at risk of developing respiratory complications or having decreased quality of care from dry nasal passages that could lead to nosebleeds or sores.</p> <p>Findings included:</p> <p>Resident #27</p> <p>Record review of Resident #27's face sheet dated 5/13/2025, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (progressive brain disorder that destroys memory and thinking skills) and Heart Failure (disorder when the heart does not pump blood as well as it should).</p> <p>Record review of Resident #27's quarterly MDS dated [DATE] revealed a BIMS score of 00 that indicated severe cognitive impairment. Record review also revealed under section O: oxygen therapy was received.</p> <p>Record review of Resident #27's Order Summary Report dated 5/13/25 revealed Change O2 tubing/water every week on Sunday night shift and PRN.</p> <p>Record review of Resident #27's May TAR printed 5/13/25 revealed Change O2 tubing/water every week on Sunday night shift and PRN.</p> <p>Record review of Resident #27's care plan printed 5/13/25 revealed the resident has oxygen therapy related to Congestive Heart Failure (disorder when the heart does not pump blood as well as it should) with intervention of oxygen settings of oxygen via nasal cannula at 3 liters continuously.</p> <p>Observation on 5/12/25 at 10:10 a.m. revealed Resident #27's humidifier bottle on her oxygen concentrator was empty while she was wearing oxygen at 2 liters via nasal cannula.</p> <p>Observation on 5/13/25 at 8:51 a.m. revealed Resident #27's humidifier bottle on her oxygen concentrator was empty while she was wearing oxygen at 2 liters via nasal cannula.</p> <p>During interview on 5/13/25 at 8:53 a.m., the DON observed Resident #27's oxygen concentrator and the DON said it was the nurse's responsibility to refill the oxygen humidifiers and should be done on Sundays.</p> <p>Resident #32</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Regency Village		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #32's face sheet dated 5/13/2025, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (high blood sugar) without complications and Heart Failure (disorder when the heart does not pump blood as well as it should).</p> <p>Record review of Resident #32's quarterly MDS dated [DATE] revealed a BIMS score of 11 that indicated moderate cognitive impairment. Record review also revealed oxygen therapy while a resident documented under section O for Resident #32.</p> <p>Record review of Resident #32's Order Summary Report dated 5/13/25 revealed Change O2 tubing/water every week on Sunday and PRN.</p> <p>Record review of Resident #32's May TAR printed 5/13/25 revealed Change O2 tubing/water every week on Sunday and PRN.</p> <p>Record review of Resident #32's care plan printed 5/13/25 revealed the resident has oxygen therapy related to Congestive Heart Failure (disorder when the heart does not pump blood as well as it should) with intervention to change oxygen tubing and water every week on Sunday and as needed.</p> <p>During interview and observation on 5/12/25 at 9:08 a.m., Resident #32 said she almost ran out of water in the oxygen humidifier bottle, and it bothered her nose, but she could not remember when the incident happened. Resident #32 was observed wearing oxygen at 4 liters via nasal cannula and there was about 3/4 inch of water in the humidifier bottle on the oxygen concentrator. Resident #32's oxygen concentrator was noted to be beeping.</p> <p>During interview and observation on 5/13/25 at 8:55 a.m., Resident #32 said my nose tells me I need some water because her nose felt dry. Observation of Resident #32 revealed she was wearing oxygen at 4 liters via nasal cannula and there was about one centimeter of water in the humidifier bottle on the oxygen concentrator. Oxygen concentrator was beeping.</p> <p>During interview on 5/14/25 at 9:02 a.m., LVN H said she normally worked the hallways where Resident #27 and #32 resided. LVN H said she checked oxygen humidifier bottles daily when she made her first rounds. LVN H said Sunday night nursing staff was responsible for refilling the humidifier bottles on the oxygen concentrators. LVN H said an effect a resident could experience if the oxygen humidifier bottle was empty was the resident's sinuses could dry out or possible have thicken secretions.</p> <p>During interview on 5/14/25 10:25 a.m., the DON said if a resident's oxygen humidifier was not filled then the resident's nasal cavity could dry out causing a nosebleed. The DON said they would have an in-service regarding oxygen humidifiers.