STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675446	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Meadows Rehabilitation and Healthcare Cent	1615 Eleventh St Floresville, TX 78114

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 4 residents reviewed for quality of care. The facility failed to accurately perform a head-to-toe-readmission assessment of Resident #1 on 12/11/25 and did not identify and assess a peripheral IV catheter located on the resident's chest until 12/14/25. This failure placed the resident at risk for complications including infection, infiltration (leakage of IV fluid or medication into the surrounding tissue instead of the vein, which can cause swelling, pain, and tissue damage), and dislodgement (movement or accidental removal of the IV catheter from the vein, which can cause bleeding, injury, or infection).Findings included: Record review of Resident #1's admission record, dated 2/18/26, revealed an [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included atrial fibrillation (an irregular and often rapid heart rhythm that can increase the risk of stroke and decreased cardiac efficiency), type 2 diabetes mellitus (a chronic condition in which the body does not effectively use insulin, resulting in elevated blood glucose levels), Gastroesophageal Reflux Disease (GERD) (a digestive disorder in which stomach acid frequently flows back into the esophagus causing irritation), open wound of right lower leg (a break in the skin and underlying tissue on the right lower leg that may be at risk for infection and requires wound care), open wound of left buttocks (a break in the skin and underlying tissue on the left buttocks requiring monitoring and treatment to prevent complications), and muscle weakness. The resident was discharged on 12/17/25. Record review of Resident #1's admission MDS, dated [DATE], revealed the resident's BIMS score was 12 (moderately impaired). Record review of Resident #1's baseline care plan, dated 12/11/25, revealed the resident did not receive any IV medications while a resident. Record review of Resident #1's hospital documents, dated 12/9/25, revealed an order for potassium chloride 20 mEq in sterile water, 100 mL premix, once, central line recommendation for this concentration and REQUIRED for IV administration for rates greater than 10 mEq/hr. Record review of Resident #1's skin assessment, dated 12/11/25, revealed Resident #1 had current skin or wound issues and they were not new. No other information was provided about an IV that was located on the resident's chest area. Record review of Resident #1's nursing progress notes, dated 2/18/26, revealed a note written on 12/14/25 resident [family member] found a peripheral IV located on left breast on resident and notified night nurse about the finding. removal of IV at 0910 [9:10 a.m.] this morning by day shift nurses. Catheter intact, no pain during or after removal. resident voiced no pain at this time.call light in reach. will be monitoring site. Written by LVN C. During an interview on 2/18/26 at 3:51 p.m. LVN B stated she was the charge nurse on 12/11/25 when Resident #1 was readmitted to the facility. LVN B stated she completed the head-to-toe assessment for Resident #1 which would have included any skin conditions or presence of any devices/IVs. LVN B stated she was not aware Resident #1 had an IV and never saw it and would have documented it (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: 675446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER: Prairie Meadows Rehabilitation and Healthcare Cent		STREET ADDRESS, CITY, STATE, ZIP CODE: 1615 Eleventh St Floresville, TX 78114	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if she had seen it. LVN B stated if an IV was not noted on a skin assessment it could get infected. During an interview on 2/20/26 at 11:42 a.m. LVN C stated when she arrived for her shift on 12/14/25 she received a report that an IV was found on Resident #1 the night of the 14th. LVN C stated her and another nurse went to remove it. LVN C stated it was a regular peripheral IV catheter and looked normal. LVN C stated normally during an head-to-toe assessment nurses would look over the entire body and notate things like an IV catheter. During an interview on 2/20/26 at 10:51 a.m. the DON stated if a resident had an IV it should have been noted on skin assessment during readmission and the assessment should have included the IV or any wound measurements. The DON stated normally if a resident had an IV they would call and notify the provider and receive orders for care of the IV to prevent any complications. Record review of the facility policy titled [company] Skin Integrity Prevention and Treatment Program, reviewed June 25, 2025, revealed, Braden Skin Risk Assessment and Documentation Standards include but not limited to: Completed within 24 hrs of admission as part of the nursing admission assessment, and further revealed, Weekly Skin Integrity Checks: Weekly assessment looking for new wounds-completed by a licensed nurse. Documented on Treatment Record, and, Weekly Wound Assessment: Each identified skin issue/area is assessed weekly in electronic medical record. A review of the facility policy titled Charting and Documentation, revised July 2017, revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record, and further revealed, The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition, and, Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 of 4 residents (Resident #2, and Resident #4) reviewed for incontinent care: 1. The facility failed to ensure CNA A wiped between Resident #2's labia folds during incontinent care. 2. The facility failed to ensure Resident #2's catheter bag was not touching the floor during incontinent care. 3. The facility failed to ensure Resident #4's catheter bag was not touching the floor. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices.1. Record Review of Resident #2's admission Record, dated 2/20/26, revealed a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE] with diagnoses including anoxic brain damage (brain injury caused by lack of oxygen resulting in impaired neurological function), contracture of muscle, right upper arm (permanent shortening and tightening of muscle limiting movement), contracture of muscle, left upper arm (permanent shortening and tightening of muscle limiting movement), tracheostomy status (presence of a surgically created opening in the neck into the trachea to assist with breathing), and neuromuscular dysfunction of bladder (impaired bladder control caused by nerve damage affecting bladder function).

