

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Prairie Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Main St Frisco, TX 75034	
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 - Few	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 observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 6 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1, who sustained a mild nasal fracture from a fall on 07/11/26, followed up with an ENT in 7 days per hospital discharge orders. The resident was discharged from the hospital on [DATE] and the appointment was not made until 07/22/26. This failure could place residents at risk for worsening of condition which could lead to serious harm. Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated 05/14/26, reflected the resident was an [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. The MDS Assessment under Section C-Cognitive Patterns reflected Resident #1's BIMS score was a 10, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 required supervision to moderate assistance with most self-care ADLs. Resident #1 required supervision assistance and use of a walker for mobility. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1's active diagnoses included: Alzheimer's Disease (brain disorder that causes loss of memory and thinking), quadriplegia (partial or total loss of use in all four limbs), osteoporosis (weak bones), and heart disease. Record review of Resident #1's Care Plan, revised 07/11/26, reflected Resident #1 was at risk for falls r/t gait and balance problems. Interventions included: keeping environment free from clutter, ensuring call light was within reach and encouraging resident to use it, educating resident and family about safety reminders, educating resident on walker safety, educating resident to wait for staff's assistance, encouraging resident to participate in activities that promote exercise, keeping fall identifiers in place, following the facility's fall protocol, and monitoring, documenting, and reporting changes in condition to the MD. This document also reflected that Resident #1 had impaired physical mobility. Interventions included: a consult with physical therapy, determining level of assistance needed based on ADLs, encouraging resident to increase activity as indicated, encouraging rest between care activities, encouraging use of prescribes assistive devices, evaluating ADLs and resident's ability to perform them, implementing measures to prevent further injury to spinal cord, monitoring for environmental barriers to mobility, observing resident's gait and posture, observing ROM in all joints, and performing a detailed neurological evaluation. Record review of Resident #1's hospital discharge records, dated 07/11/26, reflected in part the following: Patient Visit Information[Resident #1] was seen today for: Nasal fracture Back spasm Head injury Staff Physician: [Hospital physician]. Follow-up Please contact the following to make an appointment for follow-up care: [ENT] Follow-up plan: 7 days. Radiology Results CT Head: No evidence of acute intracranial hemorrhage (brain bleed), midline shift (shift of brain), or hydrocephalus (fluid on brain). Age-related (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cerebral volume loss (shrinking of brain) and mild chronic small vessel changes. CT Cervical Spine (neck region of spine):No evidence of acute fracture or traumatic subluxation (partial dislocation of a joint) to the visualized cervical spine.Degenerative changes of the cervical spine (reduced cushioning and disc space that can lead to inflammation and pain) as described with moderate to severe spinal canal stenosis at C4-C5. CT Maxillofacial (jaw and face) bone:Acute mildly displaced fracture of the bilateral (both sides) nasal bones and nasal septum. CT thoracic spine (middle region of spine):No evidence of acute fracture or traumatic malalignment (not aligned or positioned correctly) to the visualized thoracic spine. CT lumbosacral spine (lower part of back/spine):No evidence of acute fracture or traumatic malalignment (not aligned or positioned correctly) to the visualized lumbosacral spine. Record review of Resident #1's progress notes, dated 07/11/26 at 8:37 p.m. by LVN A, reflected the following: Standing by the medication cart [LVN A] hard [sic] a loud noise, as [LVN A] looked to check where the noise was coming from [LVN A] observed [Resident #1] lying on the floor by the side of her bed face down, noted she was bleeding from the nose, 911 called, [MD] and [Resident #1's RP] notified, [Resident #1] was send [sic] to [local hospital]. Record review of Resident #1's progress notes, dated 07/11/26 at 9:41 p.m. by LVN A, reflected the following: [Resident #1] back from ER with DX: of acute mildly displaced fracture of the bilateral nasal bones and nasal septum. Noted new order of Robaxin (muscle relaxer) bid will continue to monitor. Record review of Resident #1's progress notes, dated 07/22/26 at 1:41 p.m. (staff unknown), reflected an appointment was made for the resident to follow up with an ENT on 07/27/26 at 2:40 p.m. Further review of the progress notes reflected that there was no documentation for an appointment with the ENT made prior to 07/22/26. In an interview on 07/22/26 at 9:24 a.m. with the Administrator and DON, the DON stated Resident #1 had an unwitnessed fall in her room where she sustained a fractured nose. The DON stated Resident #1 was assessed by LVN A and transported to the local hospital, then returned to the facility on the same day. The DON stated Resident #1 had an order for pain medication and muscle relaxers and was being re-evaluated by therapy. The DON stated Resident #1 had a lot of yarn and craft supplies in her room, but staff helped keep it organized and out of the walkway, and the resident denied tripping over anything but could not state how she fell. The DON stated Resident #1 did not require much assistance and was able to