

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/29/2025
NAME OF PROVIDER OR SUPPLIER Estates at Shavano Park		STREET ADDRESS, CITY, STATE, ZIP CODE 4366 Lockhill Selma Shavano Park, TX 78249	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 5 residents (Resident #3) whose assessments were reviewed. The facility failed to indicate Resident #3 received oxygen on her Quarterly MDS dated [DATE]. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #3's admission Record dated 09/28/2025, revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #3's Physician Progress Note, dated 09/24/25, revealed she was a [AGE] year-old female with a past medical history which included acute respiratory failure with hypoxia (difficulty breathing resulting in low levels of oxygen in the blood), high blood pressure, congestive heart failure (inability of the heart to adequately pump blood in the body resulting in fluid around the heart and lungs) and pneumonia (a type of lung infection) and the resident received supplemental oxygen. Record review of Resident #3's Quarterly MDS Assessment, dated 09/07/2025, revealed a BIMS score of 15 out of 15 which indicated her cognitive skills for daily decision making were not impaired, and under Section O it was not checked she received oxygen. Record review of Resident #3's care plan, initiated 06/30/2025, for the focus area of I have oxygen therapy related to ineffective gas exchange, and respiratory illness revealed under Interventions was to administer oxygen at 2 LPM via nasal cannula (a specialized tube with prongs into the nose that delivers oxygen from an oxygen concentrator) to maintain blood oxygen saturations above 92%. Record review of Resident #3's Physician's Order Summary, dated 09/28/2025, revealed there was no order for oxygen administration. Record review of Resident #3's electronic clinical record vital signs sections for blood oxygen saturation revealed on 09/03/2025, 09/05/2025 and on 09/07/2025 she received oxygen via nasal cannula. Observation on 09/28/2025 at 8:52 AM revealed Resident #3 was in bed and received oxygen at 2 LPM via nasal cannula. Interview on 09/29/25 at 12:51 PM, the MDS Nurse stated she would look at the resident's entire electronic clinical record and/or their hospital record when the MDS was completed to ensure it was accurate. The MDS Nurse reviewed Resident #3's Quarterly MDS dated [DATE] and stated the oxygen was not checked because she had reviewed the MARs which did not indicate the resident had received oxygen. The MDS Nurse reviewed Resident #3's vital signs section in the electronic clinical record for oxygen saturation and verified Resident #3 received oxygen during the look-back period the MDS was completed and the MDS should have been checked the resident received oxygen. The MDS Nurse stated she was responsible for ensuring the MDS was completed accurately and the harm of not having the MDS completed accurately could result in other health care members not know the resident needed oxygen. In an interview on 09/29/25 at 1:53 PM, the Executive Clinician stated the MDS Nurse was responsible for ensuring the accuracy of the MDS assessments and the harm of an inaccurate MDS could result inaccurate plan of care for the resident. In an interview on 09/29/2025 at 2:13 PM, the Executive Director stated the Executive Clinician and the Corporate MDS Nurse oversaw the residents' MDS assessments to ensure they were accurate and if the MDS assessment was not completed accurately, then the care administered to the resident might not be appropriate for the resident. Record review of CMS's RAI Version 3.0 Manual, dated October 2025, CH 3: MDS Items O, page O-4, revealed under Section O, oxygen should be checked if a resident received oxygen either continuous or intermittent in the past 14 days. Record review of the facility's policy Resident Assessment Instrument, revised December 2024, revealed a comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews. 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice for 1 of 2 residents (Resident #3) reviewed for respiratory care. Resident #3 received oxygen at 2 liters per minute via nasal cannula without a physician order. This failure could affect residents with oxygen therapy and could lead them to a lack of care. The findings included: Record review of Resident #3's admission Record dated 09/28/2025, revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #3's Physician Progress Note, dated 09/24/25, revealed Resident #3 was a [AGE] year-old female with a past medical history which included acute respiratory failure with hypoxia (difficulty breathing resulting in low levels of oxygen in the blood), high blood pressure, congestive heart failure (inability of the heart to adequately pump blood in the body resulting in fluid around the heart and lungs) and pneumonia (a type of lung infection) and the resident received supplemental oxygen. Record review of Resident #3's Quarterly MDS Assessment, dated 09/07/2025, revealed a BIMS score of 15 out of 15 which indicated her cognitive skills for daily decision making were not impaired, and it was not checked she received oxygen. Record review of Resident #3's care plan, initiated 06/30/2025, for the focus area of I have oxygen therapy related to ineffective gas exchange, and respiratory illness, revealed under Interventions was to administer oxygen at 2 LPM via nasal cannula (a specialized tube with prongs into the nose that delivers oxygen from an oxygen concentrator) to maintain blood oxygen saturations above 92%. Record review of Resident #3's Physician's Order Summary, dated 09/28/2025, revealed there was no order for oxygen administration. Record review of Resident #3's electronic clinical record vital signs section for blood oxygen saturation revealed on 09/03/2025, 09/05/2025, 09/07/2025, 09/09/2025, 09/10/2025, 09/11/2025, 09/12/2025, 09/14/2025, 09/16/2025, 09/17/2025, 09/18/2025, 09/19/2025, 09/21/2025, 09/24/2025, 09/25/2025, 09/26/2025, 09/27/2025, and 09/28/2025 Resident #3 received oxygen via nasal cannula. Observation on 09/28/2025 at 8:52 AM revealed Resident #3 was in bed and received oxygen at 2 LPM via nasal cannula. In an interview on 09/28/25 at 2:44 PM, after LVN A reviewed Resident #3's physician orders, she stated the resident did not have an order for oxygen and Resident #3 should have an order since the resident received oxygen. LVN A stated the harm of not having an order for oxygen could cause respiratory distress if she [the resident] didn't have it [oxygen] or too much [oxygen] could be administered. In an interview on 09/29/25 at 1:53 PM, the Executive Clinician stated when a resident received oxygen, they should have an order for the oxygen and the harm of not having an order could result in the oxygen treatment not being monitored. The Executive Clinician said she and the ADON were responsible for ensuring the resident's clinical records were accurate and they would review the orders from the hospital when the resident was admitted or readmitted to the facility to ensure the orders were accurate. In an interview on 09/29/2025 at 2:13 PM, the Executive Director stated when a resident received oxygen it should be documented in their clinical record, in their plan of care, and there should be an order for the oxygen. The Executive Director stated the harm of not having an order for oxygen was there would not be any documentation that it was ordered by the physician and any treatment would have to have a doctor's order. Record review of the facility's policy Oxygen Administration, revised October 2010, revealed The purpose of this procedure is to provide guidelines for safe oxygen administration.1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.</p>		