

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2025
NAME OF PROVIDER OR SUPPLIER Remarkable Healthcare of Seguin		STREET ADDRESS, CITY, STATE, ZIP CODE 1339 Eastwood Dr Seguin, TX 78155	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident's responsible party, consistent with his or her authority, when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 6 residents (Resident #1) reviewed for notification of changes. The facility failed to notify Resident #1's responsible party when Resident #1 had a medication error, change in condition, and was transferred to the hospital on [DATE]. This failure could place residents at risk of a decreased quality of life or hospitalization resulting in a decline in psychosocial or physical health. The findings included: Record review of an undated admission record revealed Resident #1 was an [AGE] year old female, admitted [DATE], with diagnoses that included Parkinson's disease (a disorder of the nervous system that affects movement, often including tremors), fracture of the lower end of right femur (hip fracture), type 2 diabetes (a condition in which the body cannot use insulin correctly and sugar builds up in the blood) and dementia (a general term for impaired ability to remember, think, or make decisions). The admission record revealed Resident #1 had an emergency contact #1 and emergency contact #2 listed with telephone numbers and addresses. Record review of a facility document titled Brief Interview for Mental Status (BIMS) Evaluation, dated 10/17/2025, revealed a BIMS score of 03, indicating severe cognitive impairment. Record review of Resident #1's undated comprehensive care plan, revealed a care plan that stated Resident #1 had a diagnosis of Parkinson Disease with an intervention, give medications as ordered by the physician, dated 10/23/2025. Record review of an undated facility document titled, SNF/NF to Hospital Transfer Form revealed Resident #1 was transferred to the hospital for a med error at 10/21/2025 at 5:00 p.m. and the document was completed by the ADON. Record review of Resident #1's progress notes dated 10/21/2025 at 5:31 p.m., by LVN C, revealed, Patient was returning to her room after dinner and this nurse (LVN C) and staff noticed patient had altered mental status and shortness of breath. Patient was unable to hold herself up in her wheelchair. This nurse took patient to her room, administered O2 @ 2L, via nasal canula, this nurse completed a head-to-toe assessment, and this nurse immediately called [ADON]. A progress note dated 10/21/2025 at 5:45 p.m. by the ADON revealed, LATE ENTRY. Resident sent out to [hospital] via stretcher escorted by EMS per [physician] for further evaluation and treatment d/t AMS and changes in vitals. Administrator and DON informed on [sic] incident. During an interview on 10/24/2025 at 1:20 p.m., Resident #1's RP, stated the RP arrived at the nursing facility to visit Resident #1 at 10:00 a.m. on 10/23/2025 and were notified by the ADON that Resident #1 was administered five tablets at one time of her Carbidopa-Levodopa instead of following the new order, given by the NP on 10/20/2025, to give one tablet at assigned times. The RP was told Resident #1 was sent to the hospital due to a change in condition. The RP stated no one called or notified the RP or emergency contact on 10/21/2025 when Resident #1 had a change in condition and was sent to the hospital. During an interview on 10/24/2025 at 1:50 p.m., LVN C stated she was the charge nurse for Resident #1 on 10/21/2025 and stated the ADON sent Resident #1 to the hospital and completed the physician notification. LVN C stated she did not call and notify the RP of Resident #1's medication error, change in condition, or transfer to the hospital because she assumed the ADON made the notification. LVN C stated, usually the nurse who sends them out, does the discharge notification and LVN C stated the shift was changing and they had another emergency going on at the same time. LVN C stated responsible parties should be notified of changes at the time of the incident. LVN C stated it was important to notify the responsible party, because something bad can happen and they need to know that their family member is not in the building and headed out to the hospital. LVN C stated she talked to the RP on the morning of 10/22/2025 and the responsible party told LVN C that the responsible party had not been notified of the medication error, change in condition, or transfer to the hospital. During an interview 10/24/2025 at 2:07 p.m., the ADON, stated he was notified by LVN C that Resident #1 had a change in condition on 10/21/2025 around 5:00 p.m. The ADON said he contacted the physician and received an order to send Resident #1 to the hospital. The ADON stated normally it was the charge nurse's responsibility to notify the responsible party at the time of a medication errors, change in condition, and transfers to the hospital. The ADON stated we had so much going on right then that there was a mishap and miscommunication and the RP was not contacted at the time of the medication error, change in condition, and transfer to the hospital. The ADON stated Resident #1's RP arrived at the facility on 10/22/2025 and was notified at that time of Resident #1's medication error, change in condition, and transfer to hospital. The ADON stated it was</p>		

