

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

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Form Approved OMB
No. 0938-0391

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 09/17/2025
NAME OF PROVIDER OR SUPPLIER Park Manor Bee Cave		STREET ADDRESS, CITY, STATE, ZIP CODE 14058 Bee Caves Parkway, Bldg B Bee Cave, TX 78738	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for infection control. The facility failed to maintain infection control practice and proper hand hygiene when preparing meals. These failures could place residents at risk for consuming contaminated food and developing foodborne illnesses. Findings Included: An observation was conducted on 09/17/2025 at 11:15AM in the kitchen. During the observation, [NAME] A had started the meal preparation for the puree foods. [NAME] A had put on a pair of gloves and placed the menu item food into the blender. When the menu item, bread, was pureed, [NAME] A removed their gloves, rinsed their hands off and grabbed new gloves. [NAME] A did not wash their hands or use hand sanitizer after removing the gloves. After [NAME] A put the new gloves on. [NAME] A washed, rinsed, and sanitized the blender. [NAME] A then removed his gloves and placed them into the trash can, grabbed new gloves and put those on. [NAME] A grabbed a new menu item food and started the puree process again in the blender. [NAME] A finished the puree of the pasta noodles and cleaned the blender while wearing the same pair of gloves. [NAME] A did not remove his gloves or use proper hand hygiene between washing the blender and prepping the new menu item of alfredo sauce. [NAME] A continued to use the same pair of gloves until [NAME] A finished pureeing the alfredo sauce. An interview was conducted on 09/17/2025 at 11:30AM with the KM. The KM stated they had been employed at the facility for 13 months and had received training on hand hygiene and the puree process. The KM described the hand hygiene policy as:Wash hands between tasks.Wash hands when you enter the kitchen.Gloves should be changed every 4 hours of when staff go from handling one food item to another food item. The KM stated that not following proper hand hygiene and glove wearing, it could negatively affect a resident by the increased risk of cross contamination. The KM stated that [NAME] A should have discarded the gloves that were worn in between food items and performed proper hand hygiene. An interview was conducted on 09/17/2025 at 1:12PM with [NAME] A with the KM as an interpreter due to a language barrier. [NAME] A stated they had been employed at the facility for a while now. [NAME] A stated he had received training for hand hygiene. [NAME] A described the hand hygiene process asScrubbing hands with soap and water for 20 seconds. Removing gloves after staff washed the dishes. Performing hand hygiene after wearing gloves.Cook A stated that not performing proper hand hygiene and using dirty gloves, could negatively impact a resident by the possibility of infecting the food with cross contamination. [NAME] A stated he was aware that he kept on the gloves to prepare the food after washing the dishes and explained it was because he forgot. [NAME] A stated that he was nervous and did not follow proper hand hygiene protocol.An interview was conducted on 09/17/2025 at 2:50PM with the DON. The DON stated they had been employed at the facility for 1 year and 3 months. The DON stated the KM provides training for staff in the kitchen. The DON stated the expectation is to perform hand hygiene before service, after service, and in between tasks in the kitchen. The DON stated that not performing proper hand hygiene could negatively affect residents by the increased risk of cross contamination. The DON stated it was not effective practice for [NAME] A to wear the same gloves after prepping the food, (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	washing the dishes, and prepping more food. The DON stated that [NAME] A should have discarded the gloves and perform hand hygiene after prepping the food and starting the dishes. An interview was conducted on 09/17/2025 3:10PM with the ADM. The ADM stated they had been employed at the facility for 1 year and 1 month. The ADM stated he had received training on resident rights and described their rights as the right for self-determination, make their own choices and the right to choose their care. The ADM stated that the KM provides the training to kitchen staff. The ADM stated the expectation for hand hygiene in the kitchen was to perform it before, during and after the service. The ADM stated a negative impact it could have on residents if hand hygiene were not followed accurately could be infection control issues, cross contamination issues, and potentially make the residents sick. The ADM stated that it was not effective practice for [NAME] A to wear the same gloves during food preparation, washing the dishes, and continuing food preparation. The ADM stated gloves should have been removed when switching tasks or finishing a task. The ADM also stated that gloves should have been switched when leaving food prep to wash the dishes. Record review of an undated document titled 228.37 (10)(D)(vi)(I) revealed the