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	03/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that Residents were free of significant medication errors, for 3 of 8 residents (Residents #14, #23, and #27), reviewed for significant medication errors. Staff administered midodrine incorrectly per the physicians' orders, to Residents #14, #23, and #27. Midodrine is an oral medication that increases blood pressure by constricting blood vessels. It is used to treat severe drops in blood pressure upon standing. It is usually taken three times daily during waking hours. These failures could place residents at risk for injuries from low or high blood pressure.The findings include: 1. A record review of Resident #14's admission record, dated 3/11/2026, revealed Resident #14 was admitted to the facility on [DATE]. Resident #14 had diagnoses which included hypertension (high blood pressure), hypotension (low blood pressure), and dementia (a general term for a decline in mental ability-such as memory, reasoning, and behavior-severe enough to interfere with daily life). A record review of Resident #14's annual MDS assessment, dated 11/30/2025, revealed Resident #14 was a [AGE] year-old female who was admitted for long term care. Resident #14 was assessed with a BIMS score of 15 out of a possible 15, which indicated no cognitive impairment. A record review of Resident #14's care plan, dated 3/11/2026, revealed, I have hypertension . give antihypertensive medications as ordered . A record review of Resident #14's physicians orders, dated 3/11/2026, revealed the physician prescribed on 6/8/2025 for Resident #14 to receive midodrine 10mg three times a day for low blood pressure and for staff to not give the medication if the systolic blood pressure was greater than 120. A record review of Resident #14's October 2025 medication administration record revealed staff administered midodrine contrary to the physicians' orders, 20 times out of a potential 90 opportunities, as follows:- 10/2/2025 at 8:00 AM, MA E did not administer the midodrine when Resident #14 had low blood pressure, a SBP pressure of 114.- 10/3/2025 at 8:00 AM, MA E did not administer the midodrine when Resident #14 had low blood pressure, a SBP pressure of 108.- 10/3/2025 at 12:00 PM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 126.- 10/8/2025 at 8:00 AM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 127. - 10/8/2025 at 12:00 PM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 138. - 10/9/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 100. - 10/9/2025 at 12:00 PM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 122. - 10/12/2025 at 4:00 PM, MA I administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 126. - 10/14/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 116. - 10/15/2025 at 8:00 AM, LVN J administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 134. - 10/15/2025 at 12:00 PM, LVN J administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 126. - 10/18/2025 at 4:00 PM, MA K administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 121. - 10/20/20/20/2025 at 8:00 AM, MA E did (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

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	03/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 103. - 10/20/20/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 118. - 10/21/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 118. - 10/21/2025 at 12:00 PM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 122. - 10/26/2025 at 8:00 AM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 133. - 10/26/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 111. - 10/27/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 118. - 10/27/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 104. - 10/29/2025 at 8:00 AM, LVN J administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 127. A record review of Resident #14's November 2025 medication administration record revealed staff administered midodrine contrary to the physicians' orders, 34 times out of a potential 90 opportunities, as follows: - 11/2/2025 at 8:00 AM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 122. - 11/2/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 119. - 11/3/2025 at 4:00 PM, MA L administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 129. - 11/7/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 119. - 11/7/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 119. - 11/8/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 104. - 11/8/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 104. - 11/9/2025 at 8:00 AM, MA M administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 124. - 11/10/2025 at 8:00 AM, MA M administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 125. - 11/10/2025 at 4:00 PM, MA F administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 130. - 11/11/2025 at 8:00 AM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 137. - 11/11/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 120. - 11/12/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 107. - 11/12/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 104. - 11/13/2025 at 4:00 PM, MA F did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 122. - 11/14/2025 at 4:00 PM, MA F administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 133. - 11/15/2025 at 4:00 PM, MA F administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 121. - 11/16/2025 at 4:00 PM, MA F administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 123. - 11/17/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 101. - 11/18/2025 at 8:00 AM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 146. - 11/19/2025 at 4:00 PM, MA F administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 124. - 11/21/2025 at 8:00 AM, MA N administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 128. - 11/22/2025 at 8:00 AM, MA N administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 128. - 11/23/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood (continued on next page)

