

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 12/06/2024
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)
<p>F 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</p> <p>Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 8 residents (Resident #2) reviewed for resident rights.</p> <p>Resident #2's meal ticket referred to an assistive cup as a sippy cup to be used during meal service.</p> <p>This failure could place residents at risk for diminished quality of life, loss of dignity, and self-worth.</p> <p>The findings included:</p> <p>Record review of Resident #2's face sheet, dated 12/6/2024, reflected a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (condition that affects one side of the body usually caused by a stroke that can cause paralysis), a traumatic brain injury, and a cerebral infarction (stroke).</p> <p>Record review of Resident #2's quarterly MDS Assessment, dated 9/28/2024, reflected a BIMS score of 13, indicating that the resident's cognition was intact. Further record review reflected that Resident #2 needed setup or clean-up assistance with eating .</p> <p>Record review of Resident #2's Comprehensive Person-Centered Care Plan, undated, reflected that Resident #2 used a divided plate to assist with meals and an assistive cup.</p> <p>Record review of Resident #2's order summary report, dated 12/6/2024, reflected an order for a Modified diabetic (CC) diet Regular Texture, Thin (Level 0 - Thin) consistency, L7 texture, Divided Plate, 2 handle or mug with lid, with an order start date of 4/24/2024.</p> <p>Observation, record review, and interview on 12/3/2024 at 1:13 PM reflected a meal ticket with Resident #2's name on it, reflecting Assist Instructions: Divided Plate/Sippy Cup. Resident #2 stated while it did not bother him, he could see how/why it would bother someone.</p> <p>(continued on next page)</p>

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 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 12/3/2024 at 1:16 PM, LVN B was checking the meal trays against the meal tickets. LVN B stated she was making sure the textures were correct and that each tray had everything on it according to the meal ticket . LVN B stated that the dietary department is responsible for the meal tickets.</p> <p>In an observation and interview on 12/4/2024 at 12:35 PM, CS C while speaking to Resident #2, before the meal trays were delivered, stated, Resident #2, you need a 'sippy' cup? CS C stated the DM entered the terms in the computer, and that was how it was printed on the meal tickets. CS C stated, Even as I went to door of kitchen, I just asked for a cup for Resident #2, and kitchen staff replied, a 'sippy' cup, right? CS C stated that was how everyone called it [the spouted, spill proof cup], so that was what she did too. CS C stated she could possibly use the term, special cup, or adaptive cup. CS C stated no one had corrected her before and could not recall if that information was included in training .</p> <p>In an observation and record review on 12/4/2024 at 12:47 PM, Resident # 2 was assisted by staff with his tray set up. Staff were removing lids and cutting up meat. The meal ticket indicated divided plate/sippy. Please refer to P1.</p> <p>Interview on 12/6/2024 at 11:45 AM, the DM stated that she realized sippy cup was not the appropriate terminology for the assistive cups once the state surveyors began asking about it and had changed it to 2 handle cup or mug with lid on meal tickets . DM stated it could affect the dignity of residents.</p> <p>Record review of the facility policy titled, Quality of Life - Dignity, dated reviewed December 2023, reflected Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.</p>		

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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>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</p> <p>S483.20(g) Accuracy of Assessments.</p> <p>The assessment must accurately reflect the resident's status.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Quarterly comprehensive assessment accurately reflected the resident's status for 1 of 6 [Resident #33] residents reviewed for accuracy of assessments in that Residen #33's diagnosis was not coded.</p> <p>1. The facility failed to accurately code Resident #33 diagnosis status on the quarterly comprehensive assessment dated [DATE] and quarterly comprehensive assessment dated [DATE].</p> <p>These failures could place resident at risk for improper or incorrect care and services necessary for their physical, mental and psychosocial well-being.