walk using a walker. The DON stated Resident #1 did not always use the walker when walking short distances in the room, but she was encouraged to always use it. The Administrator stated following the incident staff were educated on the facility's policy and procedures regarding abuse and neglect and fall prevention. In an observation and interview on 07/22/26 at 10:21 a.m., Resident #1 was observed resting in her room with the bed in the lowest position as a fall precaution. Further observation of the room revealed the resident had a lot of personal belongings, including decor and art supplies that were not in the walkway. Resident #1 stated she was in slight pain but was receiving her medication. Resident #1 stated during the incident, she stood up from the bed to walk to the bathroom and just remembered falling to the floor. She stated she could not recall if she used her walker. Resident #1 stated she did not trip over anything and could have just been weak that day. Resident #1 stated she hit her face, so the facility sent her out to the hospital. Resident #1 stated she did not know if she followed up with a doctor. In an interview on 07/22/26 at 10:53 a.m., Resident #1's RP stated the facility notified her that the resident had a fall and sustained an injury. She stated the facility always notified her of all incidents, changes in the resident's condition, and doctor appointments. Resident 1's RP stated she was unaware that Resident #1 needed to follow up with an ENT because the facility had not informed her. Also, she stated Resident #1 would have told her if she went on an appointment outside of the facility. Resident #1's RP stated she did not have any concerns that the resident was being abused or neglected, but (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was now concerned that Resident #1 had not followed up with an ENT if it was needed. In an interview on 07/22/26 at 1:27 p.m., the Unit Clerk stated that after a resident returned to the facility from the hospital, the nurses reviewed the discharge records and if there was an order for a follow-up appointment it was his responsibility to schedule and document the appointment. The Unit Clerk stated he was aware that Resident #1 needed to follow-up with an ENT regarding her fractured nose, and since the incident happened over the weekend, he scheduled the appointment on the next business day. The Unit Clerk stated he did not document the appointment in Resident #1's EHR and just wrote it on his calendar. The Unit Clerk stated appointments were supposed to be documented in the residents' clinical chart, but he must have gotten busy and forgot to do so. In an interview on 07/22/26 at 1:39 p.m., the ENT's office representative stated the facility contacted them on 07/22/26 at 1:15 p.m. and scheduled an appointment for 07/27/26. In an interview on 07/22/26 at 2:17 p.m., the DON stated when a resident returned to the facility from the hospital, the charge nurse received the discharge summary and checked for any new orders, including follow-up appointments. The DON stated if there was a referral for a follow-up appointment, the unit managers or clerks would schedule the appointments. The DON stated once the appointment was made, the expectation was for it to be documented in the resident's clinical chart for everyone to be aware. The DON stated it was important to ensure that residents followed up on appointments for continuation of care, and not doing so could place them at risk of worsening conditions. In an interview on 07/22/26 at 3:01 p.m., LVN A stated she worked with Resident #1 on the day of the incident. LVN A stated she was at the medication cart when she heard a loud noise. LVN A stated she rushed to Resident #1's room and found her on the floor face down with her nose bleeding. LVN A stated she yelled for help and assessed Resident #1 on the floor while 911 was called. LVN A stated Resident #1 was transported to the hospital, and she notified the MD, DON, and Resident #1's RP, then completed her documentation. LVN A stated Resident #1 had a history of falling but had never sustained a serious injury. LVN A stated Resident #1 was able to walk fine as long as she used her walker. LVN A stated that when a resident returned to the facility from the hospital, the nurses were responsible for assessing the resident, orienting them back to their room, and reviewing the discharge records for new orders or appointments. LVN A stated if there was a referral for a follow-up appointment, the nurses would inform the unit managers for the appointment to be scheduled. In an interview on 07/22/26 at 3:25 p.m., the MD stated he was notified that Resident #1 had an unwitnessed fall and sustained an injury. The MD stated the expectation was for the facility to follow up on all discharge orders and he was made aware that Resident #1 had an appointment with the ENT on 07/27/26. The MD stated with a mild fracture, there was probably not much an ENT could do for Resident #1. The MD stated the facility was still expected to schedule the follow-up appointment per hospital discharge orders, unless otherwise advised by him. The MD stated Resident #1 was a long-term care resident and was seen by him at least quarterly; however, the NP visited weekly and usually saw residents after an incident. The MD stated he would check his notes to see if the NP documented anything. Record review of the facility's policy titled, Provision of Physician Ordered Services, revised 12/0125, reflected in part the following: Policy: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. Definition: Professional Standards of Quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline [NAME] a specific clinical situation or setting. Policy Explanation and Compliance Guidelines: Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity. 4. Documentation of consultations, (continued on next page)		

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