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	04/29/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for one (Resident #1) of four residents reviewed for pharmaceutical services. The facility failed to ensure Resident #1 was administered her prescribed Keppra (anticonvulsant), Buprenorphine (for pain), and Buspirone (for depression and anxiety) until five hours after the scheduled administration time on 04/22/25 causing her to be in increased pain, anxiety, and continuous spasms in her legs. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements or could result in worsening or exacerbation of chronic medical conditions. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including cerebral palsy (a group of disorders that affect movement and muscle tone or posture), major depressive disorder, post-traumatic stress disorder, chronic pain, and generalized anxiety disorder. Review of Resident #1's quarterly MDS assessment, dated 03/06/25, reflected a BIMS score of 15, indicating she was cognitively intact. Review of Resident #1's quarterly care plan, dated 01/14/25, reflected she was taking anti-anxiety and anti-depressant medication with an intervention of giving anti-anxiety and anti-depressant medications as ordered by the physician. Review of Resident #1's physician order, dated 01/07/25, reflected Buprenorphine HCl - Give one film sublingually every 12 hours for pain. Review of Resident #1's MAR Audit, dated 04/22/25, reflected her Buprenorphine was scheduled for 8:00 AM but not was administered until 1:01 PM by the ADON. (continued on next page)

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

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's physician order, dated 02/18/25, reflected Buspirone HCl Oral Tablet - 10 MG - Give two tablets by mouth two times a day related to major depressive disorder and generalized anxiety disorder. Review of Resident #1's MAR Audit, dated 04/22/25, reflected her Buspirone was scheduled for 8:00 AM but not was administered until 12:55 PM by the ADON. Review of Resident #1's physician order, dated 04/17/25, reflected Keppra Oral Tablet - 250 MG - Give one tablet by mouth one time a day for anticonvulsants. Review of Resident #1's MAR Audit, dated 04/22/25, reflected her Keppra was scheduled for 8:00 AM but not was administered until 12:55 PM by the ADON. During an interview on 04/29/25 at 9:29 AM, Resident #1 stated medications were administered late very often. She stated she had not received her morning medications yet. She stated it was frustrating because not getting her medications on time, especially her Cerebral Palsy medications, truly affected her. She stated one day a week prior, morning medications were not administered until 1:00 PM. She stated she could not function or get out of bed. She stated she was in so much pain, was extremely anxious, and her legs would not stop jerking uncontrollably which was very uncomfortable. She stated she felt like she was going to have a panic attack just waiting for her medications. During a telephone interview on 04/29/25 at 1:04 PM, NP A stated some medications were not as time sensitive as others. She stated usually missing a dose by an hour or two would not be that big of a deal. She stated regarding Resident #1 and her diagnoses and the medications she was on, not getting her medications until five hours after they were scheduled could definitely cause her a lot of pain, anxiety, and for her legs to have increased jerking/spasming. She stated anxiety was one of her main issues and she hoped being administered medications that late was a rare occasion. During a telephone interview on 04/29/25 at 1:38 PM, NP B stated usually scheduled medications were to be administered within an hour before or an hour after the scheduled time. If a resident did not receive their medication until after a five-hour timeframe from the scheduled time she would expect for them to be in increased pain, primarily. During an interview on 04/29/25 at 2:15 PM, the ADON stated he did not normally pass medications. He stated he was new to the facility and did pass medications on 04/22/25. He stated he probably was late with administering the medications because he was training with the DON. He stated he was not running on time due to him explaining all the medications to the residents. He stated medications should be administered punctually. He stated normally the orders have a window (timeframe), but Resident #1's medications did not. He stated it was more important that she received the medications than not get the medications. He stated not getting the medications all together would be a more serious situation. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/29/25 at 2:47 PM, the DON stated her expectations on medication administration was that they were administered effectively per the residents' MAR. She stated she wanted to make all the medication times liberalized so that the timeframe would be, for example, between 7:00 AM and 12:00 PM for morning medications. She stated on 04/22/25 it was the ADON's first day being trained all the medication cart. She stated he was trying to explain all of the medications to the residents, and she realized they ran late with the administration . She stated a negative outcome of receiving medications late could be increased pain or anxiety. She stated, however, Resident #1 was always experiencing pain and anxiety. Review of the facility's Medication Administration Policy, revised 11/13/18, reflected the following: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. . Medications are administered within (60 minutes) of scheduled time . Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.