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F 0755 Level of Harm - 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. (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 6 residents (Resident #1) reviewed for drug administration. Resident #1 was administered 5 tablets of Carbidopa-Levodopa 25-100mg on 10/21/2025 at noon. The physician order was Carbidopa-Levodopa 25-100mg give 1.5 tablets at 11 a.m. Resident #1 was transferred to the hospital on [DATE] for altered mental status. The noncompliance was identified as PNC. The facility corrected the noncompliance before the survey began. This failure could place residents at risk for not receiving a therapeutic effect or being over-medicated. The findings included: Record review of an undated admission record revealed Resident #1 was an [AGE] year old female, admitted [DATE], with diagnoses that included Parkinson's disease (a disorder of the nervous system that affects movement, often including tremors), fracture of the lower end of right femur (hip fracture), type 2 diabetes (a condition in which the body cannot use insulin correctly and sugar builds up in the blood) and dementia (a general term for impaired ability to remember, think, or make decisions). The admission record revealed Resident #1 had an emergency contact #1 and emergency contact #2 listed with telephone numbers and addresses. Record review of a facility document titled Brief Interview for Mental Status (BIMS) Evaluation, dated 10/17/2025, revealed a BIMS score of 03, indicating severe cognitive impairment. Record review of Resident #1's undated care plan, revealed a care plan that stated Resident #1 had a diagnosis of Parkinson Disease with an intervention to, give medications as ordered by the physician, dated 10/23/2025. Record review of Resident #1's hospital Discharge summary, dated [DATE], revealed an order, Continued carbidopa-levodopa 25-100mg tablet. 5 tab PO daily. Patient Comments: take five (5) tablet (s) by mouth daily. Record review of a hospital discharge document for Resident #1 titled, Home Medication List, dated 10/16/2025, revealed, Continue Medications. These are your current medications to keep taking at home. Further record review revealed, Carbidopa-levodopa 25-100mg tablet. Five tab oral daily. Record review of a facility document titled Drug Regimen Review, revealed Resident #1's name and revealed the regimen review was completed for Resident #1's admission to the facility and the physician or NP were notified of the review on 10/16/2025 at 6:18 p.m. Record review of Resident #1's October 2025 MAR revealed an order, Carbidopa-Levodopa oral tablet 25-100mg (Carbidopa-Levodopa) Give 5 tablets by mouth one time a day for Parkinson's. The start date was 10/17/2025 at 9:00 a.m. and discharge date was 10/20/2025 at 11:11 a.m. The MAR was initialed, indicating the Carbidopa-Levodopa was administered, on 10/17/2025, 10/18/2025, 10/19/2025 and 10/20/2025. An order revealed, Carbidopa Oral tablet 25mg (Carbidopa), Give 1 tablet by mouth two times a day for Parkinsons. One tab at [3 p.m.] & [7:00 p.m.]. The start date was 10/21/2025 at 7:00 p.m. and discharge date was 10/22/2025 at 12:16 p.m. The order was initialed, indicating it was administered, on 10/21/2025 at 4:00 p.m. An order revealed, Carbidopa-Levodopa oral tablet 25-100 mg (Carbidopa-Levodopa) give 1.5 tablet by mouth two times a day for Parkinson's. 1 1/2 tabs at 8:00 a.m. and 11:00 a.m. The start date was 10/21/2025 at 11 a.m. and discharge date was 10/22/2025 at 12:16 p.m. The order was initialed indicating it was administered on 10/21/2025 at 11:00 a.m. Record review of a facility document titled, SNF/NF to Hospital Transfer Form revealed Resident #1 was transferred to the hospital for a med error at 10/21/2025 at 5 p.m. and the document was completed by the ADON. Record review of Resident #1's progress notes, dated 10/21/2025 at 5:31 p.m., by LVN C, revealed, Patient was returning to her room after dinner and this nurse (LVN C) and staff noticed patient had altered mental status and shortness of breath. Patient was unable to hold herself up in her wheelchair. This nurse took patient to her room, administered O2 @ 2L, via nasal canula, this nurse completed a head-to-toe assessment, and this nurse immediately called [ADON]. A progress note dated 10/21/2025 at 5:45 p.m. by the ADON revealed, LATE ENTRY. Resident sent out to [hospital] via stretcher escorted by EMS per [physician] for further evaluation and treatment d/t AMS and changes in vitals. Administrator and DON informed on [sic] incident. Record review of a pharmacy medication packing list, dated 10/20/2025, revealed Resident #1's Carbidopa-Levodopa 25-100mg give 1 tablet at 3 p.m. and 7 p.m. arrived at the facility on 10/20/2025. Record review of a pharmacy blister pack, revealed Resident #1's Carbidopa-Levodopa 25-100mg give 5 tablets daily had 5 tablets in each blister pack and 4 blisters were opened and contained no tablets. Record review of a pharmacy blister pack for Resident #1's Carbidopa 25mg give 1.5 tablet at 8:00 a.m. and 11:00 a</p>		