STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676145	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Estates	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review the facility failed to ensure the resident had the right to a safe, clean, comfortable and homelike environment, including but not limited to Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 5 residents (Resident #14) reviewed for environmental conditions. The facility failed to ensure Resident #14's toilet seat was in good condition and was not broken. This failure could place residents at risk for injury and a decreased quality of life.Findings included: Observation and interview on 03/24/26 at 10:58 AM with Resident #14 stated his toilet seat had been broken for about a week. Observation of Resident #14's toilet seat in his bathroom revealed it was broken and the left side was not connected to the toilet. Resident #14 said he had told the aide and nurse about it being broken and was told someone would be by to fix it, but they never did. Resident #14 said he was scared to sit on the toilet because he did not want to fall and hurt himself. Resident #14 said he had not fallen off the toilet seat or injured himself in any way. Observation and interview on 03/26/26 at 11:47 AM, both LVN B and CNA C stated Resident #14 took himself to the bathroom and did not need assistance . LVN B and CNA C said Resident #14 never mentioned to them that his toilet seat was broken. LVN B and CNA C said they would have added the maintenance request to the maintenance log that was located at the nurse's station had they known about Resident #14's toilet seat being broken. LVN B and CNA C went to Resident #14's bathroom and confirmed the toilet seat was broken. Observation of Resident #14's toilet seat in his bathroom revealed the toilet seat was broken. Review of the Maintenance Log for the month of March 2026 did not reflect a request for Resident #14's toilet seat to be fixed due to it being broken. Interview on 03/26/26 at 1:33 PM, the Maintenance Director said he had not heard Resident #14's toilet seat was broken. The Maintenance Director said when staff were aware of something that needed to be repaired, they were supposed to put it in the maintenance book that was at the nurse's station. The Maintenance Director said he and his assistant checked the book every day and one of them normally handled small requests like that quickly. The Maintenance Director said he would normally be responsible for taking care of maintenance requests immediately. The Maintenance Director said if a resident's toilet seat was broken, that would put them at risk for falling off of it. Interview on 03/26/26 at 1:55 PM, the Maintenance Assistant said he was told about Resident #14's toilet seat being broken earlier in the day after the nurse told him about it. The Maintenance Assistant said he did not see the entry for it in the maintenance book at the nurse's station which he checked daily. The Maintenance Assistant said today was the first time he heard about Resident #14's toilet seat being broken. Interview on 03/26/26 at 3:33 PM, the Administrator said when something needed to be repaired in a resident's room, staff should put it in the maintenance book at the nurse's station. The Administrator said he expected staff to put things that needed repairing in the maintenance book as soon as they were aware of it. The Administrator said if something is broken in a resident's room it could potentially cause an injury. The Administrator said the maintenance department staff should go into resident rooms to check and make sure things are in good repair. The Administrator said he expected all things in resident's rooms to be in good repair. Review of the facility's Safe and Homelike Environment policy, dated 10/01/25, reflected the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: .3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 31 residents (Resident #24) reviewed for care plans. The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #39's colostomy (an opening in the abdominal wall that allows waste to pass into a removeable pouch). This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included:Review of Resident #24's quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included paraplegia (impairment or loss of motor sensory function in the lower half of the body), multiple sclerosis (chronic autoimmune disease where the immune system attacks the central nervous system causing nerve damage), and encounter for attention to colostomy. Resident #24 had a BIMS of 15 which indicated her cognition was intact and the MDS further reflected the resident had a colostomy. Review of Resident #24's care plan initiated on 10/30/24 did not reflect the resident had a colostomy. Review of Resident #24's Order Summary Report for March 2026 reflected the following: Colostomy - Check Placement and Empty Contents every shift to ensure it is secured. Empty Contents qshift and more often as necessary.Observation and interview on 03/26/26 at 12:03 PM, Resident #24 was observed sitting in her wheelchair alert and pleasant. Observation of the colostomy site revealed it was clean, no redness and free of infection. During an interview RN G stated they had never had any issues or concerns regarding the resident's colostomy site. Interview on 03/31/26 at 3:40 PM, the MDS Nurse stated care plans were initiated by the ADONs or the nursing staff and she was not aware that Resident #24's colostomy status was not in her care plan. The MDS Nurse said her colostomy status was on the previous computer system, and they switched to a new system in November 2025, and it appeared that her colostomy status has not transferred over. The MDS Nurse stated it was the responsibility of the nursing management, herself included, to ensure care plans were not missed. Interview on 03/26/26 at 4:18 PM, the ADON stated the MDS Nurse and nursing staff were responsible for implementing care plans. The ADON stated she did not know why Resident #24's colostomy status was not in the current system and thought that when the facility changed computer systems in November 2025, the colostomy status might have been dropped. The ADON said the MDS Nurses and other nursing staff were responsible for overseeing resident care plans to ensure they were accurate. The ADON stated it was important to make sure care plans were accurate, so the staff knew how to take care of the