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Record review of Resident #33 Admission Record dated 12/06/24 revealed resident was initially admitted [DATE], readmitted [DATE] and was [AGE] years old. 2. Record review of Resident #33 Medication Review Report dated 12/05/24 revealed diagnoses to include Adjustment Disorder with Anxiety. 3. Record review of Resident #33 Medication Administration Record (MAR) for [DATE], [DATE] and [DATE] revealed resident was receiving buspirone HCL oral tablet 10mg (Buspirone HCL) with directions to Give 1 tablet by mouth three times a day for anxiety, start date 09/21/2024. 4. Record review of Resident #33 Quarterly MDS dated [DATE] and 11/02/24, Section N, Medications N0415 High Risk Drug Classes, Section 1 was Taking and Section 2 Indication Noted, B is checked for antianxiety medication. <p>Record review of Resident #33 Minimum Data Set (MDS) dated [DATE] and 11/02/24, Section I-Active Diagnoses, Psychiatric / Mood Disorder I5700. Anxiety Disorder do not reflect diagnosis of anxiety.</p> <p>5. Record review of Resident #33 Minimum Data Set (MDS) dated [DATE] and 11/02/24, Section I-Active Diagnoses, Psychiatric / Mood Disorder I5700. Anxiety Disorder do not reflect diagnosis of anxiety.</p> <p>During interview with MDS RN A on 12/05/24 at 12:08 PM, MDS RN A confirmed resident was receiving buspirone for anxiety per physicians' order. MDS RN A confirmed MDS dated [DATE] and MDS dated [DATE] do not reflect a diagnosis of anxiety. MDS RN A reflected that this discrepancy is inaccurate and stated inaccuracy does not affect payment schedule and will be addressed accurately on next scheduled MDS.</p> <p>(continued on next page)</p>		

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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>During interview with MDS RN A on 12/05/24 at 10:08 PM, MDS RN A confirmed she is the MDS Coordinator and completed section I for MDS dated [DATE] and MDS dated [DATE]. MDS RN A confirmed she was the RN assessment coordinator and verified assessment completion.</p> <p>Record review of facility policy Resident Assessment Instrument reviewed December 2023, Policy Interpretation and Implementation, revealed, 7. All persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information.</p> <p>Record review of CMA MDS 3.0 RAI User's Manual v1.19.1 effective 10/01/2023 CH 3: MDS Items [I]revealed that Active Diagnosis in the last 7 days are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.</p> <p>During interview with DON on 12/05/24 at 12:50 p.m. revealed that these failures could place resident at risk for improper or incorrect care and services necessary for their physical, mental and psychosocial well-being.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906</p> <p>Based on observations, interviews, 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 development and transmission of communicable diseases and infections for 5 (Residents #27, #38, #9, #2, and #49) of 8 residents observed for infection control.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #27's Foley catheter bag was not touching the floor twice on 12/03/2024. 2. The facility failed to ensure Resident #38's Foley catheter bag was not touching the floor on 12/03/2024. 3. The facility failed to ensure Resident #9's Foley catheter bag was not touching the floor on 12/03/2024 and on 12/05/2024. 4. The facility failed to ensure Resident #2's Foley catheter bag was not touching the floor on 12/03/2024 and on 12/05/2024. 5. The facility failed to ensure Resident #49's Foley catheter bag was not touching the floor on 12/06/2024. <p>These failures could place residents at risk for cross contamination, urinary tract infections, hospitalization , resulting in a decline in well-being.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Record review of the Face Sheet printed on 12/06/2024 reflected Resident #27 was a [AGE] year-old female originally admitted on [DATE]. <p>Record review of the Diagnosis Report printed on 12/06/2024 reflected Resident #27 had the following diagnoses: Parkinson's Disease [movement disorder of the nervous system that worsens with time], stage 4 pressure injury to right lower back and sacral region [back and buttocks area], and malignant neoplasm [cancerous tumor] of anus.</p> <p>Record review of the comprehensive MDS assessment dated [DATE], reflected Resident #27 had a BIMS summary score of 15, indicative of intact cognition. Resident #27 had an indwelling catheter.</p> <p>Record review of the Care Plan printed on 12/06/2024, reflected Resident #27 had an indwelling catheter related to stage 4 pressure injuries to scum[sp] and right ischium; however, the CP did not include interventions for the care or management of the Foley Catheter.