document reflected the following information: Food Employees shall keep their hands and exposed portions of their arms clean. Food employees shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms: Rinse under clean, running warm water Apply cleaning compound recommended by the cleaning compound manufacturer. Rub together vigorously for 10-15 seconds Thoroughly rinse under clean, running warm water Immediately follow the cleaning procedure with thorough drying using a method as specified under 2287.175(c) Food Employees shall clean their hands and exposed portions of their arms as specified under subsection b immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and After touching bare human body parts other than clean hands and clean exposed portions of arms After handling soiled equipment or utensils During food preparation as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. Before donning (put on) gloves to initiate a task that involves working with food		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, interviews, 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 for 3 of 8 residents (Residents #44, #45 and #74) and 2 of 4 medication carts (100/300-hall nurses' cart and 600-hall med aide' cart) reviewed for pharmacy services. A) The facility failed to ensure expired medication Refresh eye P.M. Ointment for Resident #44 opened on 8/10/25, was removed from the 600-hall med aide medication carts after 30 days of opening. B) The facility failed to ensure an expired medication bottle of nitroglycerin tablets sublingual 0.4 mg was removed from the 100/300-hall nursing cart.C) The facility failed to ensure an insulin pen for Resident #74 was labeled with an open date. The failures could place residents at risk of receiving an expired medication, not reaching the intended therapeutic dose, and/or contamination from expired supplies. Record review of Resident #44's admission record, dated 09/17/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #44 had diagnoses which included: unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), memory deficit following cerebral infarction (when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients), dysphagia (difficulty swallowing) and major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #44's order summary, dated 09/17/2025, reflected an active order for Refresh P.M. Ointment (White Petrolatum-Mineral Oil) instill 1 ribbon in both eyes at bedtime for dry eyes ordered on 05/16/2022. Observation on 09/16/2025 at 03:36 PM of the 600-hall med aide's medication cart revealed one tube of sterile lubricant eye ointment with open date of 08/10/2025. During an interview on 09/16/2025 at 03:38 PM, MA E stated the nurses' medication cart was to be checked weekly on a schedule for expired medications and supplies, though she was unsure of the schedule or who was responsible for checking the carts. MA E reviewed the eye ointment found in her medication cart and confirmed it was expired. She stated that according to the facility's policy she was trained that all eye drops and ointments should be removed from the medication cart and discarded after one month post opening. She stated if medication was used on a resident after the medication's expiration date, then the medication may not be as effective and the resident may not receive the intended benefits from the medication, or the resident may have an adverse reaction to the medication. Record review of Resident #74's admission record, dated 09/17/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #74 had diagnoses which included: unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs), chronic kidney disease (a condition in which the kidneys gradually lose their ability to filter waste products from the blood) and type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels). Record review of Resident #74's order summary, dated 09/17/2025, reflected an active order for Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 23 unit subcutaneously one time a day for DM2 proscribed on 08/26/2025. Observation on 09/16/2025 at 03:15 PM of the 100/300-hall nurses medication cart revealed one insulin pen with Lantus insulin for Resident #74 was opened but not labeled with an open date. During an interview on 09/16/2025 at 03:18 PM, LVN G stated the nurses' medication cart was to be checked weekly on a schedule for expired medications and supplies. She stated that she was responsible for dating the insulin pen once it had been opened. She revealed that she was away for a (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	few days, and it was her first day to come back and she usually dated all insulin pens right away and today she was very busy and forgot. She stated if an insulin pen was opened and not dated the medication may not be as effective and the resident may not receive the intended benefits from the medication, or the resident may have an adverse reaction to the medication. The record review of undated facility policy on Insulins and storage requirements for Insulin Glargine (Lantus) revealed insulin should be labeled immediately after opening and stored once opened on medication cart once in use and not refrigerated for 28 days. Record