

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 08/08/2024
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)		
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on interview and record review, the facility failed to ensure residents' right retain and use personal possessions for 3 of 8 residents (Residents #56, 68, and 74) reviewed for rights. The facility failed to ensure the former administrator introduced herself and requested permission to search the rooms of Residents #56, 68, and 74 prior to doing so on an undisclosed date. This failure placed residents at risk of misappropriation and feelings of indignity. Findings included: Review of the undated face sheet for Resident #56 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included major depressive disorder, anxiety disorder, history of transient ischemic attack (temporary blockage of blood flow to the brain), muscle weakness, and need for assistance with personal care. Review of the quarterly MDS assessment for Resident #56 dated 05/20/24 reflected a BIMS score of 15, indicating intact cognition. During an interview on 08/06/24 at 03:45 PM, Resident #56 stated she had walked in on the former administrator in her room looking through her things. Resident #56 stated the former administrator did not ask permission or even notify Resident #56 that she would be looking through her things. Resident #56 stated the former administrator confiscated some body spray and some lotion, and Resident #56 was annoyed by it. She stated the former administrator had said something about having to remove items that someone could use to harm themselves if they had dementia and wandered into a room. Resident #56 stated she did not care that much about the items themselves, but it was the principle of having her room searched without permission. Review of the undated face sheet for Resident #68 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included seizures, epilepsy, major depressive disorder, Wernicke's encephalopathy (neurological symptoms caused by biochemical lesions of the central nervous system after exhaustion of B-vitamin reserves), anxiety disorder, insomnia, muscle weakness, cognitive communication deficit, and bipolar disorder. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676373	Facility ID: 676373 If continuation sheet Page 1 of 33

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment for Resident #68 dated 07/12/24 reflected a BIMS score of 15, indicating intact cognition. During an interview on 08/06/24 at 04:40 PM, Resident #68 stated the former administrator had come into her room looking for e-cigarettes. Resident #68 stated the former administrator did not ask permission to look in her room. Resident #68 stated she never had an e-cigarette in her room or anywhere else and knew they were against the rules. Resident #68 stated she did not think the search of her room was fair, and the former administrator did not introduce herself. Review of the undated face sheet for Resident #74 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included spinal stenosis (a condition that narrows the space inside the backbone, putting pressure on the spinal cord and nerves), radiculopathy (pinched nerve), low back pain, generalized anxiety disorder, major depressive disorder, multiple sclerosis (potentially disabling disease of the brain and spinal cord), cognitive communication deficit, and chronic pain syndrome. Review of the quarterly MDS assessment for Resident #74 dated 06/06/24 reflected a BIMS score of 13, indicating intact cognition. During an interview on 08/07/24 at 09:30 AM, Resident #74 stated two weeks prior, she had felt bad and was resting in her bed in the middle of the day. She stated the former administrator walked into her room without knocking, did not introduce herself, and began looking through Resident #74's belongings. Resident #74 stated the former administrator was looking in her cabinets and closet and through all her things. Resident #74 stated she asked the former administrator what was going on, and the former administrator said there was a black purse missing in the facility. Resident #74 stated she had a black purse that belonged to her so Resident #74 became upset and told the former administrator she did not have the purse. Resident #74 stated the former administrator staid it was a mistake and left the room. Resident #74 stated she would have given the former administrator permission to look through her things if she had asked. Resident #74 stated it made her feel insulted. An attempt was made to interview the former administrator by telephone on 08/07/24 at 05:15 PM. A voicemail was left but no return contact was made. During an interview on 08/08/24 at 03:24 PM, the ADM stated if they needed to search a resident's room, they had to ask for permission and could not confiscate items without resident permission. The ADM stated the potential impact on residents was financial, and it was a rights violation. A facility policy on Personal Privacy was requested but not provided by the time of exit.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 38073 Based on interview and record review, the facility failed to consider the views of the resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility or to demonstrate their response and rationale for such response for 1 of 1 resident council reviewed. The facility failed to follow up on concerns and requests expressed in resident council meetings from May 2024 through June 2024 . This failure placed residents at risk of not having their preferences honored. Findings included: Review of Resident Council minutes reflected the following with no documentation of the facility's responses to the grievances: 05/31/24 Dietary: suggestion when they bring certain things can we please have condiments. Had salad for two weeks with no dressing. They work hard, but they don't understand exactly how to put things for better. I think that it would be good to have one designated person to speak English for better communication. Dry pinto beans. Too much salt and too much pepper. Food has been overcooked and dried out lately. Eggs were undercooked. Dark place on ticket that says what we don't want, but nobody reads it. The dressing to the salad is never available but we don't have a choice. Maybe if we change a few things at a time and fix those problems we can move onto the next set of issues. Resident said the food is horrible and there is no fruit. Sloppy cake and nasty noodles. Maintenance: (former maintenance director) does everything he's supposed to do and (former maintenance director) needs help. Nursing: they desperately need some CNAs and extra help because they have not had any help on the floor. CNA came in and threw something in the room and walked out. Resident said we only have one CNA for both halls five and six at nighttime. If they can close the door when they are changing people. There was a girl in there who didn't like me, and she was very rude. CNAs are pathetic at nighttime. Resident said she's about to go to the state because some CNAs are working two and three hallways by themselves. 06/26/24 Dietary: the food here is very unhealthy, everything is fried. The apple juice and cranberry juice are watered down. Resident want someone who can communicate in English to be in the kitchen at all times. The residents were informed the facility is not willing to spend the money on healthier options. Everything is fried. (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance: things have not been getting fixed very good. One resident had to clean her own filter in her A/C. Another resident said the A/C never gets cleaned. Nursing: 'so we got a new DON.' The CNAs are overworked. The residents want a new doctor on staff or PA . 07/29/24 Nursing: expressed a desire for a consistent nurse on the 200 hall and inquired about a particular nurse absence. They also want to know the status of the (local hospital) contract and requested regular CNAs instead of relying solely on agency staff. Laundry: residents requested stain ed sheets and towels be replaced. Tattered fitted sheets. Also need to be discarded. One resident reported that her blue towel was bleached. Dietary: residents collectively agreed that the food has improved. However, when resident reported not receiving silverware with her meals, and another complaint of receiving duplicate meals in her room. Concerns were also raised about the cleanliness of the fryer and the flavor of the pasta, which has shown some improvement During a Resident Council meeting on 08/06/24 at 04:06 PM, eight anonymous residents stated the facility used to be really good but had become horrible. They all stated they notified staff about the problems and were always told we're working on it. They all stated they were not aware of any method by which the facility management provided resolutions to the concerns that came up in the resident council minutes. They all stated most of the complaints were about the food, the facility being short staffed, and the maintenance of the physical environment. They stated they did not have meal of the month or discuss their rights during meetings. They stated they had never seen any kind of written paper or grievance form that reflected their concerns and requests during resident council or explained any resolution. They stated they had become tired of saying anything to the staff, because nothing ever changed. They stated the AD did a great job and listened to them, and they did not feel the problem was with the AD. They stated the problem was because there had been a revolving door of administrators, and they never knew who was in charge. They stated they had just learned that a new administrator had started that day, and they hoped he would do something about all the issues they had. One resident stated they wanted a public restroom for the inmates. The other seven residents