</p> <p>Record review of the Order Summary Report printed 12/06/2024 reflected Resident #27 had physician's orders for Foley Catheter 16 French with 10 ml balloon for pressure injury with a start date of 12/02/2024.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 12/03/2024 at 10:30 AM, Resident #27 was observed with the Foley catheter drainage bag sitting on the floor.</p> <p>In an observation and interview on 12/03/2024 at 2:38 PM, Resident #27 was observed with the Foley catheter drainage bag sitting on the floor. Resident #27 stated she has had the catheter for a long time.</p> <p>2. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #38 was a [AGE] year-old female, admitted on [DATE]. Resident #38's BIMS summary score was 11, indicative of moderately impaired cognition. Resident #38's active diagnoses included: renal insufficiency, renal failure, or end-stage renal disease [kidneys are not functioning at their full capacity], and neurogenic bladder [muscles in the bladder wall do not contract and relax properly, causing problems with urination]. Resident #38 was coded as having an indwelling urinary catheter.</p> <p>In an observation on 12/03/2024 at 10:50 AM Resident #38 was observed with the Foley catheter bag touching the floor.</p> <p>3. Record review of the Face Sheet printed 12/06/2024 reflected Resident #9 was a [AGE] year-old female originally admitted on [DATE].</p> <p>Record review of the Diagnosis Report, printed on 12/06/2024 reflected Resident #9 had the following diagnoses: Stage 4 pressure injury of the left lower back and sacral region, and type 2 diabetes mellitus.</p> <p>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #9 did not have a BIMS conducted due to being rarely/never understood, with short-, and long-, term memory problems, and moderately impaired cognitive skills for daily decision making. Resident #9 was coded as having an indwelling urinary catheter.</p> <p>Record review of the Order Summary Report printed 12/06/2024 reflected Resident #9 had a physician's order for Foley Catheter, 18 French [indicative of the size of the tubing] with 10 ml NS balloon [10 ml normal saline filled balloon holds the tubing inside the bladder] for patency every shift, with an order date of 10/10/2024. Additional orders included: keep the urinary drainage bag below the level of the bladder at all times every shift and as needed, with an order date of 8/13/2024.</p> <p>Record review of the Care Plan printed 12/04/2024 reflected Resident #9 had a focus area of I have indwelling catheter related to pressure injury to left ischium and sacrum, stage 4; with the following interventions: position catheter bag and tubing below the level of the bladder and away from entrance room door. [CP did not address keeping the Foley catheter bag off the floor.]</p> <p>In an observation on 12/03/2024 at 1:09 PM, Resident #9 was seated in an extra tall-backed wheelchair, being assisted with her meal in the dining room. The Foley catheter bag was hooked under the seat of the extra tall-backed wheelchair too low resulting in it dragging on the floor.</p> <p>In an observation on 12/05/2024 at 12:38 9M Resident #9 was observed with the Foley catheter bag touching the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Record review of Resident #2's face sheet, dated 12/06/2024, reflected a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (condition that affects one side of the body usually caused by a stroke that can cause paralysis), a traumatic brain injury, and a cerebral infarction (stroke).</p> <p>Record review of Resident #2's Comprehensive Person-Centered Care Plan, undated, reflected that Resident #2 had a suprapubic catheter related to obstructive & reflux uropathy & BPH with no interventions related to preventing the catheter bag from dragging on the floor.</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 9/28/2024, reflected a BIMS score of 13, indicating that the resident's cognition was intact. The MDS assessment further reflected that Resident #2 utilized an indwelling catheter.</p> <p>Record review of Resident #2's Order Summary Report, dated 12/06/2024, reflected an order which read, Keep urinary drainage bag below the level of the bladder at all times.</p> <p>In an observation on 12/03/2024 at 1:29 PM Resident #2's Foley catheter bag was observed to be dragging on the floor under his wheelchair while being assisted from the dining room back to his room.</p> <p>In an observation on 12/05/2024 at 8:58 AM Resident #2 was observed with the Foley catheter bag touching the floor under his wheelchair while in the communal hallway to the therapy gym.