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	03/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure, a SBP pressure of 109. - 11/23/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 113. - 11/24/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 115. - 11/24/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 111. - 11/25/2025 at 4:00 PM, MA F administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 122. - 11/28/2025 at 4:00 PM, MA F administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 145. - 11/29/2025 at 8:00 AM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 109. - 11/29/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 101. - 11/30/2025 at 8:00 AM, MA E administered midodrine when Resident #14 had blood pressure higher than the physician ordered, a SBP pressure of 126. - 11/30/2025 at 12:00 PM, MA E did not administer midodrine when Resident #14 had low blood pressure, a SBP pressure of 113. During an interview on 3/11/2026 at 1:46 PM, MA E stated he was the Medication Aide for Resident #14 on [TF7] 3/11/2026 from 6:00 AM to 2:00 PM. MA E stated Resident #14 was prescribed Midodrine with instructions to give the medication when Resident #14 had low blood pressure. MA E recalled an unknown LVN, who did not work at the facility anymore, had told him specifically for Resident #14 to not give her the Midodrine for episodes of low blood pressure. MA E stated he did not administer Resident #14's midodrine in the morning when she had a low blood pressure of 109/64 and again at noon when she had low blood pressure of 106/66. MA E stated he believed midodrine raised blood pressure but was uncertain. MA E stated the nurse on duty was LVN G. MA E stated he had not reported the held dosages of midodrine to anyone. MA E stated he had also administered midodrine to other residents in the facility and could not recall their names without a record review. During an interview on 3/11/2026 at 1:58 PM, the ADON stated Resident #14 [TF9] was prescribed midodrine 10mg for hypotension and had physicians' parameter to not administer the medication when Resident #14 had a blood pressure greater than 120 SBP. The ADON stated she reviewed the medication administration record for Resident #14 and recognized on 3/11/2026 at 9 AM Resident #14 had a blood pressure of 109/64 and MA E did not administer the midodrine and again on 3/11/2026 at noon Resident #14 had a blood pressure of 106/66 and MA E did not administer the midodrine. The ADON stated MA E should have administered the medication. The ADON stated MA E should have reported the held medications to the nurse. The [TF10] ADON stated she had not received a report Resident #14 had any medications held. The ADON stated if she had received a report, she would have assessed Resident #14 for adverse reactions for her not receiving her prescribed medications[TF11] . 2. A record review of Resident #23's admission record, dated 3/13/2026, revealed Resident #23 was admitted to the facility on [DATE]. Resident #23 had diagnoses which included hypertension (high blood pressure), hypotension (low blood pressure), and dementia (a general term for a decline in mental ability-such as memory, reasoning, and behavior-severe enough to interfere with daily life). A record review of Resident #23's quarterly MDS assessment, dated 1/1/2026, revealed an [AGE] year-old male who was admitted for long term care. Resident #23 was assessed with a BIMS score of 10 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #23's care plan dated 3/11/2026 revealed, I have hypertension . give antihypertensive medications as ordered . A record review of Resident #23's physicians orders, dated 3/11/2026, revealed the physician prescribed on 10/16/2025 for Resident #23 to receive midodrine 10mg three times a day for low blood pressure and for staff to not give the medication if the systolic blood pressure was greater than 120. A record review of Resident #23's March 2026 medication administration record revealed staff administered midodrine contrary to the physicians' orders, 8 times out of a potential 30 opportunities, as follows: - 3/4/2026 at 9:00 PM, MA O administered midodrine when Resident #23 had blood pressure higher than the physician ordered, a SBP pressure of 128. - 3/6/2026 at 5:00 PM, MA L administered midodrine when Resident #23 had blood pressure higher than the physician (continued on next page)

