STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745001	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates at Shavano Park	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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that licensed nurses have the specific competencies, and skill sets necessary to care for two (2) residents' (Resident #1 and Resident #2) needs for one (1) of five (5) licensed nurses (the ADON) reviewed for staff competency. 1. While providing wound care for Resident #1 on 11/24/2025, the ADON did not fully cover the resident's wound bed with the calcium alginate dressing per physician order.2. While providing wound care for Resident #1 on 11/25/2025, the ADON did not date or initial the wound dressing.3. While providing wound care for Resident #2 on 11/25/2025, the ADON did not date or initial the wound dressing. These failures could place residents at risk for improper care and complications of residents' medical care.The findings included: 1. Record review of Resident #1's admission Record, dated 11/24/2025, reflected a [AGE] year-old female. She was admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 11/24/2025, revealed diagnoses included enterocolitis (an inflammation that occurs in a person's digestive tract) due to clostridium difficile (a bacterium that causes severe diarrhea), diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 10, indicating she had moderate cognitive impairment. She had a diabetic foot ulcer with an application of dressings to the feet for treatment. Record review of Resident #1's Care Plan Report, undated and electronically accessed 11/24/2025, revealed the following focuses and corresponding interventions/tasks: - Focus: I have Diabetic Ulcer to right heel r/t Diabetes/PVD, date initiated 09/03/2025 and date revised 11/11/2025. - Intervention: Ensure appropriate protective devices are applied to affected areas., date initiated 09/03/2025. - Focus: Resident is at risk for pressure ulcers r/t decreased mobility., date initiated 09/18/2025 and revised 11/11/2025. - Intervention: Administer treatments as ordered and monitor for effectiveness., date initiated 09/18/2025. Record review of Resident #1's Order Summary Report, dated 11/24/2025 at 04:47 p.m. with active orders as of 11/24/2025, revealed the following order:- Cleanse R heel with wound cleanser or normal saline [water with dissolved salt]. pat [sic] dry. Apply santyl [sic; a topical medication used to remove dead tissue from wounds and promote healing] and calcium alginate [a type of wound dressing that absorbs the secretions from a wound and promotes healing] to wound bed and cover with dry dressing. daily [sic] and prn. every [sic] day shift for wound care, order status noted as active and dated 11/24/2025. During an observation and interview on 11/24/2025 at 03:55 p.m., Resident #1 was observed lying in bed with heel protective booties on both feet. She revealed she had had a wound on her right foot for at least a week or two. She stated she was waiting for the nurse to provide treatment for it. She stated she was not concerned about the care provided by the nursing staff. During an observation on 11/24/2025 at 04:34 p.m., the ADON performed wound care for Resident #1. During wound care, the ADON cleansed the wound with wound cleanser and patted dry. She applied the Santyl ointment, followed by the calcium alginate dressing to the wound bed. The calcium alginate dressing was observed not applied to the center of the wound resulting in a visible portion of the medial (towards the center of the body) half of the wound not covered by the calcium alginate dressing. A dry dressing with the date and the ADON's initials was applied over the entire wound. 2. During an observation on 11/25/2025 at 10:34 a.m., the ADON performed wound care for Resident #1. During wound care the ADON was observed to apply the dry dressing to cover the wound. The dry dressing was undated and not initialed. 3. Record review of Resident #2's admission Record, dated 11/25/2025, reflected a [AGE] year-old male. He was admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #2's Diagnosis Report, dated 11/25/2025, revealed diagnoses included unsteadiness on feet, moderate protein-calorie malnutrition (lack of proper nutrition), colostomy status (an opening in the colon that allows stool to exit the body into a pouch without going through the anus), and stage four pressure ulcer (defined as the most severe form of an injury to the skin and tissue below the skin caused by prolonged pressure on a specific area of the body with full-thickness tissue loss) of sacral region (the triangular region at the base of the spine and just above the buttocks). Record review of Resident #2's admission MDS, dated [DATE], revealed the resident had a BIMS score of 15, indicating he was cognitively intact. He had an ostomy (a surgically created opening in the body which may include a colostomy, which is a surgical opening in the intestine allowing organic matter to exit the body without going through the anus), one stage 4 pressure ulcer was present