</p> <p>5. Record review of the Face Sheet printed 12/06/2024 reflected Resident #49 was a [AGE] year-old male originally admitted on [DATE].</p> <p>Record review of the quarterly MDS dated [DATE], reflected Resident #49 had a BIMS summary score of 11, indicative of moderately impaired cognition. Resident #49 was coded as having an indwelling catheter. Active diagnoses included: obstructive uropathy [blockage of urinary flow], and cerebrovascular accident [loss of blood flow to part of the brain, stroke].</p> <p>Record review of the Order Summary Report printed 12/06/2024 reflected Resident #49 had a physician's order for Foley catheter, 16 French [indicative of the size of the tubing] with 30 ml balloon [30 ml of fluid filled balloon holds the tubing inside the bladder] with an order date of 11/20/2024.</p> <p>Record review of the Care Plan printed 12/06/2024 reflected Resident #49 had a focus area of I have indwelling catheter related to obstructive and reflux uropathy and BPH ; with the following interventions: position catheter bag and tubing below the level of the bladder and away from entrance room door. [CP did not address keeping the Foley catheter bag off the floor.]</p> <p>In an observation on 12/06/2024 at 10:20 AM Resident #49 was seated in his wheelchair with the Foley catheter attached to wheelchair, with the drainage bag making contact with the floor.</p> <p>In an interview on 12/03/2024 at 1:35 PM LVN B stated the Foley catheter bags should not drag on the floor as it could be a risk to the residents. LVN B stated Foley catheter bags should be under the wheelchair, but not to where they drag on floor. LVN B stated the bag could leak due to friction or be a source of infection .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/06/2024 at 11:07 AM LVN E stated the Foley catheter bag should be positioned on the wheelchair on the left side at the front, where there was a stabilizing bar that was good to hook the Foley Catheter. LVN E stated that when the Foley catheter was placed on the cross bar [underneath the seat of the wheelchair], the Foley catheter bag would slide down to the lowest point of the X and then touch the floor. LVN E stated that staff were trained that the Foley catheter bag should always be lower than the level of the bladder and not glide on the floor due to infection control. LVN E stated this information was trained in annual competencies and in-services frequently .</p> <p>In an interview on 12/06/2024 at 11:16 AM, the DON stated none of the current residents who had Foley catheters self-managed their Foley catheters or the drainage bag. The DON stated it was her expectation that staff ensure the Foley catheter bag was kept below the level of the residents' bladder and not touch the floor for infection control prevention. The DON stated this requirement was trained upon new hire on boarding, at annual competencies, and during in-servicing trainings as necessary. The DON stated that the staff assisting the resident with a Foley Catheter bag was responsible for ensuring that it was not touching the floor. The DON stated that any staff member who saw a Foley Catheter bag touching the floor should either self-correct or alert the appropriate care giver if that staff member was not a direct care giver such as a nurse, CNA, or other clinician.</p> <p>In an interview on 12/06/2024 at 11:38 AM Lead CNA G stated that Foley catheter bags should have covers for privacy, Foley catheter bags should be maintained at a level lower than the bladder, but not touch the floor due to infection control concerns. Lead CNA G stated that she or another lead trained new hires, and she recommended that the Foley catheter bag be hooked towards the front of the wheelchair, as the cross bar at the back and under the seat was too low and the bag could drag on the floor. Lead CNA G stated this procedure was trained upon at hire, at annual competency check offs, and as in-services PRN. Lead CNA G stated that she did random spot checks to ensure the Foley catheter bags were positioning correctly and if not, she would offer immediate counseling to fix it. Lead CNA G stated she was not aware that any Foley catheter bags were reported as touching the floor recently.</p> <p>In an interview on 12/06/2024 at 11:48 AM CNA H stated the Foley catheter drainage bag was always to be placed below the level of the resident's waist to prevent back flow. CNA H stated the Foley catheter bag should be hung on the side of the wheelchair, where it would not fall or drag on the floor. CNA H stated the Foley catheter bag could degrade and leak or could pick up germs from the floor.