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	03/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered, a SBP pressure of 130. - 3/7/2026 at 9:00 AM, MA E administered midodrine when Resident #23 had blood pressure higher than the physician ordered, a SBP pressure of 125. - 3/7/2026 at 1:00 PM, MA E administered midodrine when Resident #23 had blood pressure higher than the physician ordered, a SBP pressure of 126. - 3/7/2026 at 5:00 PM, MA E administered midodrine when Resident #23 had blood pressure higher than the physician ordered, a SBP pressure of 122. - 3/9/2026 at 1:00 PM, MA M administered midodrine when Resident #23 had blood pressure higher than the physician ordered, a SBP pressure of 123. - 3/9/2026 at 5:00 PM, MA L administered midodrine when Resident #23 had blood pressure higher than the physician ordered, a SBP pressure of 124. - 3/11/2026 at 9:00 PM, ADON administered midodrine when Resident #23 had blood pressure higher than the physician ordered, a SBP pressure of 130. 3. A record review of Resident #27's admission record, dated 3/13/2026, revealed Resident #27 was admitted to the facility on [DATE]. Resident #27 had diagnoses which included hypertension (high blood pressure), hypotension (low blood pressure), and dementia (a general term for a decline in mental ability-such as memory, reasoning, and behavior-severe enough to interfere with daily life). A record review of Resident #27's quarterly MDS assessment, dated 11/29/2025, revealed Resident #27 was an [AGE] year-old male who was admitted for long term care. Resident #27 was assessed with a BIMS score of 15 out of a possible 15, which indicated no cognitive impairment. A record review of Resident #27's care plan, dated 3/11/2026, revealed, I have altered cardiovascular status related to hypertension . give antihypertensive medications as ordered . I have orthostatic hypotension (a sudden drop in blood pressure occurring when standing up from a sitting or lying position. It causes dizziness, lightheadedness, blurred vision, or fainting due to inadequate blood flow to the brain) . give medications as ordered . A record review of Resident #27's physicians orders, dated 3/11/2026, revealed the physician prescribed on 2/16/2025 for Resident #27 to receive midodrine 5mg two times a day for low blood pressure and for staff to not give the medication if the systolic blood pressure was greater than 120. A record review of Resident #27's March 2026 medication administration record revealed staff administered the midodrine contrary to the physicians' orders, 8 times out of a potential 20 opportunities, as follows: - 3/1/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 138. - 3/2/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 133. - 3/3/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 147. - 3/4/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 147. - 3/7/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 135. - 3/8/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 140. - 3/9/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 147. - 3/10/2026 at 9:00 PM, MA F administered midodrine when Resident #27 had blood pressure higher than the physician ordered, a SBP pressure of 140. During an interview on 3/11/2026 at 10:20 AM, the Medical Director stated he had not received a report that residents had not received their midodrine as prescribed. The Medical Director stated his expectations were for the staff to follow physicians' orders and administer medications as prescribed. The Medical Director stated the drug midodrine was a drug which could raise a person's blood pressure and if given incorrectly could raise a person's blood pressure beyond intended therapeutic effects - or - the resident may not receive the therapeutic effects of the medication if the medication was not administered when the resident needed the medication. During an interview on 3/13/2026 at 11:00 AM, the DON stated the expectation was for staff to administer medications as prescribed. The DON stated she received reports that some residents had not received their midodrine as prescribed. The DON stated she reviewed all residents who received midodrine and recognized Residents #14, #23 and #27 had not received their (continued on next page)

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	03/13/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications as prescribed by the physician. The DON stated she assessed the residents for safety and had not discovered any injuries. The DON stated she had begun corrective actions which included re-enforced training and supervision for the identified nursing staff and re-enforced training for all the nursing staff. The DON stated the potential negative outcome for Residents who had not received their midodrine as prescribed by the physician could be they may not have received the intended therapeutic effects of their medications. A record review of the facility's Administering Oral Medications policy, dated December 2025, revealed, . Preparation, verify that there is a physician's medication order for this procedure. Review the residence care plan to assess for any special needs of the resident, . Steps in procedure . select the drug from the unit dose drawer or stock supply, check the label on the medication and confirm the medication name and dose with the medication administration record, check the medication dose. Recheck to confirm the proper dose.