Record Review of Resident #2's annual MDS assessment, dated 1/19/26, reflected Resident #2 had severely impaired cognition for daily decision making and was always incontinent of bladder and always incontinent of bowel.

Record review of Resident #2's care plan, initiated 5/2/25, revealed a care area for Resident #2 had an indwelling catheter related to atonal bladder (loss of bladder muscle tone resulting in inability to effectively empty the bladder) and neurogenic bladder, with interventions to position the catheter bag and tubing below the level of the bladder and away from entrance room door.

Record review of Resident #2's physician order summary, dated 2/20/26, revealed orders for foley catheter care every shift and as needed, with a start date of 2/16/26, and no end date. Foley catheter 16-18 fr 10-30 cc bulb change as needed for dislodgement or obstruction, with a start date of 2/16/26, and no end date.

During an observation on 2/20/26 at 10:06 a.m. CNA A provided incontinent care to Resident #2, who was lying in bed and had a bowel movement. Before starting peri care the catheter bag was hanging on the side of the resident's bed and was touching the floor. During peri care CNA A used disposable wipes to cleanse the resident's perineal area and wiped the external front perineal area without separating the resident's legs or the labia. After CNA A completed the incontinent care and repositioned the resident, CNA A was asked to demonstrate how incontinent care had been provided. CNA A then repositioned the resident's legs and separated the labia, at which time brown fecal matter was observed present in the pubic hair and inner labial area. CNA A then obtained soap, water, and clean wipes and proceeded to cleanse the perineal area. During cleansing, the disposable wipes used by CNA A were observed to contain brown fecal matter.