</p> <p>Review of policy entitled Catheter Care, Urinary, reviewed December 2023, reflected instructions under the heading Infection Control 2b. Be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>Review of Lippincott procedures, Indwelling urinary catheter (Foley) care and management, revised 11/17/2024, accessed from</p> <p>https://procedures.lww.com/lnp/view.do?pld=4420099&hits=care,catheter,catheters,carefully&a=true&ad=false&q=catheter%20care, accessed on 12/05/2024, reflected under the heading Clinical Alert, instructions to keep the drainage bag below the level of the patient's bladder; however, don't place the drainage bag on the floor to reduce the risk of contamination and subsequent catheter associated urinary tract infection.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906</p> <p>Based on observations, interviews, and record review the facility failed to ensure its medication error rate was not 5% or greater. The facility had a medication error rate of 11.54%, based on 3 errors out of 26 opportunities which involved 2 of 2 residents (Resident #52 and #18) and 1 MA, reviewed for medication administration and medication errors.</p> <p>1.) The facility failed to ensure medications were administered timely for Resident #52 on 12/5/2024.</p> <p>2.) The facility failed to ensure medications were administered timely for Resident #18 on 12/5/2024.</p> <p>These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.</p> <p>The findings included:</p> <p>1.) Record review of the Face Sheet printed 12/6/2024, reflected Resident #52 was a [AGE] year-old male originally admitted on [DATE].</p> <p>Record review of the Diagnosis Report printed on 12/6/2024, reflected Resident #52 had the following diagnoses: chronic kidney disease [long term condition that affects the organ that filters waste products and extra fluids from the body which helps control blood pressure], hypertensive heart disease [long term condition that develops after many years of high blood pressure] with heart failure [thickening and weakening of the heart muscle which makes pumping the blood more difficult], and hypertension [high blood pressure].</p> <p>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #52 had a BIMS summary score of 15, indicative of intact cognition. High-risk drug classes section reflected Resident #52 was taking diuretics [medications that promote removal of salt and fluid from the body, helps reduce excess fluid, and lower blood pressure]. Resident #52 was coded as having received scheduled and PRN pain relieving medications in the last 5 days of the assessment, with a frequency of experiencing pain almost constantly.</p> <p>Record review of the Care Plan printed on 12/6/2024, reflected Resident #52 had a focus area of fluid overload or potential fluid volume overload related to chronic kidney disease; with the following associated interventions: administer medications as ordered, with a date initiated 4/17/2024. Additional focus area of I have (acute/chronic [unspecified]) pain; with the following associated interventions: administer analgesia [pain relief medication] as per orders with a date initiated 4/18/2024; evaluate the effectiveness of pain interventions; review for compliance, alleviating of symptoms, dosing schedules . with date initiated 4/18/2024. Further focus area of I am on diuretic therapy; with the following associated interventions: administer medication as ordered, with a date initiated 6/24/2024.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Order Summary Report printed on 12/6/2024, reflected Resident #52 had the following active physician orders: bumex [a medication to help remove excessive fluid in the body] oral tablet 1 mg, give one tablet by mouth three times a day for diuretic, with a start date of 11/30/2024; gabapentin [a medication for nerve pain] oral capsule 100 mg, give one capsule by mouth three times a day for neuropathy [nerve] pain, with a start date of 11/30/2024.</p> <p>In an observation on 12/05/2024 at 8:54 AM, MA F administered the following medications to Resident #52: bumex and gabapentin. Both medications were due at 7:00 AM.</p> <p>Review of Medication Admin Audit Report, printed 12/5/2024, reflected Resident #52 had bumex and gabapentin administered at 8:54 AM by MA F, when the medications were scheduled for 7:00 AM.</p> <p>2.) Record review the Face Sheet printed 12/6/2024, reflected Resident #18 was a [AGE] year-old female originally admitted on [DATE].