residents and were updated on any changes. Interview on 03/26/26 at 4:37 PM, the DON stated care plans were implemented by the nursing staff which included the MDS Nurse and the MDS Nurse was responsible for overseeing they were accurate. The DON said he was not aware Resident #24's colostomy status was not on the current plan, and it appeared it might have dropped off when they switched to the new computer system in November 2025. The DON said it was important to ensure resident care plans were accurate, so the staff knew how to take care of the residents. Review of the facility's policy titled Comprehensive Care Plans dated 10/01/25 reflected the following: PolicyIt is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 8 residents (Resident #137) reviewed for intravenous medication. The facility failed to ensure Resident #137's intravenous medication bag and tubing were labeled with the date, time, and initials.These failures could place residents at risk for medication error, delay in medication administration, infections and cross-contamination. Findings include:Findings include:Record review of Resident #137's annual MDS Assessment, dated [DATE], reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #137's diagnoses included chronic respiratory failure with hypoxia (lungs cannot adequately transfer oxygen into the blood), hyperlipidemia (high cholesterol), Non-Alzheimer's Dementia (brain disorders causing cognitive decline), and anxiety disorder. Resident #137's BIMS score was 13, which indicated her cognition was intact. Record review of Resident #137's care plan, dated [DATE], reflected: Focus: The resident is on antibiotic therapy (Ceftriaxone 1gm qd x 7 days) r/t infection UTI/Elevated WBC End date -[DATE]. Goal: The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions: Administer ANTIBIOTIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT.Record review of Resident #137's [DATE] physician orders reflected the following: Ceftriaxone Sodium Solution Reconstituted 1GM. Use 1 gram intravenously one time a day related to Urinary Track Infection for 7 Days. Order date [DATE]. Observation and interview on [DATE] at 2:38 PM, revealed Resident #137 in her room, sitting in her wheelchair watching television. She was observed to have a PICC line on her left arm; it had a dressing with a date of [DATE]. No signs of redness or drainage were observed. Resident #137 stated she received her antibiotics at nighttime. The intravenous medication bag was observed hanging on the pole and the IV tubing was not labeled with the date, time, and initials.Interview on [DATE] at 3:20 PM, LVN A stated she was the 2PM-10PM nurse assigned to Resident #137. She stated Resident #137 was on antibiotics, and she received the antibiotics during the second shift. LVN A stated she was the nurse who provided the antibiotics on [DATE]. LVN A entered Resident #137's room and observed the intravenous medication bag hanging on the pole and stated the medication bag was missing the time, date and initial. She stated she got busy and forgot to label the medication with the date and time when she hung it up. She stated it was important to date, time and initial the medication bag and tubing so that next staff knows whether the tubing was good to be used. She stated the tubing should be disposed after 24 hours. She stated the potential risk of not dating and labeling the medication bag and tubing would be infection. Interview on [DATE] at 2:37 PM, ADON stated she expected staff to date and initial the medication bag and tubing when administering the medications. She stated staff should make sure they followed the 6 rights, right resident, right medication, right dosage, right route, right time, and right documentation. She stated the potential risk of not dating and labeling the medication bag and tubing would be not knowing when it was administered. Interview on [DATE] at 4:38 PM, the DON stated the expectation when administering IV medication, staff should check to make sure it was the correct medication, right patient, right time and ensure the medication was not expired. He stated staff should label the medication bag and tubing with the time and date. The DON stated it should be labeled with the time and date so that the staff were aware of how long the medication had been infusing and know the duration of when the medication was hanged. He stated the potential risk would be staff not knowing when it was administered. The DON stated he had done training with staff on labeling and putting initials on bags and tubing and had done skill checks with the nurse. Record review of the facility's Intravenous Therapy policy, revised [DATE], reflected the following: The facility will adhere to accepted standards of practice regarding infusion practices.5. All IV tubing is to be labeled with date, time and initials.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable) to meet the needs of each resident for 2 of 5 medication carts (Halls 100 medication Aide medication cart and Hall 900 nurses' medication cart) reviewed for medication storage .1. The facility failed to ensure expired medications were removed from the Hall 100 medication aide cart and Hall 900 nurses' medication cart. This failure could place residents at risk of not receiving the therapeutic benefit of medication or an adverse drug reaction.Observation on 03/25/2026 at 1:19 PM, Hall 100 medication aide cart revealed one bottle of Calcium 500mg/Vitamin D 400unit (used as dietary supplement designed to support bone health and improve calcium absorption with an expiry date of December 2025.Interview on 03/25/2026 1:30 PM, LVN E stated Medication Aide F was responsible for checking the cart for expired medications. She stated failing to remove the expired medication could result in the medications being administered which could cause reactions, or the residents would not get the required therapy.Interview on 03/25/2026 1:40 PM, MA F revealed she was responsible for checking the cart for expired medications. She stated she had not checked her cart on 03/25/26, she only checked every couple of days, and she was not specific on which days. She stated failing to remove the expired medication could result in the medications being administered which could make residents sick. She stated she could not recall training, but she had been instructed verbally to be checking the carts for expired medications. Observation on 03/25/2026 at 1:57 PM, of