review of Resident #45's admission record, dated 09/17/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #45 had diagnoses which included: spinal stenosis (a condition where the spinal canal, the space within the spine that houses the spinal cord and nerve roots, becomes narrowed), type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), and heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs). Record review of Resident #45's order summary, dated 09/17/2025, reflected an active order for Nitroglycerin Tablet Sublingual 0.4 MG Give 1 tablet sublingually every 5 minutes as needed for Chest Pain x 3 doses ordered on 08/13/2024. Observation on 9/16/2025 at 04:32 PM of the 100-hall nurses medication cart revealed one medication bottle of nitroglycerin tablets sublingual 0.4 mg with an expiration date [DATE] prescribed to Resident #45. During an interview on 09/17/2025 at 03:22 PM, DON stated the staff responsible for the medication cart were responsible for checking for expired medications in the cart every shift. She stated the pharmacy consultant ensured all expired medications were removed from the medication carts, but she was unsure of the frequency. She stated that ADONs also randomly picked medication carts for audit on a weekly basis. The DON stated if expired medications were administered to residents, then the resident would not get the therapeutic dose of the medication. She confirmed that according to the facility policy expiration date for eye drops was 30 days once opened and dated. She stated that nurses were required to date insulin once opened and date it to ensure it stored on the nursing cart for up to 28 days. Record review of the facility's policy titled Policy/Procedure- Nursing Clinical. Medication access and storage, dated 05/09/2007, reflected: Outdated, contaminated, or deteriorated medications removed from stock, disposed according to procedures for medication destruction, and reordered from the pharmacy if a current order exist.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored in locked compartments and permitted only authorized personnel to have access to the keys for 1 of 6 medication and treatment carts. The facility failed to ensure that a treatment cart located in the activity room area between the 100 and 200 halls was locked with keys left on the cart accessible to anybody including residents in the facility. The failure could place residents at risk of injury if medications and biologicals left unsecured were consumed. During an observation on 09/15/2025 from 09:31 PM - 10:05 AM revealed a nurse's treatment cart was left unlocked and unattended with keys left on the top of the cart near the activity room between the 100 and 200 halls. During the observation multiple nursing staff passed the cart without securing the cart and taking the keys. At 10:05 AM the MDS nurse approached the cart and secured it and took the keys with her. The cart drawers were opened by the surveyor to verify that the cart was unlocked. During an interview on 09/15/2025 at 10:05 AM, the MDS nurse stated she did not know who left the keys on the nursing treatment cart which was a spare treatment cart, and these keys were a spare set of keys too. She stated that leaving the cart unlocked could potentially harm the residents if they opened drawers and accessed potentially hazardous items like sharp tools and strong cleaning solutions. She confirmed that unauthorized access to the treatment cart could compromise a sterile environment, patient and staff safety, and maintaining inventory control. During an interview on 09/16/2025 at 3:12pm, LVN G stated that nursing staff assigned to the medication or treatment carts were responsible for locking the carts to prevent potential risk to residents' health. She stated that she was in- serviced regarding the facility's policy on Medication Access and Storage which required securing medication carts. During an interview on 09/16/2025 at 3:45pm, the MA E stated that she always secured her medication cart when not using it and was in-serviced regarding the policy of Medication Access and Storage. She stated that the potential risk to residents' health if left the nursing cart unattended and unlocked would be them getting into the cart and swallowing the medications and potentially poisoning themselves. During the interview on 09/17/2025 at 1:55PM, the DON stated her expectation of staff when they walk away from the medication or treatment carts was to lock them and not leave keys unattended. She confirmed that staff who was assigned to work on those carts are responsible for locking them. DON could not identify who was assigned to that treatment cart as it was a spare treatment cart. She stated herself, her ADONs and charge nurses visually monitor nursing, medication and treatment carts daily. She stated that if left unlocked medication or treatment carts can be accessed by residents and potentially consume medications or biologicals kept on the cart which could cause the harm to their health. Record review of undated facility policy Policy/Procedure - Nursing Clinicals. Care and Treatment: Medication Access and Storage revealed Procedure 2: Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.		