stated they felt like calling themselves inmates and not residents. (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/07/24 at 03:42 PM, the AD stated she had worked at the facility for one year. She stated she attended the Resident Council and wrote down minutes for the meetings. She stated when the residents at Resident Council had a concern or a problem, she wrote it down and turned it in to the department head responsible. The AD stated she spoke to the DON or the former director of nursing, to the DM or the former dietary manager, or to the MAINT or the former maintenance director. The AD stated the DON had only been working at the facility for one month, the DM had only been working at the facility for two weeks, and the MAINT had only been working at the facility for about three weeks. The AD stated she thought the concerns were written down on paper after they were brought to the department head responsible, but she did not see any official forms that were ever turned back into her or submitted. The AD stated the concerns about the food, the nursing staff, the maintenance issues, and the lack of supplies were all documented in the Resident Council minutes, and she did not know how the issues were resolved or what was communicated to the Resident Council. The AD stated things were not being fixed when they were broken, and she had conveyed that to the former administrator. The AD stated the former director of nursing, and the former administrator told her they were handling the concerns, and she did not have the authority to question that. The AD stated the former dietary manager and maintenance director took the concerns, but she did not know what she did with them. The AD stated most of what she reported about maintenance and dietary were reported directly to the former administrator. The AD stated the resolution of concerns had been a roller coaster for the residents due to the staff turnover, but she felt the new team would become stable and fix the issues that had not yet been fixed. The AD stated she had not reported all the issues from six months of Resident Council minutes to the new department heads, but she had been to them with new concerns. The AD stated the ADM had just started the day before, so she had not reported anything to him. The AD stated she had developed her method for addressing Resident Council concerns herself and had not been trained in any other method. She stated she was responsible for holding the Resident Council itself, but the department heads were responsible for resolutions to problems in their departments. She stated the potential negative impact of not having resolutions to their concerns was that Resident Council members might feel like they had no power in their homes. During an interview on 08/08/24 at 12:07 PM, the DON stated she had seen none of the concerns from Resident Council, because everything was going through the former administrator. The DON stated she had only been working at the facility for one month and did not know how the Resident Council concerns were addressed prior to her being at the facility. During an interview on 08/08/24 at 03:24 PM, the ADM stated the procedure for Resident Council ought to have been whoever was there should have documented and readdressed the resolutions with the Council. The ADM stated it was only his third day in the position, so he had not had a chance to develop a system for addressing Resident Council concerns, but the interdisciplinary team should have followed up with the Council regardless of the system in place. The ADM stated the AD was responsible for hosting the Resident Council meetings, but he would need to work with his team to figure out how follow up with the Council occurred and with whom. The ADM stated the potential impact of not having the Resident Council receive follow up on their concerns was psychological in that it could make them feel defeated. Review of facility policy dated 12/23 and titled Grievances reflected the following: It is the policy of this facility to establish a grievance process that allows the residents a way to execute their right to voice concerns or grievances to the facility or other agencies/entity without fear of discrimination or reprisal. General concerns may be voiced at resident and/or family council meetings. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy dated 07/07 and titled Resident Council Meeting reflected the following: It is the policy of this facility to 1. Provide a forum, through which constructive suggestions, ideas and concerns may be offered and projects initiated for the mutual benefit of the institution and the residents of the facility; 2. Provide information to the residence on action taken on recommendations made at the resident council meetings; and 3. Give residents a certain degree of self-determination, the planning of upcoming recreational events, outings, and contributions to schedule activities.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment for 2 of 8 residents (Residents #40 and 56) reviewed for environment. The facility failed to ensure lightbulbs were promptly replaced when they began blinking in light fixtures in Residents #40 and 56's rooms. This failure placed residents at risk of diminished quality of life and falls. Findings included: Review of the undated face sheet for Resident #56 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included major depressive disorder, anxiety disorder, history of transient ischemic attack (temporary blockage of blood flow to the brain), muscle weakness, and need for assistance with personal care. Review of the quarterly MDS assessment for Resident #56 dated 05/20/24 reflected a BIMS score of 15, indicating intact cognition. Review of the maintenance log from July 2024 to August 2024 on 08/06/24 reflected a lightbulb out in Resident #56's room was listed as a closed maintenance item. The light in Resident #40's room was not listed on the log. During a Resident Council meeting on 08/06/24 at 04:06 PM, eight anonymous residents stated the facility used to be really good but had become horrible. They all stated they notified staff about the problems and were always told we're working on it. They all stated they were not aware of any method by which the facility management provided resolutions to the concerns that came up in the resident council minutes. They all stated there were issues with the maintenance of the physical environment. They stated they had never seen any kind of written paper or grievance form that reflected their concerns and requests during resident council or explained any resolution. They stated they had become tired of saying anything to the staff, because nothing ever changed. They stated the AD did a great job and listened to them, and they did not feel the problem was with the AD. They stated the problem was because there had been a revolving door of administrators, and they never knew who was in charge. They stated they had just learned that a new administrator had started that day, and they hoped he would do something about all the issues they had. During an interview on 08/06/24 at 04:06 PM, Resident #56 stated the middle light bulb in her vanity had been flickering for a couple of months and she had reported it several times to her aides and nurses, but it was still not fixed. She stated she had finally asked a CNA to unscrew the bulb so it would stop flickering. She stated she did not know why nobody ever came to fix the maintenance issues in their rooms. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/07/24 at 08:20 AM revealed Resident #56's vanity light over the bathroom sink was not lit while the other two lights were lit. Review of the undated face sheet for Resident #40 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia, mixed receptive-expressive language disorder, weakness, history of transient ischemic attack, expressive language disorder, cognitive social or emotional deficit following cerebral infarction (stroke caused by a blocked blood vessel), and apraxia (dysfunction in certain regions of the brain). Review of the annual MDS assessment for Resident #40 dated 06/11/24 reflected a BIMS score of 13, indicating intact cognition. Observation on 08/07/24 at 08:28 AM revealed the SC went into Resident #40's room to deliver breakfast and the overhead light in the entryway was flickering for 20 minutes of observation. During an interview on 08/07/24 at 08:55 AM, Resident #40 stated her light had been flickering like that for months, and she stated, Of course I don't like it, it is driving me crazy! She stated she had reported it , but nothing ever got done. During an interview on 08/08/24 at 10:52 AM, the MAINT stated he had rooms that needed new lightbulbs and had a list of them in his office. He stated he had just ordered light bulbs yesterday (8/7/24) and with the transition to the new administrator, there were some gaps in getting supplies ordered. He stated he did have Resident #56's vanity light on his list, but he would have to replace the entire vanity. He stated he was not aware of the issue in Resident #40's room. He stated he just started a month ago and was trying to catch up. During an interview on 08/07/24 at 11:00 AM the SC stated he did not notice the light flickering when he delivered the meal tray to Resident #40's room yesterday and has never noticed it flickering. During an interview on 08/08/24 at 03:24 PM, the ADM stated residents needed for broken or malfunctioning lightbulbs to be replaced immediately. He stated having a lightbulb not working properly could place residents in danger of falling. He stated the responsibility for these repairs was on the MAINT. A facility policy on Safe, Clean, Comfortable, Homelike Environment was requested but not provided by the time of exit.