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	07/01/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 7 residents (Resident #1) reviewed for care plans. The facility failed to update Resident #1's code status on her care plan based on her wishes and OOH DNR signed by her legally authorized representative. This failure could place residents at risk of individualized medical and nursing needs not being met resulting in injury and the residents' end-of-life wishes not being respected.Findings included: Record review of Resident #1's face sheet dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included acute respiratory failure with hypoxia (low oxygen in the body's tissues), pneumonia (infection in the lungs that can cause difficulty breathing, fever and cough), chronic kidney disease stage 4 (gradual loss of kidney function), and pain. The face sheet reflected an advance directive of DNR/Do Not Attempt Resuscitation. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. Record review of Resident #1's physician orders reflected an order with a start date of [DATE] DNR/ Do Not Attempt Resuscitation. Record review of Resident #1's EMR reflected a Out of Hospital Do Not Resuscitate (OOH DNR) Order - Texas Department of State Health Services form signed by the resident's provider and authorized family member/ decision maker on [DATE]. Record review of Resident #1's care plan reflected a focus initiated on [DATE] and revised [DATE] Resident #1 has elected full code status with interventions that included: Initiate full code measures in case of cardiac arrest to include CPR and AED use Update residents' chart to reflect elected code status, staff must be aware of code status election. During an interview on [DATE] at 01:11 PM with Resident #1's family member, she stated it was Resident #1's wishes to be DNR. She stated it was a conversation that she had with Resident #1 long ago and as an authorized representative helped make her wishes known to the facility. She stated she expected all of Residents #1's records to reflect her wishes of being DNR. During an interview on [DATE] at 02:35 PM with LVN A she stated the purpose of a care plan was to know the best way to treat a patient and how to take care of them. She stated that the care plan was to be continuously updated to reflect the care a resident presently required. LVN A stated that code status was a part of the care plan. She stated in the event of an emergency nurses pass along information to EMS which included knowing a residents code status. She stated a potential negative outcome of not having updated code status information would be it could cause confusion; if someone is supposed to be DNR and you bring them back it could be really bad, and you would not be honoring their wishes. She stated nursing staff was responsible for updating the care plan. During an interview on [DATE] at 03:14 PM with the DON she stated the purpose of the care plan was to have resident centered care and to follow guidelines. She stated it was the expectation that care plans were updated to maintain accuracy. She stated if care plans were not updated it could affect different things depending on who is looking at it. She stated Resident #1 has been DNR since (continued on next page)

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

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	07/01/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the beginning of the year that she knew of and it should have been updated. She stated that in full transparency, she recently replaced the nursing staff member responsible for updating the care plans because she noticed a few were not getting updated. She stated they were working on auditing all care plans and getting them updated presently. During an interview on [DATE] at 03:43 PM with the ADM, he stated the purpose of the care plan was to provide and outline guidance for the care needs of the resident and should be person centered. He stated if a care plan was not updated to reflect the care needed it could prevent the fulfillment of the need that was impacted. He stated a residents code status should be reflected in the care plan. He stated it was the MDS and nursing staff that were responsible for updating the care plan. Record review of the facility Advance Directives and Associated Documentation policy last revised 04/2025 reflected:It is the policy of this facility that a residents choice about advance directives will be recognized and respected. The facility recognizes and respects the residents right to choose their treatment and make decisions about care to be received at the end of their life. Do Not Resuscitate- indicates that in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) have directed that no cardiopulmonary resuscitation (CPR) is to be attempted. Once the advance directive or information regarding resident preferences regarding treatment options is received by the facility, it will be confirmed in the residents medical record and communicated to members of the care plan team. Advance care planning will occur periodically (at least quarterly, annually, and on a change of condition) to review the advance directive and/or preferences regarding treatment options with the resident or their representative to ensure that they are still the wishes of the resident. Such reviews will be made during the assessment process and recorded in the medical record. Record review of the facility Comprehensive Person Centered Care Planning policy last revised 12/2023 reflected: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and timeframes to meet a residents medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The residents comprehensive plan of care will be reviewed and/ or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. Review of the facility CMS's RAI version 2.0- Formulation of the care plan policy/guidance revised 12/2002 reflected: The care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident is receiving. The care plan is an interdisciplinary communication tool. The comprehensive care plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. The care plan must be periodically reviewed and revised, and the services provided or arranged must be in accordance with each residents written plan of care.