

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2025
NAME OF PROVIDER OR SUPPLIER Park Manor Bee Cave		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the Preadmission Screening and Resident Review (PASRR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and efforts and did not incorporate the recommendations from the PASRR evaluation report into the resident's assessment, care planning, and transition of care for 1 of 1 resident (Resident #1) reviewed for PASRR. The facility failed to submit a complete and accurate request for Nursing Facility Specialized Services (NFSS) in the LTC Online Portal within 20 business days after the Interdisciplinary Team (IDT) meeting for Resident #1. This failure could place residents at risk of not receiving necessary care or specialized services, which could diminish their quality of life and ability to achieve the highest practical level of functioning. Record review of Resident #1's admission record, dated 08/18/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included aphasia (communication disorder), chronic kidney disease, muscle wasting, generalized weakness, dysphagia (difficulty swallowing), malnutrition, anemia (shortage of healthy red blood cells), and a history of cerebral infarction (past strokes). Record review of Resident #1's Quarterly MDS assessment, dated 08/10/2025, documented a BIMS score of 00, which indicated severely impaired cognitive function. Record review of Resident #1's Habilitation Service Plan, dated 03/14/2025, reflected in Section 5 the Outcome Action Plan to identify NF specialized services PT, OT, and ST. Interview with the DOR on 08/18/2025 at 4:19 PM revealed NFSS should be completed within 14 days after the IDT meeting. The DOR stated that failure to submit NFSS in a timely manner could result in the resident losing access to therapy services, limiting health improvement. Interview with the Administrator on 08/18/2025 at 5:14 PM revealed uncertainty regarding the NFSS submission timeframe after the IDT meeting. Record review of the facility's PASRR Level I Screening report reflected Resident #1's screening dated 09/10/2024. PASRR Screening reflects that there is evidence or indicators that Resident #1 has a Developmental Disability other than an Intellectual Disability. The PASRR Evaluation Summary report reflected Resident #1's Level II evaluation completed 04/15/2025. This report reflects that Resident #1 was recommended for the following Nursing Facility Specialized Services (IDD Only). Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) Specialized Assessment Speech Therapy (ST), Specialized Assessment Physical Therapy (PT), Specialized Assessment Occupational Therapy (OT). Record review of the PASRR Nursing Facility Specialized Services report reflected Resident #1's NFSS form was not submitted until 05/14/2025. The NFSS form was submitted 217 days later which is more than 20 business days past the required timeframe. Staff within the HHSC PASRR Unit reflected per 26 TAC Chapter 554, Subchapter BB S554.2704(i)(7), the facility failed to submit a complete and accurate NFSS request in the LTC Online Portal within the required timeframe.</p>

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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