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for two (2) of two (2) residents (Resident #1 and Resident #2) reviewed for infection control. 1. The facility failed to post signage on 11/24/2025 to indicate Resident #1 was ordered to be on contact isolation precautions prior to or immediately upon notification of the order. While providing wound care for Resident #1 on 11/24/2025 and 11/25/2025, the ADON did not wash her hands prior to or after providing wound care to a resident who was on contact precautions. The ADON did not sanitize her hands between glove changes. While providing wound care for Resident #1 on 11/25/2025, the ADON placed open wound care supplies directly on the resident's bed. 2. While providing wound care for Resident #2 on 11/25/2025, the ADON did not sanitize her hands between glove changes. These failures could place residents at risk for infection due to improper care practices. The findings included: Record review of Resident #1's admission Record, dated 11/24/2025, reflected a [AGE] year-old female. She was admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 11/24/2025, revealed diagnoses included enterocolitis (an inflammation that occurs in a person's digestive tract) due to clostridium difficile (a bacterium that causes severe diarrhea), diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 10, indicating she had moderate cognitive impairment. She had a diabetic foot ulcer with an application of dressings to the feet for treatment. She had an active diagnosis of pneumonia and received antibiotic medication during the last seven (7) days reviewed or since admission/entry or reentry. Record review of Resident #1's Care Plan Report, undated and electronically accessed 11/24/2025, revealed the following focuses and corresponding interventions/tasks: - Focus: I have Diabetic Ulcer to right heel r/t Diabetes/PVD, date initiated 09/03/2025 and date revised 11/11/2025. - Intervention: Monitor/document/report to MD PRN any s/sx of infection: ., date initiated 09/03/2025.- Focus: Resident has a condition which requires contact isolation. [C-diff], date initiated and revised 09/18/2025. - Intervention: Educate resident and family members on standard precautions., date initiated 09/18/2025. - Intervention: In-service direct care staff on contact isolation techniques, date initiated 09/18/2025. Record review of Resident #1's Order Summary Report, dated 11/24/2025 at 04:47 p.m. with active orders as of 11/24/2025, revealed the following order:- Cleanse R heel with wound cleanser or normal saline [water with dissolved salt]. pat [sic] dry. Apply santyl [sic; a topical medication used to remove dead tissue from wounds and promote healing] and calcium alginate [a type of wound dressing that absorbs the secretions from a wound and promotes healing] to wound bed and cover with dry dressing. daily [sic] and prn. every [sic] day shift for wound care, order status noted as active and dated 11/24/2025.- Resident is on EBP and Standard Precautions R/T wound care- any skin opening that requires a drg.Don [put on] PPE inside the room. every [sic] shift for Enhanced barrier precautions related to medical condition Staff [sic] must don gown &gloves [sic] when performing high contact care such as. dressing changes., order status noted as active and dated 11/17/2025.- Resident is on strict isolation R/T (C-diff). Contact Isolation [sic] Resident will receive all services including but not limited to.treatments and nursing services in their room. every [sic] shift for Isolation medical condition, order status noted as active and dated 11/24/2025. Record review of Resident #1's Progress Note, dated 11/24/2025 for progress notes effective 10/25/2025 to 11/25/2025, revealed:- a progress note dated 11/24/2025 at 02:27 p.m. revealed Resident #1 had a diabetic foot ulcer present on admission. - a progress note dated 11/24/2025 at 03:08 p. m. revealed Resident #1 arrived to the facility by ambulance. During an observation on 11/24/2025 at 03:51 p.m., Resident #1's door was observed to be open with the end of Resident #1's bed and her feet, in heel protective booties, visible from the hallway. Next to the door opening, a sign noted the resident was on enhanced barrier precautions. During an interview on 11/24/2025 at 03:55 p.m., Resident #1 revealed she had just returned, that same day, from the hospital. She stated she had gone to the hospital due to having diarrhea for a week prior to her transfer to the hospital. Resident #1 stated she had wounds on her feet prior to her admission to the facility and thought they were improving. She denied concerns regarding wound care provided by facility staff. She was unaware of contact precautions/ isolation during the interview. During an