</p> <p>During interview on 5/14/25 at 12:04 a.m., the ADON said if a resident's oxygen concentrator's humidifier was empty then the resident could have dried out nares which could lead to nosebleeds or ulcers.</p> <p>During interview on 5/14/25 at 3:06 p.m., the Administrator said they did not have any previous trainings to provide regarding oxygen care this year.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Regency Village		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's policy Oxygen Administration revealed Periodically re-check water level in humidifying jar.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867</b></p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that:</p> <ul style="list-style-type: none"> <li>- The facility failed to keep kitchen equipment clean and free of grease build up.</li> <li>- The facility failed to label foods for identification and dated with expiration date.</li> <li>- The facility failed to ensure that expired food items and products were not stored in the walk- in refrigerator.</li> </ul> <p>These failures could place residents at risk for food-borne illness and/or transmission-based infections.</p> <p>Findings included:</p> <p>Kitchen observation and interview on [DATE] at 8:40am, revealed one of one commercial can opener had a dark looking substance around the cutting blades and the blade holder.</p> <p>The deep fryer had dark looking grease with white floating substances on top of the grease. [NAME] G said she was off for three days and today [DATE] was her first day back. She said the grease was usually changed once a week but not sure of when it was changed last.</p> <p>Observation of the walk-in cooler and interview on ([DATE] at 8:45AM revealed the following food items.</p> <ul style="list-style-type: none"> <li>-Half 32oz Ready care dairy drink with expiration date of [DATE]</li> <li>-Sandwich in a small tray without label, [NAME] G said they were made this morning for snacks.</li> <li>-A plastic container of coleslaw dated [DATE] no label.</li> <li>-A plastic container of crushed pineapple-no date and no label.</li> <li>-Assorted sandwich meat undated and unlabeled all in a plastic bag</li> <li>-5 lbs. container of Cottage cheese dated [DATE]</li> <li>-32 oz of baking buttered milk dated [DATE].</li> <li>-,d+[DATE] full gallon of yellow mustard dated [DATE]</li> <li>-32oz of enchilada source dated [DATE]</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-1Lbs (16oz) Margarin half covered, and half exposed on the shelve with dark brown substance around the butter.</p> <p>-16oz cholate syrup dated [DATE].</p> <p>-48oz box of Lemon Crust Mix dated [DATE].</p> <p>-An unknown substance in a grocery bag. [NAME] G said she does not know what it was and have no idea who left it in the walk-in cooler.</p> <p>All undated and unlabeled items were identified and removed from the kitchen walk in cooler by cook G.</p> <p>During an interview with [NAME] G on [DATE] at 8:55AM, she said she expected all food items in the kitchen to be labeled with food item for identification and a used by date to prevent food burn, illness, and food poisoning.</p> <p>Attempt was made to communicate with the Dietary Manager on [DATE] at 2:00PM and was difficult due to hearing impairment.</p> <p>In an interview with the facility's Administrator, DON, and the Regional Clinical director on [DATE] at 4:00 PM, the Administrator said cleaning of the kitchen should be the responsibility of all staff. He said the Dietary Manager had some challenges and he was new to the position. The regional Director of Operation said the Dietary Manager would have more training on management.</p> <p>During an interview with the Registered Dietitian on [DATE] at 12:00PM, she said she expected the kitchen to be cleaned, all food items properly labeled and dated with date prepared and expiration date. She said all precooked food products are to be discard after 3 days if not used.</p> <p>Record review of facility's policy dated 2000 revised 2006 revealed- Policy Statement Food storage areas shall be maintained in a clean, safe, and sanitary manner.</p> <p>1. Food Services, or other designated staff, will maintain clean, food storage areas at all times .</p> <p>5 Prepared food stored in the refrigerator until service shall be dated with an expiration date. Such food will be tightly sealed with plastic wrap, foil, or a lid.</p> <p>10 The Food Services Manager, or his/her designee, will check refrigerators and freezers daily for proper temperatures. The Food Services Manager will maintain records of such information.</p>		