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	03/13/2026

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 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** Based on observation, interview and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included appropriate accessory and cautionary instructions, and the expiration date when applicable and in accordance with State and Federal laws, ensured all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 24 residents (Resident #2 and #70) and 1 of 3 medication carts (300-hall even nursing cart) reviewed for medication storage. 1. The facility failed to ensure Resident #2's three bottles of normal saline, used for flushing the resident's indwelling urinary catheter, were not left unattended in the resident's room on 03/10/2026. 2. The facility failed to ensure Resident #70's moisture barrier ointment cream was not left unattended inside the resident's restroom, on 03/10/2026. 3. The facility failed to ensure the 300-hall nursing cart was not unlocked and left unattended at the 300-hall on 03/12/2026. These failures could place residents at risk of not using medications correctly and medication diversion.The findings were: 1. Record review of Resident #2's face sheet, dated 03/13/2026, revealed an [AGE] year-old male who was admitted to the facility 01/23/2026. Resident #2 had diagnoses which included lack of coordination (poor muscle control that causes clumsy movement), urinary tract infection (an infection in any part of the urinary system, such as bladder), and muscle weakness. Record review of Resident #2's admission MDS assessment, dated 01/27/2026, revealed the resident's BIMS score was 12 out of 15, which indicated the resident had moderate cognitive impairment. Resident #2 had an indwelling urinary catheter. Record review of Resident #2's physician's order, dated 01/29/2026, revealed the resident had an order for Foley Catheter [indwelling urinary catheter] 20 French with 10milliters balloon. Observation on 03/10/2026 at 9:53 a.m. revealed Resident #2 was sleeping in the bed, the resident had an indwelling urinary catheter, and there were three bottles of normal saline on the resident's window frame. Interview on 03/10/2026 at 11:35 a.m., LVN-U said there were three bottles of normal saline on the resident's room window frame that were left unattended and the normal saline was for flushing the resident's indwelling urinary catheter. LVN U said facility nurses might leave three bottles of normal saline unattended after flushing the resident's catheter, and they should have been stored in a nursing cart to prevent possible inappropriate using. 2. Record review of Resident #70's face sheet, dated 03/13/2026, revealed an [AGE] year-old female who was admitted to the facility 09/18/2026. Resident #70 had diagnoses which included lack of coordination (poor muscle control that causes clumsy movement), difficulty in walking, and type 2 diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar [glucose] levels). Record review of Resident #70's quarterly MDS assessment, dated 12/26/2025, revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognition was intact. Resident #70 did not have any skin injury. Record review of Resident #70's comprehensive care plan, dated 10/01/2025, revealed Resident is at risk for additional pressure ulcers related to decreased mobility. For intervention - Follow facility policies/protocols for the prevention/treatment of skin breakdown. Observation on 03/10/2026 at 10:33 a.m. revealed Resident #5 was not in the room, but there was an ointment cream tube of Calmoseptine Ointment for protect and helps heal skin irritations left unattended inside the resident's restroom. Interview on 03/10/2026 at 11:46 a.m., the wound care nurse said there was one tube of Calmoseptine ointment, for protection and helped heal skin irritation, left in Resident #70's restroom unattended, and the cream was a medication, so it should have been stored in a nursing cart to prevent possible inappropriate use. 3. Observation on 03/12/2026 at 8:41 a.m. revealed the 300-hall nursing cart was parked at the 300-hallway. The cart was unlocked and nobody was supervising the cart. Interview on (continued on next page)

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	03/13/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/12/2026 at 8:52 a.m., LVN-A stated the 300-hall nursing cart which was parked at the 300-hall was unlocked and left unattended. The nurse said she had responsibility for locking her cart all the times and she forgot to lock the cart when she left from the cart to see some residents, and it was her mistake. The nurse stated the nursing cart should have been locked, all the time to prevent somebody from taking any medications. Interview on 03/12/2026 at 8:54 a.m., the DON said the facility nurses should have stored Resident #2's three bottles of normal saline and Resident #70's ointment in a nursing cart and should have locked the nursing carts all the time to prevent somebody to take medications. Record review of the facility's policy, titled Storage of Medications, dated 12/2025, revealed 1. Drugs and biologicals shall be stored in the packaging, containers or others dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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	03/13/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services. 