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	05/28/2025

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

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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 0695 Level of Harm - Actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practice for one (Resident #1) of three residents reviewed for respiratory care. The facility failed to ensure nurses were documenting the oxygen flow rate or response to oxygen therapy for Resident #1. The facility failed to have an ongoing system of monitoring Resident #1 as her oxygen saturations dropped below 92% on several occasions, she could no longer participate in therapy, her CO2 lab value was 40 (normal range was 23-31), and she continued to be short of breath days prior to hospitalization on 04/12/25 where she was diagnosed with acute and chronic hypoxic (low levels of oxygen in your body tissues) and hypercapnic (an excess of carbon dioxide in the blood stream) respiratory failure and CHF exacerbation. This deficient practice could place residents at risk for inadequate care, respiratory distress, and hospitalization. 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 acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe), unspecified heart disease, and dependence on supplemental oxygen. Review of Resident #1's admission MDS assessment, dated 03/31/25, reflected a BIMS of 15, indicating she was cognitively intact. Section O (Special Treatments, Procedures, and Programs) reflected she required oxygen therapy. Review of Resident #1's admission care plan, dated 03/24/25, reflected she had asthma and COPD with an intervention of monitoring for s/sx of acute respiratory insufficiency: anxiety, confusion, restlessness, SOB at rest. Review of Resident #1's preadmission clinicals, dated 03/17/25, reflected she was on continuous use of oxygen at 2 liters for chronic respiratory failure. (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 0695 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #1's physician order, dated 03/25/25, reflected O2 at 2-4 L/Min prn to keep sats >= 90% and avoid 4 liters if possible as she retained CO2. Review of Resident #1's lab results, dated 04/09/25, reflected a critically high CO2 level of 40 (Reference Range: 23-31 mEq/L). Review of Resident #1's NP note, dated 04/09/25, reflected the following: Chief Complaint: abnormal lab, increased SOB, pain . [Resident #1] reports increased dyspnea (shortness of breath), which she notes began around the same time she started using an inhaler . She is currently on 3 L of oxygen and uses a BiPAP machine due to hypercapnia. She mentions that her oxygen levels dropped during the night, and she has been experiencing difficulty taking deep breaths, describing it as laborious. . Physical Exam: General: Dyspneic, in bed, color wnl Resp: Oxygen saturation 91-95% on 3 liters of oxygen, diminished breath sounds throughout, decreased to 87% on 2 liters; no wheezing auscultated; labored breathing noted. Review of Resident #1's IDT Care Plan Review, dated 04/10/25, reflected the following: Additional Comments: [Resident #1] and FM A were concerned about the level of O2 she has been on and said that they would like her to go back to using 2 liters of O2 rather than 4. . Therapy Services Plan of Care: [OT B] participated care plan for [Resident #1] with IDT and [FM A] in order to communicate regarding recent change in condition (extreme fatigue and headache) and decreasing oxygen saturation (79%), resulting in limited participation in therapy this week, functional levels and treatment outcomes prior to this week with strength, balance, and hygiene focus, and frequency in OT and PT. Review of Resident #1's NP note, dated 04/11/25, reflected the following: Chief Complaint: abnormal urine, hypoxia . (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Some	Nursing reported that [Resident #1]'s oxygen saturation was 84% this morning but is currently 92%. She is using BiPAP but is unhappy with the current mask size and request a medium-sized mask. DON was notified of [Resident #1] asking for a different mask and this was obtained almost immediately . She is still feeling more SOB than her baseline and CXR was ordered and completed and showed no acute cardiopulmonary disease. Physical Exam: Resp: Labored, expiratory wheezing throughout. Additional Notes: Chronic obstructive pulmonary disease with acute lower respiratory infection Worse/Exac: - Oxygen sat 91-92% on 3 liters during visit. - Increased prednisone dosage: starting at 40 mg daily for 3 days, then titrating down by 10 mg every 3 days. - Initiated Brovana and budesonide via Nebulizer twice a day. - Continues on DuoNeb 4 times a day and albuterol every 4 hours as needed. - Continue on roflumilast. - Discontinued AirSupra as nebulizers provide more effective medication delivery. - Patient advised to avoid exertion and use BiPAP as needed to alleviate shortness of breath. - Can wear bipap all the time for now to assist with CO2 retention. - Follow-up