During an interview on 2/20/26 at 10:33 a.m. CNA A stated she should have opened the residents legs more so she could clean between the labia folds. CNA A stated not cleaning between then labia folds could place the resident at risk of infection.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/26 at 10:51 a.m. the DON stated staff should place a basin under the catheter bag to prevent it from touching the floor and prevent infections. The DON stated staff could also use foam peri cleanser during peri care. The DON stated staff should clean between the labia folds to prevent UTIs. A review of the facility document titled C.N.A. Orientation Check List for CNA A, dated April 1, 2025, revealed CNA A completed orientation training which included Activities of Daily Living (ADLs), including peri care. A review of the facility document titled Incontinent Care skills competency checklist for CNA A, dated April 1, 2025, revealed CNA A was evaluated and marked as MET competency for incontinent care. The checklist indicated CNA A demonstrated competency in positioning the resident with legs apart, using a wet washcloth and soap/peri wash, washing the perineal area from front to back, washing the buttocks and thighs thoroughly, rinsing thoroughly, drying with a towel, and applying a thin layer of skin barrier. A review of the facility policy titled Perineal Care, revised February 2023, revised April 16, 2024, and reviewed June 24, 2025, revealed under the section For a female resident, the policy instructed staff to wet a washcloth and apply soap or skin cleansing agent and wash the perineal area wiping from front to back. The policy further instructed staff to separate the labia and wash the area downward from front to back, continue to wash the perineum moving from inside outward to the thighs, wash the rectal area thoroughly wiping from the base of the labia toward and extending over the buttocks, and rinse and dry thoroughly. A review of the facility policy titled Foley Catheter Insertion, Female Resident, revised and reviewed June 2025, revealed the policy instructed staff to attach the catheter to the drainage tubing and secure the drainage tubing to the bed frame and allow tubing to rest on the bed surface. 2. Record review of Resident #4's admission Record dated 02/18/26 documented a [AGE] year-old male originally admitted to the facility 07/02/24 and the most recent admission on [DATE]. Resident #4's diagnoses included unspecified hydronephrosis (swelling of one or both kidneys caused by a backup of urine), and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a progressive cognitive decline affecting memory, thinking, and daily functioning, where the specific type of dementia is not identified, and there are no significant behavioral issues like aggression, psychosis, or agitation). Record review of Resident #4's Annual MDS dated [DATE], documented a BIMS score of 9 that indicated moderate cognitive impairment. Record review of Resident #4's Care Plan with the last revision date of 08/26/25 documented a focus of: [Resident #4] has impaired bowel and bladder evacuation – incontinent of B & B – utilizes a foley catheter r/t dx neuromuscular dysfunction of bladder, BPH, AKI, impaired mobility –[Resident #4] will at times remove his privacy bag and/or leg strap for his foley bag ** while sitting up in wheelchair at times he will pull on foley tubing to reach foley bag and will carry it in his lap or let it drop to floor **he will also place foley bag in bed with him – lying on mattress instead of hanging on side of bed frame ** he will also remove leg strap to hold catheter in place. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/19/26 at 11:14 am, an interview was attempted with Resident #4 who was laying on his bed located in the facility memory care unit. The catheter bag for Resident #4 was observed laying on the floor by his bed. Resident #4 stated they take good care of me and then he started asking what time do we eat? Resident #4 then dismissed this surveyor by saying OK, I'll see you later and waved. Another observation of the catheter bag on the floor was made on 02/19/26 at 11:30 am with nurse surveyor. During an interview with CNA D on 02/19/26 at 11:30 am, CNA D stated staff tried to hang the catheter bag on the side of the bed but since the bed was in a low position with a fall mat beside the bed, it was difficult to keep the catheter bag off the floor. CNA D also stated that the Resident #4 frequently moved it around himself. CNA D stated they encourage Resident #4 to use his call light so they can assist him to his wheelchair and properly position the catheter bag but he often forgets to do this and just gets up and walks while holding the bag. The catheter bag placement for Resident #4 was discussed during an interview with LVN E on 02/19/26 at 11:35 am. LVN E stated she knew the catheter bag touched the floor since the bed needed to be in the low position and that this position could cause an infection. LVN E also stated that when Resident #4 is in his wheelchair, he will often try to hook the bag on his belt and they have to tell him it needs to be lower. LVN E stated they had tried to take out the catheter but he retains urine so he must have it. LVN E further stated she was not sure what they could do to prevent infection from the catheter bag touching the floor.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 4 residents (Residents #1) reviewed for medical records. The facility failed to ensure Resident #1's medication administration report did not contain blanks. This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records.Record review of Resident #1's admission record, dated 2/18/26, revealed an [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included atrial fibrillation (an irregular and often rapid heart rhythm that can increase the risk of stroke and decreased cardiac efficiency), type 2 diabetes mellitus (a chronic condition in which the body does not effectively use insulin, resulting in elevated blood glucose levels), Gastroesophageal Reflux Disease (GERD) (a digestive disorder in which stomach acid frequently flows back into the esophagus causing irritation), open wound of right lower leg (a break in the skin and underlying tissue on the right lower leg that may be at risk for infection and requires wound care), open wound of left buttocks (a break in the skin and underlying tissue on the left buttocks requiring monitoring and treatment to prevent complications), and muscle weakness. The resident was discharged on 12/17/25. Record review of Resident #1's admission MDS, dated [DATE], revealed the resident's BIMS score was 12 (moderately impaired). Record review of Resident #1's baseline care plan, dated 12/11/25, revealed the resident required partial or moderate assistance with personal hygiene and did not self-administer medications. Record review of Resident #1's nursing progress notes, dated 2/18/26, revealed a note written on 12/10/25 Reached out to hospital. Resident is currently in [Hospital] . Written by LVN F Record review of Resident #1's nursing progress notes, dated 2/18/26, revealed a note written on 12/17/25 discharged home . Written by LVN G Record review of Resident #1's December 2025 MAR revealed blanks for 12/14/25 and 12/15/25 for esomeprazole magnesium capsule delayed release 40 mg give 1 capsule by mouth in the morning for GERD with an order date of 12/12/25 and DC date of 12/18/25. Further review of the MAR revealed scheduled orders were left blank with no coding, initials, or documentation to indicate whether the medications were administered, refused, held, or unavailable on 12/10/25, 12/17/25, and 12/18/25 for daily orders. During an interview on 2/20/26 at 10:51 a.m. the DON stated staff was expected to code something in the MAR and not leave it blank. The DON stated between 12/9/25 and 12/11/25 the resident was in the hospital. The DON stated they needed to enter the code that showed she was at the hospital. The DON stated this resident was known to refuses care and may have refused medications, but staff should have used the code to show she refused the medication. The DON stated leaving the MAR blank placed the resident at risk of not knowing if a medication was administered. Record review of facility policy titled Charting and Documentation, dated July 2001 and revised July 2017, revealed, The following information is to be documented in the resident medical record: . Medications administered. The policy further revealed, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.