1. The Dietary Manager failed to wear a beard restraint while working in the kitchen.2. Dietary Aide P and Dietary Aide R failed to wear hair restraints or beard restraints while working in the kitchen.3. The facility failed to store wet dishes to allow for air-drying.4. The facility failed to ensure all prepared items in the walk-in refrigerator were labeled and dated with the use by date. 5. The facility failed to store items off the floor in the kitchen's dry storage area.6. The facility failed to take the temperature of soup after heating it in the microwave and prior to it leaving the kitchen. These failures could place residents at risk for food borne illness. Findings include: During an observation of the facility's kitchen on 03/10/2026 at 8:54 AM revealed Dietary Aide P at the dishwasher not wearing a hair restraint or facial hair restraint. The Dietary Manager was wearing a surgical mask that covered his mouth and nose leaving the side of his face which contained facial hair uncovered. Observations of the facility's dry storage revealed a box of 8-ounce (oz) cup lids and a case of canned soup on the floor. Observations of the kitchen's refrigerator revealed an opened jar of grape jelly, a bag with two eggs, a storage container of red sauce, a large pan covered with aluminum foil, a large bottle of soy sauce, and 7 trays of cups with liquid in them being stored without labels identifying items or dates items were to be used by. Observation of the dish storage area revealed a stack of 8 bowls right side up with liquid pooling inside them. During an observation of the facility's kitchen on 03/10/2026 at 8:54 AM revealed Dietary Aide P wore a surgical mask that covered his mouth and nose leaving the side of his face which contained facial hair uncovered.Interview with the Dietary Manager on 03/10/2026 at 9:03 AM revealed he was wearing a surgical mask as a hair restraint. The Dietary Manager stated hair restraints covering all hair were to be worn while in the kitchen. The Dietary Manager stated it was important to wear hair restraints to prevent hair from falling into food which could cause contamination. The Dietary Manager stated it was the responsibility of each staff to ensure they wore hair restraints properly but ultimately his responsibility to ensure staff wore hair restraints. Observation of [NAME] Q preparing a pureed entree on 03/12/2026 at 11:12 AM revealed [NAME] Q portioned out 9 servings into a bowl. [NAME] Q then prepared the pureed entree and placed it back in the same bowl the 9 whole portions were placed. During an observation of the facility's kitchen on 03/12/2026 at 11:28 AM revealed an opened gallon of milk without a label identifying the date opened or a used by date in the refrigerator.Observation of the facility's kitchen on 03/12/2026 at 4:40 PM revealed the Dietary Manager with his surgical mask below his chin not covering his facial hair. Observation of the facility's kitchen on 03/12/2026 at 5:15 PM revealed [NAME] W opened a can of soup and poured it into a bowl. [NAME] W then placed the bowl in the microwave for 2 minutes. [NAME] W removed the bowl of soup when the microwave completed its cooking time. [NAME] W then placed clear wrap over the bowl and placed the bowl on a resident's tray. The resident's tray was placed on the rack which was then sent to the dining room. Observation of the facility's kitchen on 03/12/2026 at 5:22 PM revealed [NAME] W asked for the bowl of soup to be returned to the kitchen so the temperature could be taken before it was served to the resident. [NAME] W took the temperature of the bowl of soup which was 135 F. Interview with [NAME] Won 03/12/2026 at 5:20 PM revealed [NAME] W did not take the temperature of the soup prior to it being sent to the dining room to be served to a resident. [NAME] W stated the resident requested soup for dinner, so [NAME] W heated up a can of soup in the microwave. [NAME] W did not say why he did not take the temperature of the soup prior to placing it on the resident's tray to be served. [NAME] W stated the failure could have resulted in serving the resident soup that was either too hot causing burns or too cold causing an unenjoyable meal.Interview with [NAME] Q on 03/13/2026 at 6:28 AM revealed staff (continued on next page)

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	03/13/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were to wear hair restraints while in the kitchen to prevent food from being contaminated by hair. [NAME] Q stated contaminated food could cause residents to get sick. [NAME] Q stated it was the responsibility of staff to ensure they wore hair restraints. [NAME] Q stated all items being stored in the refrigerator were to be labeled with the date opened and/or the date to be used by to prevent residents from being served spoiled foods. [NAME] Q stated residents could become ill if served spoiled foods. [NAME] Q stated it was the responsibility of any staff placing prepared or opened food in the refrigerator to label them. [NAME] Q stated it was the dietary aides responsibility to store dishes to allow airflow allowing them to air dry. [NAME] Q stated dishes being stored in a way that did not allow water to dry could cause bacteria to grow causing residents to be sick. [NAME] Q stated all items being stored in the dry storage should be stored on a shelf and off