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38073 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's mental and psychosocial needs for 5 of 8 residents (Residents #14, 32, 74, 76, and 77) reviewed for care plans. The facility failed to ensure the care plans for Residents #14, 32, 74, 76, and 77 included person-centered goals and interventions for activities. This failure placed residents at risk of not having their recreational and social needs met. Findings included: Review of the undated face sheet for Resident #14 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Major depressive disorder, generalized anxiety disorder, dementia, lack of physical exercise, muscle weakness, and cognitive communication deficit. Review of the quarterly MDS assessment for Resident #14 dated 04/17/24 reflected a BIMS score of 15, indicating intact cognition. Review of the care plan for Resident #14 dated 05/08/24 reflected no care planning for activities. It reflected the following: Potential for adjustment issues due to admission. Will maintain the ability to seek social contact and stimulation through the review date. Will receive daily opportunities for social contact through the review date. Encourage ongoing family involvement. Invite family to attend special events, activities, meals. o Encourage to participate in conversation with staff, other residents daily. o Introduce to residents with similar background, interests and encourage/facilitate interaction. Review of the undated face sheet for Resident #32 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia, type two diabetes mellitus, major depressive disorder, muscle atrophy (wasting or thinning of muscle mass), muscle weakness, unsteadiness on feet, lack of coordination, cognitive communication deficit, fatigue, and mild cognitive impairment. Review of the quarterly MDS assessment for Resident #32 dated 07/01/24 reflected a BIMS score of 12, indicating moderate cognitive impairment. Review of the care plan for Resident #32 dated 7/15/24 reflected the following: Dependent on staff for activities, cognitive stimulation, social interaction r/t Physical Limitations. Will attend/participate in activities of choice by next (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review date. Will maintain involvement in cognitive stimulation, social activities as desired through review date. There were no interventions related to specific activities enjoyed by Resident #32. Review of the undated face sheet for Resident #74 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included spinal stenosis (a condition that narrows the space inside the backbone, putting pressure on the spinal cord and nerves), radiculopathy (pinched nerve), low back pain, generalized anxiety disorder, major depressive disorder, multiple sclerosis (potentially disabling disease of the brain and spinal cord), cognitive communication deficit, and chronic pain syndrome. Review of the quarterly MDS assessment for Resident #74 dated 06/06/24 reflected a BIMS score of 13, indicating intact cognition. Review of the care plan for Resident #74 dated 06/28/24 reflected no care planning related to activities. It reflected the following: Potential for a psychosocial well-being problem r/t Anxiety, insomnia and depression for which no medication interventions are required at this time. Will identify individual strengths by the review date. Will demonstrate adjustment to nursing home placement by/through review date. Allow time to answer questions and to verbalize feelings perceptions, and fears. o Consult with: Social services, Psych services as indicated. o Monitor/document resident's usual response to problems: Internal - how individual makes own changes, External - expects others to control problems or leaves to fate, or luck. o Needs assistance/supervision/support with identification of potential solutions to present problems. o Observe for side effects and adverse reactions of hypnotic medications: burning or tingling in the hands, arms, feet, or legs, change in appetite, constipation, diarrhea, difficulty with balance, dizziness, weakness, drowsiness, dry mouth, headache, GI upset, stomach pain or tenderness, uncontrollable shaking of a body part, unusual dreams o Provide opportunities for family to participate in care. Review of the undated face sheet for Resident #76 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included infection and inflammatory reaction due to indwelling urethral catheter, methicillin-resistant staphylococcus aureus infection, mild persistent asthma, chronic obstructive pulmonary disease, fatigue, nausea, lack of coordination, unsteadiness on feet, cognitive communication deficit, blindness of right eye, reduced mobility, functional quadriplegia (complete inability to move without damage or injury to the spinal cord), congestive heart failure, delusional disorders, psychophysiological insomnia (heightened worries about sleep), and malignant neoplasm of scrotum (scrotal skin cancer). Review of the quarterly MDS assessment for Resident #76 dated 07/12/24 reflected a BIMS score of 15, indicating intact cognition. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for Resident #76 dated 10/11/23 reflected the following: [Resident #76] is Dependent on staff for activities, cognitive stimulation, social interaction r/t Physical Limitations. Will attend/participate in activities of choice by next review date. Invite to scheduled activities. Needs assistance/escort activity functions. There were no interventions related to specific activities enjoyed by Resident #76. Review of the undated face sheet for Resident #77 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included rheumatoid arthritis, chronic pain syndrome, major depressive disorder, unsteadiness on feet, dementia, cognitive communication deficit, and muscle weakness. Review of the quarterly MDS assessment for Resident #77 dated 06/21/24 reflected a BIMS score of 15, indicating intact cognition. Review of the care plan for Resident #77 dated 08/25/23 reflected the following: [Resident #77] is Dependent on staff for activities, cognitive stimulation, social interaction. Will attend/participate in activities of choice by next review date. Invite to scheduled activities. Needs assistance/escort activity functions. There were no interventions related to specific activities enjoyed by Resident #77. During an interview on 08/08/24 at 03:14 PM, the MDSN stated she had been in the position for a week and a half. She stated part of her role and responsibility was to create care plans from the MDS care area assessments. The MDSN stated she needed to gather information from the other department heads, especially in the area of activities, to create person-centered care plans. The MDSN stated generic care planning for activities was not consistent with policy, and the care plans should have been personalized and specific. The MDSN stated ensuring care plans were personalized would be her responsibility, but she and the DON were both new, so they had not created a system yet. The MDSN stated the potential impact of not having personalized care plans was that the resident might not have the best care possible . During an interview on 08/08/24 at 03:24 PM, the ADM stated care plans should have been personalized. He stated ultimately the care plans were the DON 's responsibility, but the whole interdisciplinary team should have been involved. Review of facility policy dated 12/23 and titled Comprehensive Resident Centered Care Plan reflected the following: It is the policy of this facility that the interdisciplinary team should develop a comprehensive person-centered care plan for each resident that includes measurable objectives, and time frames to meet a residents. Medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The facility IDT will develop and implement a comprehensive person centered, culturally, competent, and trauma informed care plan for each resident . And will include resident needs identified in the comprehensive assessment, and residence, goals, and desired outcomes, preferences for future discharge, and discharge plan.		

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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	
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 1 (Resident #77) of 8 residents reviewed for showers. The facility failed to provide Resident #77 showers as scheduled from 07/22/24 to 08/08/24. This failure placed residents at risk of skin breakdown and infection. Findings included: Review of the undated face sheet for Resident #77 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included rheumatoid arthritis, chronic pain syndrome, major depressive disorder, unsteadiness on feet, dementia, cognitive communication deficit, and muscle weakness. Review of the annual MDS assessment for Resident #77 dated 06/21/24 reflected a BIMS score of 15, indicating intact cognition. It reflected that she was totally dependent on her caregiver during baths/showers. Review of the care plan for Resident #77 dated 08/25/23 reflected the following: [Resident #77] has an ADL Self Care Performance Deficit r/t weakness. Will maintain current level of function through the review date. Bathing - assist of one. Review of CNA tasks for Resident #77 from 07/22/24 to 08/08/24 reflected Not Applicable had been marked on 07/22/24, 07/25/24, 07/30/24, 08/03/24, and 08/08/24. 08/05/24 was marked as a refusal. Review of paper shower sheets spanning 07/08/24 to 08/08/24 from the hall in which Resident #77 lived reflected no shower sheet for Resident #77. Observation of Resident #77 on 08/06/24 at 08:10 AM revealed she was lying in her bed having breakfast. She had greasy, mussed hair. During an interview on 08/07/24 at 07:35 PM, CNA C stated she had not signed off on giving Resident #77 a shower and was not sure who had last given her a shower. CNA C stated she was not sure who had Resident #77 on their list to shower that evening. Observation and interview of Resident #77 on 08/08/24 at 08:30 AM revealed her hair was very greasy. During an interview, she stated she did not know when she showered last and could not remember. She stated she thought she would get a shower later that day. During an interview on 08/08/24 at 08:34 AM, CNA B stated she had just started working on the hall where Resident #77 lived, so she did not know her that well, but she had not given Resident #77 a shower. CNA B stated Resident #77 got her shower at night on the night shift, which started at 06:00 PM. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/08/24 at 12:07 PM, the DON stated she had identified some issues with showers since she started on 06/26/24 but had not been able to create a news system yet to fix the problem. She stated showers needed to be offered as scheduled, and Resident #77 needed to have showers. She stated the potential impact was poor hygiene or infection. During an interview on 08/08/24 at 03:24 PM, the ADM stated residents should have received showers according to the shower schedule, which should have been three times per week. The ADM stated if they refused, they should have been offered the opportunity to shower at another time, and the nursing department should have ensured they tried to accommodate the needs and preferences of the residents. He stated the potential negative impact of the failure was on the resident's health and quality of life . A facility policy on ADL Care was requested but not provided by the time of exit.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on interview and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 1 of 8 residents (Resident #76) reviewed for activities. The facility failed to provide Resident #76 with activities from 08/06/24-08/08/24. This failure placed residents at risk of not having their recreational and social needs met. Findings included: Review of the undated face sheet for Resident #76 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included infection and inflammatory reaction due to indwelling urethral catheter, methicillin-resistant staphylococcus aureus infection, mild persistent asthma, chronic obstructive pulmonary disease, fatigue, nausea, lack of coordination, unsteadiness on feet, cognitive communication deficit, blindness of right eye, reduced mobility, functional quadriplegia, congestive heart failure, delusional disorders, psychophysiological insomnia, and malignant neoplasm of scrotum. Review of the quarterly MDS assessment for Resident #76 dated 07/12/24 reflected a BIMS score of 15, indicating intact cognition. It reflected he was completely dependent on staff for transfer from bed to chair and back to bed. Review of the care plan for Resident #76 dated 10/11/24 reflected the following: [Resident #76] is Dependent on staff for activities, cognitive stimulation, social interaction r/t Physical Limitations. Will attend/participate in activities of choice by next review date. Invite to scheduled activities. Needs assistance/escort activity functions. Review of the admission activity evaluation for Resident #76 completed by the AD on 07/10/24 reflected he was currently interested in: knitting and crocheting, drawing and painting, singing and music, watching TV and movies, talking and conversing, dogs and cats, and working on his internet business. It reflected his assessed needs were assistance getting in and out bed and activity reminders. Review of the one-on-one activity logs from January 2024 through August 2024 reflected Resident #76 had no activities on the logs. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/24 at 02:58 PM, Resident #76 stated he was not getting PT or OT and did not participate in any activities . He stated he was not bored, because he had his computer and his phone, and he could entertain himself. He stated he did like to go outside and having outside time was very important to him. He stated he could not remember being outside in a whole year except to go to the hospital or to a doctor. Resident #76 stated he had given up on ever spending time outside. He stated God had given him the grace to get through each day, because he did not feel bored or depressed. During an interview on 08/08/24 at 12:07 PM, the DON stated she had not seen Resident #76 receive activities. She stated she tried to make a point to walk over to that side of the facility and check on things, but she could not confirm or deny if he was gotten up to go outside or participate in activities. During an interview on 08/08/24 at 02:47 PM, Resident #76 stated he had not participated in any activities or been offered any specific activities since the surveyors had met with him on 08/06/24. During an interview on 08/08/24 at 03:00 PM, the AD stated Resident #76 did not participate in group activities and he mostly kept to himself and entertained himself. She stated she had given him materials for art and drawing, and she did bring him to the July 4th party, which was outside. She stated he did not participate in activities any more frequently than that and had not participated in activities during the survey period from 08/06/24 to 08/08/24 . During an interview on 08/08/24 at 03:24 PM, the ADM stated he had gotten to meet Resident #76 and understood that he was a younger guy who was very smart and needed activities that were tailored to his interests. The ADM stated getting outside was very important to someone who liked to be outside. He stated it was important for residents to have activities they really liked, because if they did not, it could cause depression and acting out. The ADM stated he did believe that the AD was telling the truth about Resident #76 going outside for the July 4th party, because he knew her to be a very honest person, but he confirmed that she really needed some help in the form of an activity assistant. Review of facility policy dated 12/23 and titled Activity Program reflected the following: It is the policy of this facility to ensure that activities are available to meet resident needs and interests that support the physical, mental, and psychosocial well-being of the resident. Activities may be facility-sponsored group or independent.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observation, interview, and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 2 residents (Resident #10) reviewed for quality of care. The facility failed to ensure Resident #10's wound care orders were followed on 8/6/24 as ordered. This failure could place residents at risk for worsening of wounds, development of infections, and loss of the highest practicable level of functioning. Findings include: Record review of Resident #10's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of Fracture of Left Femur (Thigh Bone) left side paralysis following stroke, Diabetes, Malnutrition, Right arm skin tear, and anxiety. Record review of Resident #10's initial MDS assessment dated 7 /10/24 revealed a BIMS score of 13, which indicated the resident's cognition level was intact. Record review of Resident #10's Care Plan, reflected a Focus area was initiated on 8/1/2024 for a right arm skin tear. The goal was for the right arm to heal, and the interventions were to: Monitor/document location, size and treatment of skin tear and perform Wound care as ordered. Record review of Resident #10's orders on 7/23/2024 reflected an order: Right arm: cleanse with normal saline/wound cleanser pat dry, apply Xeroform (Dressing) and cover with a dry dressing every-other-day and as needed for dressing removal and soilage. May discontinue when healed. Record review of Resident #10's TAR reflected, the right arm dressing was documented as changed on 8/2/24, 8/4/24, and 8/6/24- reflecting every-other-day pattern ordered by the physician. Observation on 08/08/24 at 11:12 AM revealed Resident #10 seated in her wheelchair near the nurse's station. She had a bandage on her right wrist/arm dated 08/04/24. She did not respond to any questions about the bandage. Observation on 08/08/24 at 11:46 am revealed Resident #10's uncovered right arm wound was pinkish skin with no open areas. There was no sign of infection. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/08/24 at 11:32 AM, the WND stated Resident #10 had a skin tear on her right arm and was receiving treatments every other day. The WND stated she was providing most of Resident #10's treatments, and she had performed the treatment on 08/02/24, saw the wound was almost healed, and planned to discontinue the treatment after the 8/3-8/4 weekend if the skin tear continued to look good. The WND stated, she thought she did the treatment this week (8/6/24), but she was not sure. She stated, she was sure it was in the TAR and documented. She looked at the bandage on Resident #10's arm and stated she must not have done the treatment on 08/06/24. She stated, she did not know why she signed the TAR when she did not do the treatment. The WND stated the only thing she could say was that she made a mistake and had to take responsibility for it. She stated she did not think missing the treatment would have had a negative impact on Resident #10, because the wound was already healed and treatment could have already been discontinued. In an interview on 8/8/2024 at 1:33 pm, the DON stated, the policy to follow doctors' orders on dressing change schedules and to chart it appropriately was important to ensure proper wound care is done and to promote wound healing. The DON stated the negative outcome to residents if this was not done would be worsening of wounds and potentially adverse effects. In an interview on 8/8/2024 at 1:48 pm, the ADM stated, the policy for following doctors' orders on dressing change schedules and charting it appropriately was to follow whatever the order said. The ADM stated, it was important to follow the orders and accurately document the care to prevent infection and spread of diseases and the negative outcome to the resident if it was not done would be diseases could spread. Record review of facility policy titled, Wound Management reflected, It is the policy of this facility to have a system to enable medical staff to evaluate status of wounds. The list of wounds includes lacerations. It further says treatment ordered by the physician will be used for a two-week period. If no improvement, the physician will be called for an evaluation.