STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Seguin	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Seguin	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care were developed and implemented within 48 hours of a resident's admission and included the minimum healthcare information necessary to properly care for residents, for 1 of 3 residents, (Resident #2), reviewed for comprehensive resident centered care plan. The facility failed to develop interventions for Resident #2's intravenous access when he was admitted on [DATE]. This failure could place residents at risk for harm by not having interventions in place to support their healthcare needs.The findings included: A record review of Resident #2's admission record dated 11/25/2025 revealed an admission date of 9/13/2025 and a discharge date of 10/11/2025 with diagnoses which included sepsis (a life-threatening medical emergency where the body has an overwhelming and damaging immune response to an infection). A record review of Resident #1's admission MDS assessment dated [DATE], revealed the MDS nurse assessed Resident #2 on 9/27/2025 as an [AGE] year-old male admitted for rehabilitation care for a urinary tract infection. Resident #2 was assessed with a BIMS score of 05 out of a possible 15 which indicated severe cognitive impairment. Section M skin conditions revealed, check all that apply . application of nonsurgical dressings . was unchecked and none of the above were provided . was checked. Resident #2 was receiving antibiotics. A review of section O, special treatments, procedures, and programs, revealed check all of the following treatments, procedures, and programs that were performed on admission . IV medications (intravenous, administering medication or fluids directly into a person's bloodstream through a needle) was unchecked. A record review of Resident #2's Baseline care plan dated 9/16/2025 revealed no interventions to support Resident #1's needs for developing and maintaining intravenous access. A record review of Resident #2's physicians orders dated 9/16/2025 revealed Resident #2 was prescribed to receive meropenem (a potent, broad-spectrum carbapenem antibiotic used to treat severe, often multi-drug resistant, bacterial infections in hospitalized patients) twice daily, intravenously (through a vein). A record review of Resident #2's nursing progress notes revealed LVN A documented on 9/13/2025 at 3:31 PM, Resident was brought to the facility via stretcher, by (name of ambulance service) transport. Resident is alert and oriented to self, . intravenous to left upper arm. During an interview on 11/25/2025 at 1:00 PM, the Administrator, the DON, and the ADON stated Resident #2 was admitted for rehabilitation supports for a urinary tract infection supported by intravenous antibiotics. The DON and the ADON stated a record review of Resident #2's medical records revealed LVN A failed to develop and implement a baseline care plan within 48 hours to support Resident #2's intravenous access which LVN A identified on the admission nursing progress note dated 9/13/2025. The DON and the ADON stated the MDS nurse did assess Resident #2 with having a intravenous access while a Resident, but did not document the intravenous access in Resident #2's care plan template. The Administrator, the DON, and the ADON stated, on 9/15/2025 during their IDT morning meeting, they reviewed all the previous admissions which included a review for care-plan development and implementation to which Resident #2's care plan was not accurately reviewed to reveal the lack of nursing focuses, goals and interventions for Resident #2's intravenous access for his antibiotic medications. The Administrator stated the lack of review could have potential negative outcomes for residents who had needs for support with their healthcare needs. A record review of the facility's Baseline Care Plan / Summary undated policy revealed, Purpose: Promote continuity of care and communication among staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission. Also, to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. Procedure: A baseline care plan for each resident will be developed within 48 hours of the resident's admission to this facility. The baseline care plan will be based on information available from the transferring provider as well as discussions with the Resident / representative. It will include interim approaches for meeting the residents' immediate needs and reflect changes to approaches, as necessary, that occurred before the development of the comprehensive care plan. The baseline care plan will include but not limited to this information needed to care for the Resident: initial goals based on admission orders, instruction needed to provide effective and person-centered care that meets professional standards of quality care; .