the floor. [NAME] Q was unsure of the height off the floor items were to be stored. [NAME] Q stated it was the responsibility of all staff to ensure items were off the floor in the dry storage area. [NAME] Q was unable to identify how the failure could have potentially affected the residents. Interview with Dietary Aide P on 03/13/2026 at 8:27 AM revealed staff were to wear hair restraints while in the kitchen. Dietary P stated it was his responsibility to ensure he wore it correctly. Dietary P stated if hair restraints were not worn correctly hair could fall into the food and cause residents to get sick. Dietary Aide P stated dishes were to be stored so that water would drain from them and they could air dry. Dietary Aide P stated water sitting in dishes could lead to bacteria growing and causing residents to get sick. Dietary Aide P stated it was the responsibility of the dishwashers to store dishes in a way that allowed them to air dry. Dietary Aide P stated all opened items and prepared foods being stored in the refrigerator were to be labeled with the date they were opened and the date they were to be used by to prevent residents from getting sick. Dietary Aide P stated it was the responsibility of all staff storing items in the refrigerator to ensure they were labeled. Dietary Aide P stated he did not prepare special textured foods and was unaware of the process. Dietary Aide P stated he was trained to store items in the dry pantry on the shelves but stated he did not know why or how it could affect the residents. Dietary Aide P stated it was everyone's responsibility to ensure items were stored properly. Interview with the Dietary Manager on 03/13/2026 at 11:37 AM revealed all staff were to wear hair restraints that covered both facial hair and hair on top of their heads completely. The Dietary manager stated it was the responsibility of the dietary manager to ensure all staff wore hair restraints properly to prevent hair from getting into the food. The Dietary Manager stated residents could get sick by having hair in their food. The Dietary manager stated it was the responsibility of all staff to ensure food being stored in the refrigerator was labeled and dated to prevent residents from being served spoiled foods that could cause illness. The Dietary manager stated dishes were to be stored so they could air dry and to prevent water from collecting in the dishes. The Dietary Manager stated water collecting in dishes could lead to bacteria to grow causing residents to get sick. The Dietary Manager stated it was the responsibility of all staff who washed dishes to ensure they were stored properly. The Dietary Manager stated it was his responsibility to ensure everything in the dry storage was stored properly and included items being stored off the floor. The Dietary Manager stated items needed to be stored off the floor to prevent rodents or bugs from getting into items and potentially causing the residents to get sick. The dietary Manager stated [NAME] W should have taken the temperature of the soup prior to serving. The Dietary Manager stated it was the responsibility of the cook to ensure foods were cooked and maintained at the proper temperatures. The Dietary Manager stated the failure could have caused the resident to burn themselves from food that was too hot or caused illness because food did not get hot enough to kill bacteria. Dietary Aide R was not interviewed because he resigned during the survey and did not return surveyors call. Record review of the facility's policy titled Food Storage, dated 2023, revealed Food items will be stored on shelves, with heavier and bulkier items stored on lower shelves and All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods.a. Old stock is always used first (first in - first out method or FIFO). The person designated to (continued on next page)

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	03/13/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manage stock should be trained to rotate it properly.b. Food should be dated as it is placed on the shelves if required by state regulation.c. Date marking should be visible on all high-risk food to indicate the date by which a ready-to-eat TCS food should be consumed, sold or discarded.Record review of the facility's policy titled Employee Hygiene for Food Safety, dated 2023, revealed All employees will: 1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.Record review of the facility's policy titled Cleaning Dishes/Dish Machine, dated 2023, revealed 9. Dishes should be air dried on the dish racks, not dried with towels. 10. Inspect for cleanliness and dryness and put dishes away if clean (be sure hands are clean). Dishes should not be nested unless they are completely dry.Record review of the facility's policy titled Food Temperatures, dated 2023, revealed Food Cooked in a Microwave Oven 165 F (74 C) and hold for 2 minutes after removing from microwave oven.Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (A) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the food with their handles above the top of the food and the container; (B) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon.Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 states Except as provided in, (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-305.1, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination.