scheduled for Monday to assess patient's condition and response to treatment. - Instructed to ask to go the hospital if she feels like she's not getting better or is getting worse. . New lower extremity edema - may need diuretics with elevated CO2 and treating UTI will f/u Monday. Heart Failure - Now with edema which is new today. [Resident #1] has a history of mild congestive heart failure. Review of Resident #1's x-ray results, dated 04/11/25, reflected the following: (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Some	There is no abnormal radiopaque foreign body. The cardiac silhouette is enlarged. There is no pneumothorax visible. There is no radiographic evidence of pulmonary edema. There is no radiographic evidence of pneumonia. IMPRESSION: There is no radiographic evidence of acute disease. Review of Resident #1's Infection Surveillance assessment, dated 04/11/25, reflected she had a new or increased cough, and her oxygen saturation was less than 94% on room air or a reduction in oxygen saturation of >3% from baseline with an onset of 04/10/25. She was started on Cipro (antibiotic) on 04/11/25. Review of Resident #1's progress note, dated 04/12/25 at 5:37 AM and documented by LVN C, reflected the following: CNA notified this nurse that [Resident #1] was experiencing difficulty breathing. Upon immediate assessment, [Resident #1] was noted to be in respiratory distress with O2 saturation at 54% on pulse oximeter. [Resident #1] observed with labored breathing and cyanosis (blue/purple in color) to lips. 911 was called immediately. EMS arrived promptly and initiated oxygen therapy; [Resident #1]'s O2 saturation improved to 97% following their interventions . Review of Resident #1's progress notes, from 03/24/25 - 04/12/25, reflected the nurses were not documenting the flow rate she was receiving or her response to the oxygen therapy. Review of Resident #1's hospital paperwork, dated 04/12/25, reflected the following: [Resident #1] had noticed worsening shortness of breath for the last 2-3 days . [Resident #1] was requiring increasing oxygen requirements, had to increase her O2 to 4L, received IV furosemide. . Carbon Dioxide - 39 . Final Result: Findings of CHF/volume overload. . [Resident #1] admitted to the ICU with acute and chronic hypoxic and hypercapnic resp failure and CHF exacerbation. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Some	During a telephone interview on 05/27/25 at 4:29 PM, FM A stated on multiple occasions, Resident #1 would tell the NP, I do not feel good, I feel like I need to go to the hospital. She stated the NP would respond, I cannot stop you from going to the hospital, but I think you should wait. She stated she was notified on occasions where her oxygen saturations would drop in the 80's (percent). She stated because she had COPD, they were used to them dropping low, but when they did, she was always sent to the hospital in the past. She stated she knew it was common for someone with COPD to develop CHF and that was what she was worried about because the last time Resident #1 was hospitalized , the doctor had told her she had the beginning stages of CHF. She stated instead of trying to treat what was wrong, they (facility staff) just kept increasing the liters of oxygen she was receiving. She stated at the facility, the NP would tell her everyone with COPD had CHF, and she believed that was not a reason to not treat her. She stated she received a call on 04/12/25 at 5:30 AM informing her Resident #1 was being sent to the hospital. She stated she was diagnosed with full-blown CHF with fluid on her heart and lungs. She stated the doctor at the hospital told her if Resident #1's oxygen had dropped below 88 (percent) at any time, she should have been sent to the hospital. She stated the facility did not take Resident #1 seriously, she was suffocating and drowning with the fluid build-up. She stated Resident #1 was currently at a rehab facility and would not be returning to (facility). During a telephone interview on 05/28/25 at 12:07 PM, the MD stated ideally, it would be important to document how many liters of oxygen a resident was on because it would be hard to treat a resident without knowing. She stated if a resident had a critical lab value for their CO2 levels, it would depend on what condition they were in as to what she would have done next. She stated if the resident had diagnoses of COPD or hypoxia, she would have evaluated their mental status at that time and if they were continuing to complain of shortness of breath. She stated if a resident was in hypercapnic failure, their mental status would normally be altered, and oxygen saturations would be low. She stated Resident #1 had requested a new mask which they (staff) obtained for her. She stated despite placing the new mask, she could have continued to deteriorate due to underlying issues such as pneumonia. She stated her severe obesity could play a part for how she was compensating for her hypercapnia failure, but they (staff) did the right thing by changing the mask. She stated with Resident #1 continuing to have her oxygen desaturating and with the critical level of her CO2, it would have been prudent to have sent her to the ER for further assessments/care. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Some	During an interview on 05/28/25 at 12:25 PM, Resident #1's NP stated it would sure help and make it nice for nurses to document how liters of oxygen a resident was receiving so they could tracker her oxygen saturations and on how many liters. She stated symptoms of a high CO2 level would be increased confusing, increased shortness of breath, low oxygen saturation, and lethargy. She stated some people tend to run high (CO2 levels) and it more so depended on how they were presenting. She stated in some people, an increase in CO2 could lead to death. She stated if a resident was taking off their bipap or cpap or not wearing it regularly, it could make their CO2 levels increase. She stated she was never notified of Resident #1 taking off her bipap. She stated for someone with COPD, you wanted to keep it on the lowest level of oxygen possible with still maintaining 92 percent saturations, as you did not want an unnecessary amount of oxygen. She stated Resident #1 was normally on 2-3 liters of oxygen. She stated on 04/11/25, a nurse told her she had been at 84% that morning, so she started her on prednisone (worked as an asthma treatment). She stated that same day (04/11/25), Resident #1 was more wheezy, short of breath, and more anxious. She stated if someone was short of breath, that would be the reason they were more anxious. She stated any kind of decline in someone's health could make heart failure worse, including increased levels of CO2. She stated she had not ordered for Resident #1 to be sent to the hospital sooner because sometimes going to the hospital could be worse for the residents. She stated she never told Resident #1 she could not go to the hospital. She stated her blood work had been okay, chest x-rays were fine, she started her (on 04/11/25) an antibiotic for a possible UTI, and ordered prednisone. During an interview on 05/28/25 at 2:28 PM, OT B stated Resident #1 started presenting with fatigue and headache on 04/08/25. She stated that was also when her oxygen saturations started being affected (dropping). She stated she started to not want to get out of bed and they could not encourage her to get up . She stated the nursing staff knew, and she brought it up in her care plan meeting on 04/10/25. During an interview on 05/28/25 at 3:03 PM, the DON stated the nurses would probably document the amount of liters of oxygen a resident was receiving in their skilled nursing note. She stated it was important to document so they would know how they were doing each day. She stated if a resident had abnormal lab values, she would always follow the provider's orders. She stated the NP was very involved in Resident #1's care because she was here so often. She stated her CO2 level was elevated, but because her COPD was so severe, it was not too abnormal to see that. She stated her chest x-rays had been normal and believed the next step would be starting Lasix. She stated she knew her oxygen saturations were dipping from time-to-time, but that was to be expected, especially in therapy. She stated she believed they (staff) were managing her symptoms pretty well. She stated she would expect the nurses to monitor Resident #1's oxygen saturations more often, especially if they were lower than 92 percent. She stated she believed they were doing that but should have absolute been documented in her EMR. She stated not monitoring her oxygen saturations more often could lead to a decline in her health. She stated symptoms of hypercapnia were higher CO2 levels and shortness of breath, but hypercapnia was usually figured out by blood levels which were only done in the hospital. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Some	During an interview on 05/28/25 at 3:16 PM, LVN D stated she worked with Resident #1 the day before she went to the hospital on [DATE]. She stated she remembered her oxygen saturations being in the 80's that morning and she notified the NP. She stated she could not remember how many liters of oxygen she was receiving. She stated whenever someone had low oxygen, she would re-check it and re-check it. She stated she had been fairly new to the facility and was still learning their EMR system and admitted she failed to document when she re-checked her oxygen saturation levels and the oxygen flow rate . She stated in her opinion, Resident #1 did not seem to be struggling to breathe or having a change in condition that day. Review of the facility's undated Oxygen Administration Policy reflected the following: It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. The purpose of oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. . 16. Document all appropriate information in medical record. A. Oxygen therapy B. Respiratory assessment findings C. Method of oxygen delivery D. Flow Rate E. Resident's response