the Hall 900 nurses' medication cart with RN G revealed, one bubble pack of Clonidine 0.1milligrams (used to treat high blood pressure) with an expiry date of 02/24/26 and one bottle of Tums (used to provide rapid relief for heartburn, acid indigestion, sour stomach, and upset stomach) with no expiry date. Interview on 03/25/2026 1:57 PM, RN G stated she was responsible for checking the cart for expired medications. She stated she had checked her cart for expired medications that morning , and she had missed the expired medication. RN G stated she checked her cart daily for expired medication and expiry dates. RN G said failing to remove the expired medication and having medications with no expiry dates could result in the medications being administered which could cause the residents not to get the required therapy. She stated the risk of having expired medication if administered it will not be effective. She stated she had done training on cart audit, but she could not recall when.Interview on 03/26/2026 at 2:46 PM, the ADON revealed her expectation was for nurses to check their cart for expired medications every week. She stated the ADON's were responsible for checking behind the nurses weekly. She stated she last audited the carts on 03/23/25 and she also missed the expired medications. She stated the risk of having expired medications on the cart was being administered, and they would not be effective.Interview on 03/26/2026 at 4:37 PM, the DON stated his expectation was all nurses were responsible for checking the carts weekly, to ensure expired medications were removed from the carts. He stated it was the responsibility of ADON to go behind the nurses weekly and ensure expired medications were being removed from the carts. He stated if expired medications get administered could place residents at risk of having side effects.Review of facility training records on 03/26/25 revealed facility training on carts audit and RN G was in attendance. Record review of facility's Medication Administration policy dated 02/01/25 reflected: . 13. Identify expiration date. If expired, notify nurse manager.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the storage of all drugs and biologicals were in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for 1 of 1 resident (Resident #19) reviewed for storage of medications.The facility failed to ensure Resident #19's Oxycodone-Acetaminophen tablet was not left on his over-bed table in his room by staff.This failure could affect residents by placing residents at risk of consuming unsafe medications left at bedside unattended.Findings included:Findings included:Record review of Resident #19's face-sheet revealed a [AGE] year-old male initially admitted to facility on 10/09/2023 and readmitted on [DATE]. His diagnosis included: Unspecified Dementia, Mild Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (excessive and persistent fears or worries that interfere with daily life); Chronic Ischemic Heart Disease, Unspecified (long-term condition caused by reduced blood flow to the heart muscle, primarily due to narrowed or blocked coronary arteries); Schizoaffective Disorder, Recurrent, Unspecified (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms such as depression). Record review of Resident #19's quarterly MDS dated [DATE] revealed BIMS score to be 15 with memory intact. Resident #19 able to make decisions r/t her care. Resident #19 requires set-up, supervision, and independent with ADL care. Record review of Resident #19's care plan revealed that there was no documentation r/t self-administration of medication.Record review of Resident #19's physician orders revealed no orders for self-administration of medication. Record review of Resident #19's Medication Administration Record dated 03/26/2026 noted the following medication was initialed by LVN D.Orders as noted:Oxycodone-Acetaminophen Tablet 10-325 mgGive 1 tablet by mouth 3 times a day for chronic pain Observation on 03/36/3026 at 03:20 p.m. revealed LVN D set a medicine cup with a pill in the cup on the over-bed table in front of Resident #19 and walked out of the room. LVN D did not stay and ensured Resident 19 took his pill. In an interview on 03/26/2026 at 3:25 p.m., Resident #19 revealed that he was aware the pill was his pain medication. Resident stated the nurses have left his medication at bedside before because they know he will take it. Resident #16 states that this occurs on different shifts, but not often. Resident #16 revealed he receives his medications on time, and the nurses inform him what he is being given. In an interview on 03/26/2026 at 3:40 p.m., LVN D stated she is aware of the policy for providing medication to residents at the bedside. LVN D stated the policy was to observe residents take their medications before leaving the room. LVN D stated she could not explain why she left Resident #19's medication on his over-bed table and walked out of the room. She stated Resident #16 told her he would take his medication. LVN D stated that Resident #16 was provided a pain pill. LVN D stated the risk of not observing Resident #16 taking his medication could be he may not take the medication or another resident may take the medication by mistake if resident left medication unattended. LVN D stated that it was not her normal practice to leave medication at the bedside. In an interview on 03/26/2026 at 4:00 p.m., the DON stated the policy and procedures of the facility was no medications are to be left at the resident's bedside. The DON stated the risk of nurses not observing the resident taking medications could be the resident may not take the medication or another with dementia could wander into the room and take the medication not knowing the medication does not belong to them causing harm to that resident.In an interview on 03/26/2026 at 5:10 p.m., the ADM stated his expectations r/t resident's medications are staff are to follow the medication administration policy. The ADM stated that there was not a risk for Resident #16 to self-administer his own medication. The ADM stated the possible risk may be another resident could take the medication if left unattended by Resident #16. Review of the facility's Medication (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration policy, revised 12/01/25 reflected the following: .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with standards of practice, in manner to prevent contamination or infection.