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review the facility failed to ensure residents received care, consistent with professional standards of practice to prevent pressure ulcers from developing and promote healing for 1 of 2 residents (Resident #12) reviewed for pressure ulcers prevention. The facility failed to ensure Resident #12's pressure relieving low air loss mattress was plugged in and always functioning. This failure could place residents at risk of worsening pressure ulcers and the development of new pressure ulcers. Findings included: Record review of Resident #12's AR, dated 8/6/2024, reflected an [AGE] year-old female, who admitted to the facility on [DATE]. She was diagnosed with Dementia (which was a disease that affected memory, thought, and interfered with daily life) and Pressure Ulcer of Sacral Region (which were ulcers on the resident's lower back which formed due to body weight continually pressed against other surfaces.) Record review of Resident #12's Order Summary Report, dated 8/6/2024, reflected an order for low air loss mattress to Resident #12's bed. The order entered on, and active, since 9/18/2023, indicated the low air loss mattress was supposed to be in place and functioning every shift for pressure relieving intervention. (A low air loss mattress was a mattress that had an attached electronic pressure gage, which read the air pressure in the mattress and regulated its pressure with respect to the resident's body pressure. The electronic pressure gage was housed in a small rectangular box kept at the foot of the resident's bed. There was an air hose that led to the mattress and an electricity cord that ran from the electronic box to a wall outlet. There was a power button, which illuminated green when the power was on.) Record review of Resident #12's Quarterly MDS assessment, dated 6/6/2024, reflected Section C., Cognitive Patterns: Resident's cognitive skills for daily decision making (assessed by staff) were severely impaired. Section GG., Functional Abilities and Goals: Resident had impairment on both sides of their upper (shoulder, elbow, wrist, and hand) and lower (hip, knee, ankle, and foot) extremities and utilized a wheelchair for mobility. Resident was dependent upon staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off shoes, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, chair bed transfer, toilet transfer, tub shower transfer. Dependent meant the helper did all the effort. Resident did none of the effort to complete the activity. Section H., Bladder and Bowel (Bladder:) Resident was always incontinent. Section H., Bladder and Bowel (Bowel:) Resident was always incontinent. Section M., Skin Conditions: Resident #12 had 1-Stage 4 pressure ulcer that was not present at the time of admission/reentry; Resident #12 received skin and ulcer/injury treatments, such as pressure reducing device for bed, and pressure ulcer/injury care. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's CP reflected a Focus Area for resident's potential for pressure ulcer development evidenced by history of pressure ulcers and immobility, initiated 8/4/2022. The Goal, initiated 8/23/2022, was for the resident to have intact skin by target date of 8/6/2024. The Interventions for nursing staff were to have educated the resident and responsible parties to the cause of skin breakdown, initiated 8/4/2022; having turned, repositioned, and provided assistance as necessary, initiated 8/4/2022; having protected resident's heels by having floated in protective equipment, initiated 10/27/2022; having notified nursing staff for any new skin breakdown, initiated 8/4/2022; having used a pressure reducing mattress, initiated 8/4/2022; having conducted weekly head to toe skin assessments, initiated 8/4/2022. Resident #12 had a second Focus Area for Pressure Ulcers, initiated 9/18/2023, evidenced by a stage 4 Pressure Ulcer to the lower back region. The Goal, initiated 9/18/2023, indicated the pressure ulcer would show signs of improvement by review date, 8/6/2024. The Interventions for nursing staff were to administer treatments as ordered by medical doctor and monitor for effectiveness, initiated 9/18/2023; having assessed monitored and recorded wound healing progress, initiated 9/18/2023; avoid positioning on back, initiated 9/18/2023; install a low air loss mattress, initiated 9/18/2023; transfer resident with mechanical lift with two staff members, initiated 3/26/2024. Wound management documentation: Record review of the facility's wound evaluation and management summary report, dated 9/22/2023, indicated Resident #12 had a stage 4 pressure ulcer on her lower back. The wound was 4.3 centimeters long (x) 3.8 centimeters wide (x) .9 centimeters deep. Duration - greater than 6 days; Objective- heal/maintain healing. Record review of the facility's wound evaluation and management summary report, dated 12/20/2023, indicated Resident #12 had an unstageable (unable to determine present damage or health of) pressure ulcer on her lower back. The wound was 4.0 centimeters long (x) 3.5 centimeters wide (x) .3 centimeters deep. Duration - greater than 91 days; Objective- heal/maintain healing. Record review of the facility's wound evaluation and management summary report, dated 2/28/2024, indicated Resident #12 had a stage 4 pressure ulcer on her lower back. The wound was 3.0 centimeters long (x) 3.0 centimeters wide (x) .4 centimeters deep. Duration - greater than 161 days; Objective- heal/maintain healing. Record review of the facility's wound evaluation and management summary report, dated 5/8/2024, indicated Resident #12 had a stage 4 pressure ulcer on her lower back. The wound was 2.5 centimeters long (x) 2.5 centimeters wide (x) .1 centimeters deep. Duration - greater than 231 days; Objective- heal/maintain healing. Record review of the facility's wound evaluation and management summary report, dated 8/7/2024, indicated Resident #12 had a stage 4 pressure ulcer on her lower back. The wound was 1.8 centimeters long (x) 2.0 centimeters wide (x) .1 centimeters deep. Duration - greater than 322 days; Objective- heal/maintain healing. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 8/6/2024 at 2:54 PM of Resident #12 revealed a 2-person mechanical lift transfer, by CNA M and CNA N, from the resident's padded Geri-chair to her low air loss mattress (a Geri-chair was a large ambulation device, similar to a wheel-chair, with a high back, foot stirrups, and extra padding; a mechanical lift was a sturdy based electronic lifting device that raised and lowered the resident.) Resident showed no signs of distress and made no verbal sounds of distress. Interview with CNA M revealed Resident #12 was transferred by mechanical lift with 2 people every time she was moved. When in bed, or in her Geri-chair, the resident was repositioned every two hours, or as needed. Resident was observed having been positioned on her right side and propped up with a pillow and blanket; not placed on her lower back area. Observations and interview on 8/7/2024 at 9:55 AM of Resident #12 revealed her in bed, positioned on her side, quietly resting. No distress noted. Observations of Resident #12's low air loss mattress system revealed the small rectangular box, kept at the foot of the resident's bed to regulate air pressure, did not show signs of power supply. The air hose was connected to the mattress and the electric cord led under the resident's bed; however, the green light was not illuminated and there were no sounds emitting from the small rectangular box. The facility's WND inspected the low air loss mattress system for power disruption. The WND discovered the power cord, which led under the resident's bed to the wall outlet, was not plugged into the wall outlet. The low air loss mattress system was not functioning as ordered because it was not plugged in. The WND was observed plugging the cord into the wall. The green light, on the small rectangular box, illuminated and there were sounds emitting from the small rectangular box. Interview with the WND revealed that nursing staff was trained to ensure the low air loss mattress systems were plugged in and always functioning. She did not know why the machine was unplugged. The WND stated Resident #12's inoperable low air loss mattress placed the resident at risk of worsening pressure ulcers and increased risk of skin breakdown in other areas. Interview on 8/7/2024 at 11:49 AM with CNA O revealed her shift began at 6:30 AM on 8/7/2024 and Resident #12 was in one of her assigned rooms. CNA O stated the purpose of Resident #12's low air loss mattress was to regulate the pressure of the resident's body weight against the mattress and make pressure adjustments as needed. When she came on shift, 6:30 AM on 8/7/2024, she stated she did not notice the green light on the small rectangular box was not illuminated. If the mattress was not functioning correctly, the air mattress could go flat, and the resident's body weight would press against the bed frame and cause skin breakdown. CNA O stated her instructions were to check on, and reposition, Resident #12 every two hours, or as needed to protect her skin. CNA O had not received any special instruction on troubleshooting the low air loss mattress system, or making sure it was always plugged in. Observation on 8/7/2024 at 12:35 PM of Resident #12's room revealed the low air loss mattress system was plugged in and the power light was illuminated green. Resident was not in the room. The plug, which attached to the wall outlet, was a firm connection. It did not wiggle to the touch. Observation on 8/7/2024 at 12:38 PM of Resident #12 in the lobby near the nurse's station revealed her resting in her padded Geri-chair. She was well groomed and was looking at her surroundings. She did not appear to be in any distress. Resident #12 was not interviewable. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 8/7/2024 at 2:15 PM with Resident #12's RP revealed he was aware that Resident #12 was treated for pressure ulcers. Resident #12's RP stated he was in the facility, on or about 8/1/2024, and noticed the low air loss mattress system was unplugged. He did not know why, and he did not say anything at the time. Resident #12's RP did not think Resident #12's care was neglected. Interview on 8/8/2024 with LVN P revealed that nursing staff was trained to check on, and reposition, residents every 2 hours or as needed for pressure ulcer prevention. Interventions for pressure ulcer relief were the use of soft materials to shift a resident's body weight from a particular spot, or to use special low air loss mattresses. LVN P stated nursing staff was trained to make sure the air mattresses were always plugged in. Inoperable low air loss mattress systems placed the resident at risk of worsening pressure ulcers and skin breakdown in other areas. Interview on 8/8/2024 at 9:25 AM with CNA Q revealed nursing staff was trained to prevent pressure ulcers in residents by making sure residents were out of the bed as much as possible, repositioned every 2 hours, and received barrier creams after incontinent care. CNA Q stated nursing staff was trained to make sure low air loss mattresses were in place, aired up, and under power. Residents who did not receive adequate treatment for pressure ulcers risked the worsening of existing wounds and the development of new wounds. Interview on 8/8/2024 at 9:54 AM with the DON revealed staff was trained to prevent pressure ulcers and skin breakdown by getting residents up, and out of bed, as much as possible. When in bed, or in a chair, staff was trained to check on, and reposition, residents every 2 hours. Nursing staff was trained to verify low air loss mattresses were filled with air, plugged in, and to check for supplied power. Residents who did not receive effective pressure ulcer prevention risked worsening wounds or the development of new wounds. There were no specific safeguards in place to have drawn attention to check for low air loss mattresses power supply. Interview on 8/8/2024 at 12:00 PM with HKS revealed her cleaning staff did not utilize electric equipment to clean the facility. She stated the housekeeping staff would not have had any reason to remove an electric cord from the wall in a resident's room. Interview on 8/8/2024 at 12:07 PM with the ADM revealed he expected his staff to provide pressure ulcer prevention in accordance with wound care/prevention policies, the CP, and doctor's orders. The failure to make sure the low air loss mattress system was plugged in fell upon staff observation while performing room rounds or providing care. There were no specific safeguards in place to periodically check for power supply to the low air loss mattress system. A resident having not received adequate pressure ulcer prevention risked delayed progress in healing current wounds and further development of others. Record review of the facility's In-Service Training, dated 7/2/2024, reflected it covered the facility's Skin and Wound Monitoring and Management Policy, dated December 2023. LVN staff attended training for skin and wound monitoring/management, completing daily wound care, and weekly skin assessments. It was the policy of the facility to have ensured any resident having had a pressure injury received any necessary treatments and services to have promoted healing, prevented infection, and prevented new avoidable pressure injuries from having developed. Prevention in the development of skin breakdown, or to have prevented existing pressure ulcers from worsening, required the use of pressure relieving/reducing devices such as low air loss mattresses. CNAs were supposed to review the CP for interventions; Licensed nursing staff were supposed to document the presence of reducing devices. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Pressure Ulcer Management Protocol Policy, dated May 2007, reflected the goal of pressure ulcer management/treatment was to prevent further deterioration of pressure ulcers. An intervention for pressure ulcers was the use of pressure relief devices, as indicated, based on therapy assessments.		

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F 0695 Level of Harm - Minimal harm or potential for 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** 49065 Based on observations, interviews, and record review the facility failed to ensure a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 3 of 3 residents (Residents #20, 46, and 298). The facility failed to ensure Resident #20's, #46's, and #298's oxygen tubing and humidifier bottles were dated to ensure they were changed weekly. This failure placed the residents at risk of developing a respiratory infection from contamination of the tubing and humidifier water. Findings include: Record review of Resident #20's undated face sheet reflected he was a [AGE] year-old male admitted [DATE] with diagnoses of Orthostatic Hypotension (unstable blood pressure), Malnutrition, COPD (lungs do not exchange oxygen well), Diabetes, Anxiety Disorder, Legal Blindness, Tumor of Pancreas, and Obesity. Record review of Resident #20's initial MDS assessment dated [DATE], reflected a BIMS score of 15, which indicated the resident's cognition was intact. The MDS also reflected the need for Oxygen treatments. Record review of Resident #20's Care Plan, reflected a Focus area was initiated 7/5/2024 for risk for skin impairment related to morbid obesity, limited mobility and oxygen use with a goal to maintain intact skin. Record review of Resident #20's Orders reflected a 7/4/2024 order for Oxygen at 3 Liters/Minute via nasal canula continuous flow. The orders also reflected an order to change oxygen tubing and humidifier bottle weekly, every Sunday night shift. Observation on 8/6/2024 at 10:28 am revealed Resident #20 with humidified oxygen connected to a nasal canula tubing with a flow rate of 3 liters/minute. The tubing and the humidifier water bottle did not have a date to indicate when they were last changed. Record review of Resident #46's undated face sheet reflected she was a [AGE] year-old female admitted [DATE] with diagnoses of COPD (lungs do not exchange oxygen well), Chronic Respiratory Failure with hypoxia (low oxygen), Reflux, Anemia, Malnutrition, weakness, and a 2nd degree burn. Record review of Resident #46's initial MDS assessment dated [DATE], reflected a BIMS score of 15, which indicated the resident's cognition was intact. Record review of Resident #46's Care Plan, reflected a Focus area was initiated 7/3/2024 for her breathing disease, COPD. The goal was to avoid rehospitalization and the interventions included oxygen therapy as ordered by the physician. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #46's Orders reflected a 6/20/2024 order for Oxygen at 2-4 Liters/Minute via nasal canula continuous flow. The orders also reflected a 6/20/2024 order to change oxygen tubing and humidifier bottle weekly, every Sunday night shift. Observation on 8/6/2024 at 10:12 am revealed Resident #46 with humidified oxygen connected to nasal canula tubing with a flow rate of 3 liters/minute. The tubing and the humidifier water bottle did not have a date to indicate when they were last changed. Record review of Resident #298's undated face sheet reflected he was a [AGE] year-old male admitted [DATE] with diagnoses of Cerebral Infarction (Stroke), Dysphagia (difficulty swallowing), left side paralysis, COPD (lungs do not exchange oxygen well), Chronic Respiratory Failure, Heart Failure, and Myocardial Infarction (heart attack). Record review of Resident #298's initial MDS assessment dated [DATE], reflected that the resident was too severely impaired to perform a BIMS. Resident was non-verbal himself and extremely limited in non-verbal responses. Record review of Resident #298's Care Plan, reflected a Focus area was initiated 7/21/2024 for Tracheostomy related to acute respiratory failure secondary to a stroke. The goal was to remain free of infection and the intervention included, Administer oxygen as needed. Record review of Resident #298's Orders reflected a 7/28/2024 order to change all respiratory connecting tubing, suction catheters, water trap, mask weekly, every Wednesday night shift. Observation on 8/6/2024 at 10:03 am revealed Resident #298 with humidified oxygen connected to tracheostomy tubing. Neither the tubing nor the humidifier bottle had a date to indicate when they were last changed. In an interview on 8/8/24 at 1:33 pm the DON stated the policy for changing oxygen tubing and the humidifier bottle was to change every 7 days on Wednesday night. She stated, changing it timely was important to prevent bacteria and infection. The DON stated, if it was not changed the resident would be at risk for an infection. In an interview on 8/8/24 at 1:48 pm the ADM stated, the policy for changing oxygen tubing and the humidifier bottle was that they are generally changed 1 x per week and changing it timely was important for infection control and preventing bacteria from growing. The ADM stated the negative outcome to residents if it was not changed, would be infections. Record review of the facility policy titled Oxygen Administration (Mask, Cannula, Catheter) with a last revised date of 05/2007 reflected the following: Oxygen tubing is to be replaced every 7 days. Oxygen mask or nasal prongs are to be replaced every 7 days. Replace disposable humidifiers every 7 days or as needed when empty. the policy did not address the labeling/dating.		