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 development and transmission of communicable diseases and infections for 4 residents out of 20 residents (Resident #72, #3, #19, and #82) reviewed for infection prevention and control measures. 1. NP B and LVN A entered Residents #72 and #3's droplet precaution isolation room without wearing the appropriate PPE. 2. The facility failed to ensure CNA-T performed hand hygiene after changing gloves during incontinent care for Resident #19. 3. The facility failed to ensure MA-M disinfected the blood pressure cuff after using it on another resident. These failures could place residents at risk for contracting infectious diseases. The findings include:A record review of Resident #72's admission record, dated 3/10/2026, revealed an admission date of 11/22/2024. Resident #72 had a diagnosis which included Alzheimer's disease (a progressive, irreversible neurodegenerative brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks). A record review of Resident #72's annual MDS assessment, dated 11/29/2025, revealed a [AGE] year-old female who was admitted for long term care with ADLs complicated by Alzheimer's disease. Resident #72 was assessed with a BIMS score of 5 out of a possible 15, which indicated severe cognitive impairment. A record review of Resident #72's orders revealed, on 3/9/2025, the physician ordered Resident #72 to be cared for under an isolation droplet precaution related to her diagnosed flu infection. During an observation and interview on 3/10/2026 at 11:12 AM revealed Resident #72's room door closed and signage and PPE hung on the door. The PPE supplies included surgical masks, gowns, gloves, and a face shield. The signage on the door read Stop Droplet Precautions to prevent the spread of infection anyone entering this room must: hand hygiene, N95 Mask, gloves, gown. LVN A donned a surgical mask and entered into Resident #72's room. LVN A exited Resident #72's room and continued with the surgical mask and upon exiting the room had a conversation with an unidentified CNA. After the short conversation with the CNA, LVN A doffed her surgical mask into the trash. LVN A stated she had donned the surgical mask and no other PPE and entered into Resident #72's room to answer Resident #72's call light and then had exited Resident #72's room, spoke to a CNA and then doffed the surgical mask. LVN A stated Resident #72 was diagnosed with influenza, a respiratory virus which could be spread from 1 person to another and was on isolation droplet precautions. LVN A stated the signage posted on the door instructed anyone who would enter the room to wear PPE to include a N95 FFR, gloves, a gown, and eye protection. LVN A stated she only wore a surgical mask and should have worn gloves and a gown as well. LVN A stated the signage was wrong because her training was to wear a surgical mask, a gown, and gloves. LVN A stated the failure of wearing gloves and a gown could result in the spread of infections. A record review of Resident #3's admission record, dated 3/10/2026, revealed an admission date of 10/8/2025. Resident #3 had diagnoses which included orthopedic aftercare following surgical amputation (resident had a toe amputated) and diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar levels). A record review of Resident #3's MDS assessment, dated 2/25/2026, revealed a [AGE] year-old male who was admitted for long term care for ADL care and colostomy care. (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #3's orders revealed, on 3/5/2025, the physician ordered Resident #3 to be cared for under an isolation droplet precaution related to his diagnosed flu infection. An observation and interview on 3/12/2026 at 3:43 PM revealed Resident #3's room door closed and had signage and PPE hung on the door. The PPE supplies included surgical masks, gowns, gloves and a face shield. The signage on the door read Stop Droplet Precautions to prevent the spread of infection anyone entering this room must: hand hygiene, N95 Mask, gloves, gown. NP B entered Resident #3's room and only wore a surgical mask as her PPE. NP B exited Resident #3's room into the hallway without doffing the surgical mask. NP B stated she had not recognized the signage and had not donned the appropriate PPE for Resident #3's isolation droplet precautions. NP B stated she should have also donned a gown and gloves as well as the mask and doffed the PPE immediately prior to exiting the room. NP B stated the potential negative outcome could be the spread of infectious diseases. During an interview on 3/13/2026 at 2:24 PM, the DON stated her expectation for infection prevention and control specific for residents who were under isolation precautions was for all who needed to enter those rooms were to DON and doff PPE as posted and as trained. The DON stated the expectation was for staff to perform hand hygiene, don a surgical mask, gown, and gloves prior to entering an isolation protocol room and to doff the PPE immediately prior to exiting the room. The DON stated the potential negative outcome could be the spread of infectious diseases. A record review of the facility's policy Personal Protective Equipment – Using Gowns dated December 2025 revealed, . To prevent the spread of infections to prevent soiling of clothing with infectious material, to prevent splashing or splattering blood or body fluids onto clothing or exposed skin, and to prevent exposure to the HIV and hepatitis B viruses from blood or body fluids. Obtain the gown, wash hands, unfold the gowns that the opening is at the back, put your arms into the sleeves of the gown, don the gown at the neck, tie at the neck, overlap the gown at the back, be sure clothing is completely covered, secure at the waist, . removing the gown, untie unfasten the back of the gown, remove gloves and discard them into waste receptacle in the room, untie the neckband, while still holding the neck strings pull the gown off the shoulders, remove the gown by rolling it away from the body, handle the inside of the gown only, discard the gown into the waste receptacle inside the room, wash hands, if a mask was used during the procedure or services remove it at this time and discard it into the waste receptacle inside the room, wash hands. 