STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676373	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor Bee Cave	14058 Bee Caves Parkway, Bldg B Bee Cave, TX 78738

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39269 Based on observation, interview, and record review the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services for 1 of 3 residents (Resident #1) reviewed for urinary catheters in that: The facility failed to ensure Resident #1's Foley catheter was secure to prevent trauma and CNA A failed to provide catheter care properly to Resident #1 to prevent infection. Findings included: Review of Resident #1's face sheet date 08/01/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Urinary Tract Infection (infection in any part of the urinary system), infection and inflammatory reaction due to indwelling urethral catheter, acute cystitis with hematuria (bladder infection with blood in the urine). Review of Resident #1's Nursing Home Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 which indicated no cognitive impairment. The MDS also reflected Resident #1 had an indwelling catheter. Review of Resident #1's care plan initiated 10/05/2023 and revised 07/26/2024 reflected Resident #1 was on antibiotic therapy for a UTI, had ADL's self-care performance deficit related to quadriplegia (paralysis of all four limbs) , bladder incontinence due related to quadriplegic, indwelling catheter due to neurogenic bladder (is a condition where a person loses control of their bladder due to problems in the brain, spinal cord, or nerve). with goal to be free from catheter related trauma through the review period target date of 08/06/2024. Review of Resident #1's physician's order reflected the following orders: Catheter care every shift, monitor urethral site for sign and symptoms of skin breakdown, pain, discomforts, unusual odor, urine characteristics or secretions, catheter pulling causing tension dated 07/11/2024. Secure catheter with leg strap/leg band or anchor to minimize catheter related injury and accidental removal or obstruction of urine outflow dated 07/11/2024. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bactrim DS Tablet 800-160 MG (Sulfamethoxazole- Trimethoprim) Give 1 tablet by mouth every 12 hours for bacterial infection dated 07/19/2024. Review of Resident #1's TAR reflected RN A signed off on the TAR indicating Resident #1's catheter was secured 07/29/2024 and 07/30/2024. During an interview on 08/01/2024 at 10:27 am Resident #1 stated he had concerns regarding his Foley catheter. Resident #1 stated the facility staff was supposed to have a strap to keep his Foley catheter in place to prevent it from pulling but it was never there. Resident #1 also stated he was concerned that he was always being diagnosed with a UTI , and his catheter care was not being done properly . During an observation on 08/01/2024 at 10:52 am, revealed RN A and CNA B were observed during a skin assessment and catheter care on Resident #1. It was observed Resident #1 did not have leg strap as ordered to secure his Foley catheter. CNA B was observed cleaning Resident #1's penis and wiping in the direction of the Foley catheter insertion site. CNA B was also observed wiping from back to front multiple times when performing peri care. While still performing catheter care, CNA B stated, The catheter is pulling out. And Resident #1 stated, It is always like that. RN A stated, I did not see a stat-lock (catheter securement device) the last time I worked. Resident #1's urethral was noted to have some split/tear. During an interview on 08/01/2024 at 11:08 am CNA B stated she had been trained on peri care and catheter care. CNA B stated she was supposed to wipe away from the Foley catheter insertion site and wipe from front to back but was not sure if Resident #1's skin still had BM, so she wanted to make sure it was clean. CNA B stated wiping away from the Foley catheter insertion site and wiping from front to back was to prevent infection. CNA B stated Resident #1's Foley catheter was pulling out when she was performing foley catheter care and he stated it hurt , and that Resident #1 had complained in the past but like RN A said, she looked and did not find the stat-lock to secure Resident #1's catheter. During an interview on 08/01/2024 at 11:34 am RN A stated she did not observe the catheter care when CNA B was performing it. RN A stated she observed some part of the peri care when CNA B was wiping Resident #1 and CNA B did a couple of back and forth wiping. RN A stated CNA B was supposed to wipe from front to back to prevent, away from the front to keep the dirty away from the clean. RN A stated she worked with Resident #1 on 07/30/2024 and he did not have a stat-lock to prevent his Foley catheter from pulling out and trauma; she looked for stat-lock on 07/30/2024 and did not find one. RNA B stated central supply was responsible to ensure stat-lock was in the facility and they were aware there were no stat-locks in the facility. During an interview on 08/01/2024 at 3:03 pm the DON said it was her expectation that catheter care was done every shift and with every peri care. The DON stated catheter care was cleaning from the meatus outward (away from the insertion site) and peri care from the tip of the penis downward, never go upwards to prevent introducing infection to the resident. The DON stated it was important to anchor the Foley catheter to prevent trauma to catheter insertion site, if a stat-lock is not in place, there would be trauma and hypothetically the catheter would be pulled out. The DON stated the facility had stat-locks in stock in the nurse's supply closet. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/01/2024 at about 3:15 pm, the Surveyor and the DON observed stat-locks in the 2 nurses' supply closets. Review of facility's policy titled Indwelling Urinary Catheter Care-Quality of Care revised 01/2022 reflected: Policy --It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) for soiling. Purpose --To promote hygiene, comfort, and decrease the risk of infection for a resident with an indwelling urinary catheter. Procedure --Using moistened disposable wipe, clean the catheter in a downward motion (front to back) beginning at the urinary meatus (insertion point) and at least 4 inches down (from resident toward the collection bag). Use a new disposable wipe for each one cleansing motion. --Dry the resident perinea! area with a clean cloth if soap and water was used in place of disposable wipes. --May secure the tubing with a securement device, as needed (PRN) to prevent migration, friction, or tension of the catheter. Review of facility's policy titled IPCP Standard and Transmission-Based Precaution: Infection Control revised 07/20222 reflected: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. In Long Term Care (LTC), it is appropriate to individualize decisions regarding resident placement (shared or private), balancing infection risks with the need for more than one occupant in the room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident. It is therefore appropriate to use the least restrictive approach possible that adequately protects the resident and others. Maintaining isolation longer than necessary may adversely affect psychosocial well-being. Where possible, the goal is to isolate the organism, not the resident.