</p> <p>Record review of the Diagnosis Report printed on 12/6/2024, reflected Resident #18 had the following diagnoses: type 2 diabetes mellitus [metabolic disorder marked by impaired ability to produce or respond to insulin with diabetic neuropathy and hereditary [passed down from parents to offspring] and idiopathic [spontaneous, or from an obscure or unknown cause] neuropathy.</p> <p>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #18 had a BIMS summary score of 15, indicative of intact cognition. Resident #18 was coded as having received scheduled and PRN pain relieving medications in the last 5 days of the assessment, with a frequency of experiencing pain almost constantly.</p> <p>Record review of the Care Plan printed on 12/6/2024, reflected Resident #18 had a focus area of I have (acute/chronic [unspecified]) pain; with the following associated interventions: administer analgesia [pain relief medication] as per orders with a date initiated 5/01/2024.</p> <p>Record review of the Order Summary Report printed on 12/05/2024, reflected Resident #18 had the following active physician orders: gabapentin oral capsule 600 mg, give one capsule by mouth two times a day for neuropathy pain, with a start date of 6/27/2024.</p> <p>In an observation on 12/05/2024 at 9:08 AM, MA F administered the following medication to Resident #18: Gabapentin. This medication was due at 7:00 AM.</p> <p>Review of Medication Admin Audit Report, printed 12/5/2024, reflected Resident #18 had gabapentin administered at 9:08 AM by MA F, when the medication was scheduled for 7:00 AM.</p> <p>In an interview on 12/5/2024 at 11:48 AM, MA D stated policy allows for medication administration up to one hour prior to the scheduled time and up to one hour after the scheduled time .</p> <p>In an interview on 12/5/2024 at 11:59 AM, LVN E stated policy allows for medication administration up to one hour prior to the scheduled time and up to one hour after the scheduled time . LVN E stated that pharmacy does spot checks monthly but was unsure of the scope or outcome.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/06/2024 at 11:36 AM, the DON stated medications were to be administered within the designated time window as per the physician's order. The DON further explained medications could be administered in the hour prior to the scheduled time, or up to an hour after the schedule time. The DON stated this information was provided at new hire on-boarding, during annual competency assessments, and in in-service trainings as needed. The DON stated the risk for not receiving medications timely, could be a change in the expected therapeutic response.</p> <p>Record review of Medication Administration Schedule policy, revised December 2023, reflected under the heading Policy Interpretation and Implementation, 1.) Medications are to be administered according to the following routine schedule. They may be changed due to patient preference/sleep patterns/pharmacy recommendations [schedule for either TID or BID medications, reflected morning administration would be 8:00 AM]. 2.) Routine medication administration schedules may be changed only by submitting a request to the corporate office. Administration times can be changed to meet each facility's unique resident population. 3.) A physician's order for specific times supersedes any routine schedule. 4.) Resident may request alternate medication schedules. Such times must be documented on the MAR and CP.</p> <p>Review of Lippincott procedures, Safe Medication administration practices, long-term care, accessed from https://procedures.lww.com/lnp/view.do?pld=4419880&hits=medications,medication,administration&a=true&ad=false&q=medication%20administration, on 12/05/2024, revised on 5/19/2024, reflected under the heading Introduction, instructions .administer the medication at the right time . Under the heading Ensuring timely administration of scheduled medication, instructions, Be sure to administer medications that require more frequent administration than daily but not more frequently than every 4 hours (two or three times per day [BID or TID]) within 1 hour of their scheduled administration time.</p> <p>Record review of the National Library of Medicine's website, Nursing Rights of Medication Administration - StatPearls - NCBI Bookshelf, accessed from https://www.ncbi.nlm.nih.gov/books/NBK560654/#:~:text=It%20is%20standard%20during%20nursing%20education%20to%20receive,%E2%80%98five%20rights%E2%80%99%20or%20%E2%80%98five%20R%E2%80%99s%E2%80%99%20of%20medication%20administration., accessed 12/10/2024, entitled Nursing Rights of Medication Administration updated 09/04/2023, revealed, Definition/Introduction: Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration.[1] It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. These 'rights' came into being during an era in medicine in which the precedent was that an error committed by a provider was that provider's sole responsibility and patients did not have as much involvement in their own care.[2]; The five traditional rights in the traditional sequence include: . 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</p> <p>Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #31) reviewed for medication administration.</p> <p>Resident #31 was provided medications, Amlodipine Besylate and Carvedilol, outside of physician parameters.</p> <p>This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications.</p> <p>The findings included:</p> <p>Record review of Resident #31's face sheet, dated 12/5/2024, reflected an [AGE] year-old resident with an initial admitted [DATE] and diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (condition that affects one side of the body usually caused by a stroke that can cause paralysis), unspecified atrial fibrillation (a heart condition that causes an irregular and often rapid heartbeat), and hypertension (high blood pressure).</p> <p>Record review of Resident #31's quarterly MDS assessment, dated 11/12/2024, reflected Resident #31 was assessed with a BIMS score of 8 out of a possible 15 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #31's comprehensive person-centered care plan revealed Resident #31 had coronary artery disease r/t Atherosclerosis (a disease that occurs when plaque builds up in the inner lining of arteries), atrial fibrillation (a heart condition that causes an irregular and often rapid heartbeat), hypercholesterolemia (a condition where there are abnormally high levels of fat in the blood), and hypertension (high blood pressure) initiated on 11/29/2024, with interventions to, Give all cardiac meds as ordered by physician.</p> <p>Record review of Resident #31's Order Summary Report, dated 12/6/2024, reflected an order for Amlodipine Besylate Oral Tablet 5 MG (amlodipine Besylate) give 2 tablet via PEG-Tube one time a day for Hypertension give 2 tablets equal to 10 mg daily hold for systolic less than 110 and HR less than 60 indicating the medication should not be provided to the resident if their systolic blood pressure (the top number, which measures the pressure in your arteries when your heart beats) is over 110 or when the residents heart rate was under 60 beats per minute. Further review reflected an order for Coreg Oral Tablet 12/5 MG (Carvedilol) Give 1 tablet via PEG-Tube two times a day for hypertension hold for systolic less than 110 and HR less than 60 indicating the medication should not be provided to the resident if their systolic blood pressure (the top number, which measures the pressure in your arteries when your heart beats) was less than 110 or when the residents heart rate was less than 60 beats per minute.</p> <p>Record review of Resident #31's November 2024 medication administration record dated 12/5/2024, reflected Resident #31 could have been administered Amlodipine Besylate 30 times from 11/1/2024 through 11/30/2024 and was administered Amlodipine Besylate out of parameters as follows:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On 11/4/2024, LVN L administered Amlodipine Besylate to Resident #31 while his pulse was 57 at 9:00 AM.</p> <p>2. On 11/6/2024, LVN L administered Amlodipine Besylate to Resident #31 while his pulse was 56 at 9:00 AM.</p> <p>3. On 11/8/2024, LVN M administered Amlodipine Besylate to Resident #31 while his pulse was 58 at 9:00 AM.</p> <p>4. On 11/12/2024, LVN L administered Amlodipine Besylate to Resident #31 while his Systolic Blood Pressure was 101 at 9:00 AM.</p> <p>5. On 11/18/2024, LVN L administered Amlodipine Besylate to Resident #31 while his pulse was 57 at 9:00 AM.</p> <p>Record review of Resident #31's November 2024 medication administration record, dated 12/5/2024, reflected Resident #31 could have been administered Carvedilol 60 times from 11/1/2024 through 11/30/2024 and was administered Carvedilol out of parameters as follows:</p> <p>1. On 11/4/2024, LVN L administered Carvedilol to Resident #31 while his pulse was 57 at 9:00 AM.</p> <p>2. On 11/6/2024, LVN L administered Carvedilol to Resident #31 while his pulse was 56 at 9:00 AM.</p> <p>3. On 11/8/2024, LVN M administered Carvedilol to Resident #31 while his pulse was 58 at 9:00 AM.</p> <p>4. On 11/12/2024, LVN L administered Carvedilol to Resident #31 while his Systolic Blood Pressure was 101 at 9:00 AM.</p> <p>5. On 11/15/2024, LVN N administered Carvedilol to Resident #31 while his Systolic Blood Pressure was 103 at 9:00 PM.