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	09/10/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 6 residents reviewed for quality of care. The facility failed to ensure Resident #1's brief was changed, and she was put back in bed after she was transferred to her wheelchair on [DATE] at 8:45 AM until approximately 6:00 PM which resulted in skin breakdown on her sacral area. This failure could place residents at risk of not receiving adequate care, harm, or injuries. Findings included: Review of Resident #1 face sheet dated [DATE] reflected a [AGE] year old female admitted on [DATE] and discharged on [DATE] with diagnoses of dysphagia (difficulty swallowing), aphasia following nontraumatic subarachnoid hemorrhage (difficulty with speaking due to brain bleed), tracheostomy status (surgical procedure that creates an opening in windpipe to help with breathing), chronic respiratory failure (condition where lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period), muscle wasting and atrophy (loss of muscle tissue, size and strength), muscle weakness, other lack of coordination, and nontraumatic subarachnoid hemorrhage (bleeding in the brain without external trauma). Review of Resident #1's initial care plan dated [DATE] reflected Resident #1 had pressure ulcer or potential for pressure ulcer development on sacrum related to bed bound status and poor nutritional station. Goal included pressure ulcer will show signs of healing and remain free from infection by / through review date, and Resident #1 will have intact skin, free of redness, blisters or discoloration by/through review date Interventions included roll left and right, sit to lying, and lying to sitting on side of bed. Review of Resident #1's MDS 5-day assessment dated [DATE] reflected Resident #1 had a short-term and long-term memory problem. Review of functional abilities reflected at admission Resident #1 was dependent of for all ADLs (eating, oral hygiene, toileting hygiene, shower/bathing). Further review reflected Resident #1 was dependent for chair/bed-to-chair transfers, going from sitting to lying position, and rolling left and right and. Review also reflected that resident was always incontinent of bowel and bladder. Review of MDS skin conditions reflected Resident #1 had no pressure ulcer/injury upon admission and was at risk for developing pressure injuries or ulcers. Review reflected resident had other open lesions or rashes and moisture associated skin damage. Review of Resident #1's initial admission record dated [DATE] reflected Resident #1 used alternating air mattress and pressure re-distributing overlay mattress. Resident #1 was admitted alert to person, but was not alert to place or time and was unable to follow simple commands. Further review reflected resident was incontinent of bowel and bladder and required briefs. Skin problems noted upon admission included traumatic tongue wound prior to admission and surgical site from ankle fracture. Review of Resident #1's skin assessment dated [DATE] reflected Resident #1 had a traumatic tongue wound prior to admission and surgical site to right ankle. There were no other skin issues noted on the assessment. Review of grievance resolution form dated [DATE] reflected Resident #1's family had concerns regarding frequency of checks and new redness to perineal area. Resolution reflected that the DON spoke with family and implemented check and change for frequent rounding. Review of visual/bedside Kardex (electronic health record) report for Resident #1 dated [DATE] reflected under the skin section resident needed monitoring/remining/assistance to turn or reposition. Review reflected Resident #1 required 2 person mechanical lift for all transfers. Review of POC (plan of care) response history for Resident #1 reflected incontinence care was marked as provided on [DATE] at 3:32 AM and 11:41 PM. Review reflected incontinence care was marked as not provided on [DATE] at 11:38 AM. Review of 1 hour checks for Resident #1 reflected sections titled Check, Change, Suctioning and Trach Care. Review for 09-05-2025 hour checks reflected change was not selected between 9:00 am and 6:00 PM. Note on the document reflected Qhour Checks: Please indicate care provided during rounding. Review reflected Resident #1 was checked each hour between 9:00 am and 6:00 pm. Review reflected resident had suctioning completed at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM,6:00 PM, 7:00 PM, 8:00 PM, 9:00 PM, 10:00 PM and 11:00 PM. Review reflected tracheostomy care was provided at 4:00 AM, 8:00 AM, 10:00 AM (nebulizer treatment), 2:00 PM (nebulizer treatment), 6:00 PM (nebulizer treatment), 7:00 PM (nebulizer treatment), 8:00 PM, 9:00 PM, 10:00 PM and 11:00 PM. Review of occupational therapy treatment encounter note dated [DATE] reflected OT checked Resident #1's brief and it was dry and fresh. Review reflected OT then transferred Resident #1 with mechanical lift from bed to geriatric chair. OT then informed ADON that