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Seguin	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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Seguin	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews 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 3 residents (Resident #2) reviewed for providing care without a physician's orders. The facility failed to recognize Resident #2 had received medications and fluids through an intravenous access without orders for the intravenous access. This failure could place residents at risk for harm by receiving care without physician's orders. The findings included:[A record review of Resident #2's admission record dated 11/25/2025 revealed an admission date of 9/13/2025 and a discharge date of 10/11/2025 with diagnoses which included sepsis (a life-threatening medical emergency where the body has an overwhelming and damaging immune response to an infection). A record review of Resident #2's nursing progress notes revealed LVN A documented on 9/13/2025 at 3:31 PM, Resident was brought to the facility via stretcher, by (name of ambulance service) transport. Resident is alert and oriented to self, . intravenous to left upper arm. A record review of Resident #1's admission MDS assessment dated [DATE], revealed the MDS nurse assessed Resident #2 on 9/27/2025 as an [AGE] year-old male admitted for rehabilitation care for a urinary tract infection. Resident #2 was assessed with a BIMS score of 05 out of a possible 15 which indicated severe cognitive impairment. record review of section M skin conditions revealed, check all that apply . application of nonsurgical dressings . was unchecked and none of the above were provided . was checked. Further review revealed Resident #2 was receiving antibiotics. A review of section O, special treatments, procedures, and programs, revealed check all of the following treatments, procedures, and programs that were performed on admission . IV medications (intravenous, administering medication or fluids directly into a person's bloodstream through a needle) was unchecked. A record review of Resident #2's physicians orders dated 9/13/2025 revealed Resident #2 had no orders for an intravenous access. Further review of physician orders revealed on 9/16/2025 Resident #2 was prescribed to receive meropenem (a potent, broad-spectrum carbapenem antibiotic used to treat severe, often multi-drug resistant, bacterial infections in hospitalized patients) twice daily, intravenously (through a vein). A record review of Resident #2's care plan dated 11/24/2025 revealed no interventions to support Resident #1's needs for developing and maintaining intravenous access. A record review of Resident #2's nursing progress notes revealed LVN B documented on 9/21/2025 at 10:03 AM, Note Text: PIV [peripheral intravenous] to left upper arm dc'd [discontinued] d/t [due to] not flushing. New PIV started with 22g [gauge of needle] intracath to right wrist x 1 attempt. IV antibiotics infusing via new PIV. Will continue to monitor. During an interview on 11/25/2025 at 11:00 AM, LVN B stated he was the nurse for Resident #2 on 9/21/2025, and Resident #2 was prescribed to receive an intravenous antibiotic through the intravenous access on his left upper arm. LVN B stated he could not administer the antibiotic because the intravenous access was occluded (clogged). LVN B stated he removed the intravenous access and instilled a new intravenous access in Resident #2's right wrist and then proceeded to successfully administer Resident #2's antibiotic. LVN B stated he had not checked Resident #2's physicians orders for an intravenous access order, and stated, I assumed he had an order for the IV since he was receiving IV antibiotics . he should have had an order. LVN B stated he had not called the physician to give a report of the discontinued intravenous access and the establishment of a new intravenous access. LVN B stated he believed he did not need to report to the physician because the physician wanted Resident #2 to have an IV since the physician ordered an intravenous antibiotic. During an interview on 11/25/2025 at 1:00 PM, the Administrator, the DON, and the ADON stated Resident #2 was admitted for rehabilitation supports for a urinary tract infection supported by intravenous antibiotics. The DON and the ADON stated a record review of Resident #2's medical records revealed LVN A failed to develop and implement a baseline care plan within 48 hours to support Resident #2 intravenous access which LVN A identified on the admission nursing progress note dated 9/13/2025. The DON and the ADON stated the MDS nurse did assess Resident #2 with having a intravenous access while a Resident but did not document the intravenous access in Resident #2's care plan template. The Administrator, the DON, and the ADON stated, on 9/15/2025 during their IDT morning meeting they reviewed all the previous admissions which included a review for orders and intravenous access however, Resident #2's intravenous access was not reviewed and the order for the intravenous access was not reviewed. The DON stated on 9/16/2025 Resident #2 was prescribed by the physician to receive intravenous antibiotics, and he had not recognized Resident #2 had