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F 0755 Level of Harm - Minimal harm or potential for 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** 38073 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident and to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 1 of 8 residents (Resident #74) reviewed for pharmaceutical services. The facility failed to ensure Resident #74's discontinued APAP/Codeine Tab 300-30 mg was removed from the medication cart and the failure to remove the discontinued APAP/Codeine resulted in one tablet of APAP/Codeine being removed and unaccounted for. This failure placed residents at risk of drug diversion and giving the wrong medication. Findings included: Review of the undated face sheet for Resident #74 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included spinal stenosis (a condition that narrows the space inside the backbone, putting pressure on the spinal cord and nerves), radiculopathy (pinched nerve), low back pain, generalized anxiety disorder, major depressive disorder, multiple sclerosis (potentially disabling disease of the brain and spinal cord), cognitive communication deficit, and chronic pain syndrome. Review of the quarterly MDS assessment for Resident #74 dated 06/06/24 reflected a BIMS score of 13, indicating intact cognition. It also reflected she had received scheduled and PRN pain medications and experienced pain frequently during the assessment period. Review of the care plan for Resident #74 reflected the following: [Resident #74] has potential for pain r/t MS, lumbar spinal stenosis, chronic pain and lumbar radiculopathy. Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Follow pain scale to medicate as ordered. Review of physician orders for Resident #74 reflected an order for APAP/Codeine Tab 300-30 mg started on 06/03/24 and discontinued on 07/10/24. Review of the July 2024 MAR for Resident #74 reflected APAP/Codeine Tab 300-30 mg administered on 07/07/24 and discontinued (with an x in the section indicating administration) on 07/10/24. Review of the Individual Patient's Antibiotic/Narcotic Record for Resident #74 dated 06/03/24 reflected an administration on 07/07/24 which brought the count to 29. This administration was documented by LVN I. An administration was documented on 07/15/24 (after the discontinue date) by someone with different handwriting, which brought the count to 28, but this administration had a line drawn through it. Another administration followed, this one with the date 09/17 , and this brought the count to 28. There was a number 27 in the Amt Remaining column, but it was crossed out. These last two lines had an illegible signature in the Nurse/Med Aide Signature column. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/24 at 09:30 AM, Resident #74 stated she did have pain, and she was given Tylenol for that sometimes. During an interview on 08/08/24 at 09:25 AM, LVN G stated she thought Resident #74 received Tylenol with codeine. She opened the medication cart and opened the narcotics drawer within. Observation on 08/08/24 at 09:26 AM revealed a blister package of APAP/Codeine Tab 300-30 mg for Resident #74 in the narcotics drawer of the medication cart serving halls 200 and 300. The blister package contained 28 pills. During an interview on 08/08/24 at 12:07 PM, the DON stated she had a quality improvement plan in place and had been doing spot checks more recently, but she had not addressed the specific system for making sure discontinued medications were pulled. She stated the process should have been to give her the discontinued medication. She stated she did not know who had administered the medication as she did not recognize the signature on the narcotic log for Resident #74's APAP/Codeine. She stated she did not have a way to track who was signing the narcotics log so she could be sure to address any discrepancies with the staff responsible. The stated the potential impact of the failure was giving the wrong medication. Review of in-services reflected one dated 06/15/24 and ongoing on MAR omission and Narcotics Process, signed by seven facility nurses. It also reflected an in-service conducted in July 2024 on medication errors and medication administration signed by medication aides and nurses.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were stored properly for 1 (Hall 200) of 2 Medication storage rooms reviewed for drug storage. The facility failed to ensure 2 expired I.V. PICC Line Stat lock Plus Stabilizations devices, 1 expired Covid 19 Test, and 3 expired laboratory bacterial swabs were removed from the Hall 200 medication storage room. These failures could place residents who needed I.V. medications at risk to have unsecured IV PICC Lines, which could cause the resident to have an unnecessary invasive PICC replacement procedure or put them at risk of infection. Expired Covid test and lab swabs could lead to inaccurate diagnosis and worsening of resident's health due to inaccurate and ineffective treatments. Use of these supplies would not meet acceptable standards of medical practice and could result in resident's harm. Findings include: Observation on [DATE] at 9:20 am of the Medication Room on hall 200 revealed the following: 2 I.V. PICC Line Stat lock Plus Stabilizations Devices-Expiration date of [DATE]. Lab supply: 1 Covid 19 Test Kit-Expiration date of [DATE] Lab supply: 3 Bacterial Swabs-Expiration date of [DATE] In an interview on [DATE] at 9:33 am LVN-A stated, the risk of using expired items is they may not be effective for treatment. Resident lab testing may not get appropriate result and an expired Stat Lock may not stick to the skin to maintain sterility and this could increase the risk of infection. LVN-A stated expired lab swabs and Covid Test may not catch accurate results. In an interview on [DATE] at 1:33 pm the DON stated, the policy for expired medical supplies is to destroy them. She stated this is important because they create a risk for altered lab results and identification of the wrong bacteria causing infections. The DON stated the negative outcome to residents would be infections, wrong medications, or wrong diagnosis of Covid. In an interview on [DATE] at 1:48 pm the ADM stated, the policy for expired medical supplies in the medication storage area is for them to be disposed of as the manufacturer recommends. He stated this is important because the supplies may not work as the manufacturer intended and that could cause infections for residents, or some items could lose potency if expired. Record review of the undated facility policy titled, Medication Storage reflected, Medications that are discontinued, expired, or deteriorated .are removed from the locked medication storage area and disposed of in accordance with the Facility policies and procedures.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that accommodated resident preferences for 1 of 8 residents (Resident #60) reviewed for food preferences. The facility failed to ensure Resident #60's lunch tray was free of iced tea, in accordance with his dislikes listed on his meal ticket, on 08/06/24, 08/07/24, and 08/08/24. This failure placed residents at risk of diminished quality of life. Findings included: Review of the undated face sheet for Resident #60 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral infarction (stroke caused by blocked blood vessel), hemiplegia and hemiparesis (paralysis on one side of the body), major depressive disorder, gastroesophageal reflux disease, benign prostatic hyperplasia (prostate swelling and disfigurement) with lower urinary tract symptoms, chronic kidney disease stage four, and cognitive communication deficit. Review of the quarterly MDS assessment for Resident #60 dated 07/22/24 reflected a BIMS score of 9, indicating moderate cognitive impairment. It reflected he required only supervision and set up with eating. Review of the care plan for Resident #60 dated 06/30/24 reflected the following: [Resident #60]'s ADL Self Care Performance Deficit r/t CVA with R sided weakness, impaired mobility. Will maintain current level of function in ADLs through the review date. EATING: The resident is able to feed self. Observation on 08/06/24 at 01:17 PM revealed Resident #60 had a meal ticket on his lunch tray with iced tea printed as one of his dislikes but iced tea was on his tray. Observation on 08/07/24 at 12:57 PM revealed Resident #60 had a meal ticket on his lunch tray with iced tea printed as one of his dislikes but iced tea was on his tray. Observation on 08/08/24 at 01:08 PM revealed Resident #60 had a meal ticket on his lunch tray with iced tea printed as one of his dislikes but iced tea was on his tray. During an interview on 08/08/24 at 01:00 PM, a FM of Resident #60 stated it was important that he not drink dark liquids such as tea and coffee, because he had kidney disease and was susceptible to dehydration. The FM stated he would not drink the tea because he knew better, but it felt insulting that the kitchen staff did not pay attention to his preferences. During an interview on 08/08/24 at 01:03 PM, DA H stated she spoke only Spanish. She stated she got the drinks ready on the trays. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/08/24 at 01:06 pm, the DM stated he thought DA H could read English on the tickets but was not sure. The DM stated he ensured resident preferences were honored by explaining to the kitchen staff about allergies and preferences and that dislikes were especially important. He stated a negative impact was the resident could get frustrated and depending on how cognitive they were, it might put them in an emotional state to shut down in the facility. During an interview on 08/08/24 at 03:24 PM, the ADM stated preferences needed to be followed. He stated it was the DM's responsibility to ensure that happened, and the nurse on the floor was also responsible for checking the trays to make sure they were accurate. He stated a potential impact of not honoring preferences on the residents was dissatisfaction. Review of facility policy dated 12/23 and titled Food and Nutrition Services reflected the following: It is the policy of this facility to assure that menus are developed and prepared to meet the nutritional needs of the residents and resident choices, including their nutritional, religious, cultural, and ethnic needs while using established national guidelines. Reasonable effort means assessing individual resident needs and preferences and demonstrating actions to meet those needs and preferences.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 38073 Based on observation, interview, and record review, the facility failed to ensure a nourishing snack was served at bedtime, when more than 14 hours and up to 16 hours elapsed between a substantial evening meal and breakfast the following day for 3 of 6 halls (100, 200, and 300 halls on the long-term care unit) reviewed for evening snack. The facility failed to offer or serve a substantial snack on the evening of 08/07/24 after dinner was served at 05:15 PM and breakfast was not served the next day until 08:00 AM (14.75 hours between meal services). This failure placed residents at risk of hunger and weight loss. Findings included: Observation on 08/07/24 at 07:30 PM revealed a snack tray on the long-term care side of the facility nurse's station (the station serving halls 100, 200, and 300) with sandwiches, bananas, oatmeal cream pies, pudding, juice, and peanut butter crackers at the nurse's station. The nurse's station had an open area where staff sat and documented and could see out and where residents could see in. There was another area of the nurse's station that was behind a wall and not visible to anyone not behind the desk. The snack tray was on the desk behind the wall where no residents could have seen it. There was a total of 20 food snacks and five cups of juice. Observation from 07:30 PM to 08:00 PM revealed the snacks were not offered to any resident, and no resident asked for the snacks. During an interview on 08/07/24 at 07:34 PM, CNAs E and F stated dining set out a snack tray at the nurse's station for residents to come get a snack if they wanted one. They stated they did not usually go around to each room and offer a snack. CNA E stated if every single resident wanted a snack, there would only be a snack on the tray for half the residents on that side of the facility. Observation on 08/07/24 at 07:37 PM revealed no tray of snacks on the skilled nursing side of the facility (halls 400, 500, and 600). During an interview on 08/07/24 at 07:35 PM, CNA C stated she was not sure who passed out snack on the skilled nursing side of the facility. During an interview on 08/07/24 at 07:40 PM, LVN D stated there had been snacks on the skilled side of the facility that night and they were being passed out. During interviews on 08/07/24 between 07:45 and 08:00 PM six anonymous residents stated they did not receive snacks regularly around bedtime and had not received any snacks that night and did not know there were any available. Each of the six residents stated they did want snacks and would have enjoyed having a snack at bedtime. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/08/24 at 01:06 PM, the DM stated dinner had been served at 05:15 PM the night before and breakfast served that morning at 08:00 PM. He stated he prepared the snack trays for bedtime hour, but he did not ensure they were offered. He stated snacks should have been offered at night, because there were more than 16 hours between supper and breakfast. He stated a potential impact of not offering snacks was they might get hungry or not have their nutritional needs met. During an interview on 08/08/24 at 03:24 PM, the ADM stated snacks should be offered to residents at night, not just sit at the nurse's station for people to come request. The ADM stated he had already talked to the DON about how snacks should have been offered and that bowls of snacks should be more available. A potential negative impact of not offering snacks at bedtime was residents might be hungry or depressed. A facility policy on Snacks was requested but not provided by the time of exit.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections for 1 of 1 resident (Resident #12) reviewed for infection control. The facility failed to ensure WND performed proper hand hygiene when performing wound care on Resident #12. This failure could place residents at risk for development of communicable diseases and infections. Findings include: Record review of Resident #12's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Dementia, Multiple Sclerosis (Disease that weakens muscles), Malnutrition, Stage 4 Pressure Ulcer, and Dysphagia (difficulty swallowing). Record review of Resident #12's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 3, which indicated the resident's cognitive ability was severely impaired. The MDS also indicated she was at risk for pressure ulcers. Record review of Resident #12's Care Plan, reflected a Focus area was initiated for a Stage 4 pressure wound coccyx, on 12/18/23 with a goal to remain free from infection. Resident #12's interventions included to administer treatments as ordered by physician. Record review of Resident #12's Orders, reflected wound care ordered 1/31/2024 for Stage 4 pressure wound coccyx (tailbone) full thickness. Cleanse site with normal saline/wound cleanser, pat dry, apply Leptospermum Honey and Silver Alginate Calcium, cover with foam with border dressing daily. Record review of Resident #12's Orders, reflected wound care ordered 11/15/2023 for peg (feeding tube) site MASD (Moisture-Associated Skin Damage): clean area with Vashe wound cleanser, pat dry, apply Calcium Alginate and cover with split gauze, change daily and as needed for soiling or dislodgement. Observation on 8/7/2024 at 10:16 am revealed WND removed Resident #12's soiled dressing from the coccyx pressure ulcer wound, cleaned the site, and reapplied a new dressing as ordered by the physician. WND did not change her gloves and sanitize her hands between the soiled dressing removal and reapplying the clean dressing. The pressure ulcer did not show any signs of infection. Observation on 8/7/2024 at 10:16 am revealed after completing the pressure ulcer dressing, WND then changed her gloves and sanitized her hands. Observation then revealed that WND removed the soiled dressing from the feeding tube site, cleaned the site and reapplied a new dressing as ordered by the physician. WND did not change her gloves and sanitize her hands between the soiled dressing removal and reapplying the clean dressing. The tube site did not show any signs of infection. (continued on next page)		

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 08/08/2024
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/7/2024 at 10:41 am the WND stated, she did not remove her gloves and sanitize her hands between removing the 2 soiled dressings and applying the new dressings and there was no sanitizing gel on her table of supplies. She stated that she knows to perform that step and usually does do it, but she forgot today. The WND stated the reason to change gloves and sanitize between the dirty step (removing soiled dressings) and the clean step (applying new dressings) was to avoid cross-contamination for infection control. She stated the result of not doing so could lead to infections in the wounds. She also stated, the coccyx wound had improved and then worsened again. In an interview on 8/7/2024 at 1:33 pm the DON stated, the policy for using hand hygiene during wound care was to do hand hygiene before, during, and after. She stated hand hygiene should be done between dirty and clean steps, during wound care. The DON stated, it was important to do hand hygiene between dirty and clean steps to prevent infection and the negative outcome to a resident if it was not done was wound infections and worsening wounds. In an interview on 8/7/2024 at 1:48 pm the ADM stated, the policy for using hand hygiene during wound care was to do hand hygiene before and after. He stated hand hygiene was important for infection control and to stop bacteria and the negative outcome to residents if it was not done would be increased infections. A record review of the facility policy titled, Hand Hygiene and dated 05/2007 with a last revision date of 12/2023 reflected the following: It is the policy of this facility to provide the necessary oversight to ensure healthcare workers perform hand hygiene, which is one of the most effective measures to prevent the spread of infection, based on accepted standards. Use an alcohol- based hand rub g) before handling clean or soiled dressings, gauze pads, etc . Use an alcohol- based hand rub h) before moving from a contaminated body site to a clean body site during resident care. Use an alcohol- based hand rub k) after handling used dressings.		