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 three (Resident #2, Resident #3, and Resident #4) of six residents reviewed for respiratory care. The facility failed to ensure RN G did not test the yankauer (tool for suctioning) in an open container of water prior to suctioning Resident #2's tracheostomy. The facility failed to ensure RN G monitored Resident #2's oxygen during tracheostomy care. The facility failed to ensure RN G did not continue with tracheostomy care when the yankauer was not functioning for Resident #2. These failures could place residents at risk of inadequate care, respiratory distress and hospitalization. Review of Resident #2's face sheet dated 09/09/2025 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of anoxic brain damage (occurs when brain is deprived of oxygen for an extended period), acute respiratory failure (life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide), dysphagia (difficulty swallowing), and tracheostomy status (surgical procedure that creates an opening in windpipe to help with breathing). Review of Resident #2's physician orders dated 09/09/025 reflected an order for an x-ray due to increased secretions. Review reflected and order dated 07/01/2025 to check and record oxygen saturation every shift while suctioning for Resident #2. Further review reflected an order dated 07/01/2025 for tracheostomy care as needed and every shift. Review reflected continuous oxygen at 8 liters per minute to maintain oxygen saturation of 92% and above dated 07/22/2025. Review of Resident #2's September 2025 MAR reflected oxygen saturation was checked each shift (twice a day) from 09/01/2025 through 09/09/2025. Further review reflected Resident #2's oxygen saturation was checked while suctioning every shift from 09/01/2025 to 09/09/2025 and remained above 92%. Review reflected tracheostomy care was provided for Resident #2 each shift from 09/01/2025 to 09/09/2025. Review of Resident #2's quarterly MDS dated [DATE] reflected Resident #2 had a short term and long-term memory problem and having tracheostomy present. Review of Resident #2 care plan dated 08/15/2025 reflected a goal to have no signs of symptoms of infection with interventions of administer oxygen as ordered. Further review of care plan reflected Resident #2 has oxygen therapy with no signs or symptoms of poor oxygen absorption with interventions to provide oxygen per physician orders. Review of chest x-ray results for Resident #2 dated 09/09/2025 reflected lungs are clear and well inflated bilaterally with no findings. Observation on 09/09/2025 at 12:45 PM revealed Resident #2 laid in bed with continues oxygen via tracheostomy flowing at 8 liters per minute. Resident #2 was observed to have drool around her mouth and oxygen mask with white colored mucus. Observation on 09/09/2025 at 1:16 PM revealed RN G donned surgical mask, donned gown and donned gloves without performing hand hygiene. RN G grabbed yankauer from packaging in Resident #2's bedside table and placed it in an open container of clear liquid that sat on Resident #2's bedside. Observation of the container reflected there was no label to indicate a date or contents of the container. RN G suctioned oxygen mask of Resident #2 and cleared mucus. RN G then placed yankauer in open container of clear liquid and placed it back in packaging in Resident #2's bedside table. RN G doffed the gown and gloves and washed his hands. Observation on 09/09/2025 at 2:29 PM revealed an open container of clear fluid placed on Resident #2's bedside table, the container was undated and unlabeled. Further observation revealed a container of normal saline placed on the beside table. Observation and interview on 09/10/2025 at 12:15 PM revealed RN G gathered 2 100 ml bottles of normal saline, 1 tracheostomy with [NAME] gloves kit and a vinyl gown. RN G entered Resident #2's room washed his hands in the bathroom and returned to the medication cart just outside Resident #2's room door. RN G donned a gown, surgical mask and gloves. RN G proceeded to lock his medication cart with the gloves on, touch the light switch and closed Resident #2's room door with the same gloves on. RN G approached Resident #2's bedside and opened the tracheostomy kit over the bedside table. RN G did not sanitize the bedside table and had other items (towel, plastic syringe) that remained on the table. RN G raised the bedside table with the same gloves on and lowered the oxygen to 4 liters per minute. RN G laid a towel across Resident #2's chest. RN G opened a bottle of saline and poured contents in one side of a two-sided tracheostomy tray kit. RN G opened a second bottle of saline and poured contents into the other section of the tracheostomy tray kit that sat on the tray table. RN G turned his back to the sterile field (tray table with open saline) and disconnected tracheostomy oxygen mash (no hand hygiene or gloves changed prior). RN G grabbed yankauer from package in Resident #2's beside table ad attempted to suction thick light yellow