</p> <p>6. On 11/18/2024, LVN L administered Carvedilol to Resident #31 while his pulse was 57 at 9:00 AM.</p> <p>7. On 11/19/2024, LVN N administered Carvedilol to Resident #31 while his [NAME] was 59 at 9:00 PM.</p> <p>8. On 11/25/2024, LVN N administered Carvedilol to Resident #31 while his [NAME] was 58 at 9:00 PM.</p> <p>Interview on 12/6/2024 at 11:03 AM, LVN M stated that when providing residents medications that have parameters, the required vitals such as blood pressure and pulse were taken before giving the resident the medication. LVN M stated that they regularly have training on medication administration to include parameters, and that there were also regular competency checks to ensure medications were being given within appropriate parameters. LVN M stated that he did not work the hall that Resident #31 was on frequently and was not very familiar with his care .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/6/2024 at 11:16 AM, the DON stated that parameters for medications were to ensure that the medications were provided when necessary and so that if a resident was consistently out of parameters, they could request that the physician review the medications and parameters to see if any necessary changes needed to be made. The DON stated she was not aware of the medications being provided out of parameters and that her expectation for if a medication was provided out of parameters would be to inform the residents physician and the DON and to monitor after the fact to ensure there were no adverse effects.</p> <p>Record review of Facility Policy titled, Medication Error or Adverse Consequences, dated reviewed December 2023, reflected, A 'medication error' is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</p> <p>Based on observations, interviews, and record review the facility failed to provide special eating equipment for residents who needed them and appropriate assistance to ensure that the resident could use the assistive devices when consuming meals for 1 of 8 residents (Resident #2) reviewed for special eating equipment and assistance when consuming meals.</p> <p>The facility failed to ensure Resident #2 was provided with a divided plate to meet Resident #2's need for assistance while eating.</p> <p>This failure could place residents at risk for harm by weight loss, diminished independence, and self-esteem.</p> <p>The findings included:</p> <p>Record review of Resident #2's face sheet, dated 12/6/2024, reflected a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (condition that affects one side of the body usually caused by a stroke that can cause paralysis), a traumatic brain injury, and a cerebral infarction (stroke).</p> <p>Record review of Resident #2's Quarterly MDS Assessment, dated 9/28/2024, reflected a BIMS score of 13, indicating that the resident's cognition was intact. Further record review reflected that Resident #2 needed setup or clean-up assistance with eating.</p> <p>Record review of Resident #2's Comprehensive Person-Centered Care Plan, undated, reflected that Resident #2 used a divided plate to assist with meals.</p> <p>Record review of Resident #2's order summary report, dated 12/6/2024, reflected an order for a Modified diabetic (CC) diet Regular Texture, Thin (Level 0 - Thin) consistency, L7 texture, Divided Plate, 2 handle or mug with lid, with an order start date of 4/24/2024.</p> <p>Observation and record review on 12/3/2024 at 1:13 PM reflected a meal ticket with Resident #2's name on it, reflecting Assist Instructions: Divided Plate/Sippy Cup. A regular, flat, undivided plate was observed to be on Resident #2's plate. Resident #2 was observed to be struggling with his meal, to include spilling his coleslaw after struggling to pick up the bowl it was in. There were no observations of staff interference until the state surveyor intervention. Resident #2 completed his meal in an undivided plate. Other residents were observed to have divided plates.</p> <p>Interview on 12/6/2024 at 11:20 AM, the DON stated that if there was an assistive device ordered, it should come out on the tray. The DON stated that if the assistive device was not on the tray, it should be noticed by the nurse who was tasked with checking the resident's meal tickets and comparing them to what was on the tray before they were given to residents .</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Facility Policy, undated, titled, Assistive Devices and Equipment, reflected, Our facility provides, maintains, trains and supervises the use of assistive devices and equipment for residents.</p>		