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #2) of 6 residents observed for infection control. The facility failed to ensure RN G performed hand hygiene before and during tracheostomy care glove changes for Resident #2. The facility failed to ensure RN G did not test the yankauer in an open container of clear fluid and then suction Resident #2. The facility failed to ensure RN G sanitize the area prior to placing sterile supplies for tracheostomy care performed for Resident #2. These failures placed residents at an increased risk of exposure to infections, development of infections, decreased quality of life and/or hospitalizations.Findings included: Review of Resident #2 face sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of anoxic brain damage (occurs when brain is deprived of oxygen for an extended period), acute respiratory failure (life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide), dysphagia (difficulty swallowing), and tracheostomy status (surgical procedure that creates an opening in windpipe to help with breathing). Review of Resident #2 physician orders dated 09/09/025 reflected an order for an x-ray due to increased secretions. Review reflected and order dated 07/01/2025 to check and record oxygen saturation every shift while suctioning for Resident #2. Further review reflected an order dated 07/01/2025 for tracheostomy care as needed and every shift. Review reflected continuous oxygen at 8 liters per minute to maintain oxygen saturation of 92% and above dated 07/22/2025. Review of Resident #2 September 2025 MAR reflected oxygen saturation was checked each shift (twice a day) from 09/01/2025 through 09/09/2025. Further review reflected Resident #2's oxygen saturation was checked while suctioning every shift from 09/01/2025 to 09/09/2025 and remained above 92%. Review reflected tracheostomy care was provided for Resident #2 each shift from 09/01/2025 to 09/09/2025. Review of Resident #2 quarterly MDS dated [DATE] reflected Resident #2 had a short term and long-term memory problem. Review of Resident #2 care plan dated 08/15/2025 reflected a goal to have no signs of symptoms of infection with interventions of administer oxygen as ordered. Further review of care plan reflected Resident #2 has oxygen therapy with no signs or symptoms of poor oxygen absorption with interventions to provide oxygen per physician orders. Observation on 09/09/2025 at 1:16 PM revealed RN G donned surgical mask, donned gown and donned gloves without performing hand hygiene. RN G grabbed yankauer from packaging in Resident #2's bedside table and placed it in an open container of clear liquid that sat on Resident #2's bedside. Observation of the container reflected there was no label to indicate a date or contents of the container. RN G suctioned oxygen mask of Resident #2 and cleared mucus. RN G then placed yankauer in open container of clear liquid and placed it back in packaging in Resident #2's bedside table. RN G doffed the gown and gloves and washed his hands. Observation on 09/09/2025 at 2:29 PM revealed an open container of clear fluid placed on Resident #2's bedside table, the container was undated and unlabeled. Further observation revealed a container of normal saline placed on the beside table. Observation and interview on 09/10/2025 at 12:15 PM revealed RN G gathered 2 100 ml bottles of normal saline, 1 tracheostomy with [NAME] gloves kit and a vinyl gown. RN G entered Resident #2's room washed his hands in the bathroom and returned to the medication cart just outside Resident #2's room door. RN G donned a gown, surgical mask and gloves. RN G proceeded to lock his medication cart with the gloves on, touch the light switch and closed Resident #2's room door with the same gloves on. RN G approached Resident #2's bedside and opened the tracheostomy kit over the bedside table. RN G did not sanitize the bedside table and had other items (towel, plastic syringe) that remained on the table. RN G raised the bedside table with the same gloves on and lowered the oxygen to 4 liters per minute. RN G laid a towel across Resident #2's chest. RN G opened a bottle of saline and poured contents in one section of the tracheostomy tray kit and opened a second bottle of saline and poured contents into the other section of the tracheostomy tray kit that sat on the tray table. RN G turned his back to the sterile field (tray table with open saline) and disconnected tracheostomy oxygen mash (no hand hygiene or gloves changed prior). RN G grabbed yankauer from package in Resident #2's beside table and attempted to suction thick light yellow secretions and it was revealed that no contents were suction out of the oxygen mask. RN G then placed tip of yankauer in open contain of clear fluid on Resident #2's bedside table. RN G then moved a switch on suction device and placed tip of yanauer again in open contain of clear fluid. RN G placed the yankauer back