2. Record review of Resident #19's face sheet, dated 03/13/2026, revealed a 101-years-old female, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Resident #19 had diagnoses which included heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), urinary tract infection (an infection in any part of the urinary system, such as bladder), and hypertension (high blood pressures). Record review of Resident #19's quarterly MDS assessment, dated 12/01/2025, revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognition was intact. Resident #19 was frequently incontinent to bowel and bladder. Record review of Resident #19's comprehensive care plan, dated 10/10/2024, the resident had the care plan of I have a History of Urinary Tract Infection. For intervention - Obtain vital as ordered/facility protocol. Observation on 03/12/2026 at 12:40 PM CNA-T opened Resident #19's dirty brief to provide (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent care, cleaned the resident, left the groin area and genital area on separating the area, then turned the resident to side. CNA-T cleaned the resident's buttock area and changed gloves without washing or sanitizing her hands, then put the new brief under the resident. Interview on 03/12/2026 at 12:58 PM with CNA-T said she just changed her gloves without sanitizing or washing her hands after cleaning Resident #19's buttock area. The CNA said she should have sanitized or washed her hands when changing gloves to prevent possible infection. Interview on 03/13/2026 at 2:18 p.m. with the DON said the CNA should have sanitized or washed her hand when changing gloves to prevent possible infection. 3. Record review of Resident #82's face sheet, dated 03/13/2026, revealed a 74-years-old female who was admitted to the facility on [DATE]. Resident #82 had diagnoses which included pulmonary embolism (sudden blockage in a lung artery), peripheral vascular disease (reduced circulation of blood to a body part other than the brain or heart), and dependence on renal dialysis (require dialysis treatment of chronic kidney diseases or acute kidney injury). Record review of Resident #82's admission MDS assessment revealed the assessment was in progress on 03/13/2026 because the resident was admitted to the facility on [DATE]. Record review of Resident #82's baseline care plan, dated 03/07/2026, revealed the resident had the baseline care plans of Infection control intervention to reduce the transmission of multidrug-resistant organisms. Record review of Resident #82's physician order, start dated 03/07/2026, revealed the resident had the order of Weights &Vital signs per facility policy. Observation on 03/12/2026 at 8:22 a.m. revealed MA-M came out from another resident's room with a blood pressure cuff and entered Resident #82's room. MA-M took Resident #82's blood pressure without cleaning the blood pressure cuff. Interview on 03/12/2026 at 8:37 a.m., MA-M said she did not clean the blood pressure cuff and measured Resident #82's blood pressure without cleaning it. The MA-M stated she forgot cleaning it, and she should have cleaned the blood pressure cuff after using it to prevent possible infection. Interview on 03/13/2026 at 2:18 p.m., the DON said the facility did not have a policy regarding cleaning the blood pressure cuff after using it, but the MA-M should have cleaned the blood pressure cuff after using it to prevent possible infection. A record review of the facility's policy Personal Protective Equipment – Using Gowns dated December 2025 revealed, . To prevent the spread of infections to prevent soiling of clothing with infectious material, to prevent splashing or splattering blood or body fluids onto clothing or exposed skin, and to prevent exposure to the HIV (human immunodeficiency virus) and hepatitis B viruses from blood or body fluids. Obtain the gown, wash hands, unfold the gowns that the opening is at the back, put your arms into the sleeves of the gown, don the gown at the neck, tie at the neck, overlap the gown at the back, be sure clothing is completely covered, secure at the waist, . removing the gown, untie unfasten the back of the gown, remove gloves and discard them into waste receptacle in the room, untie the neckband, while still holding the neck strings pull the gown off the shoulders, remove the gown by rolling it away from the body, handle the inside of the gown only, discard the gown into (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the waste receptacle inside the room, wash hands, if a mask was used during the procedure or services remove it at this time and discard it into the waste receptacle inside the room, wash hands. Record review of the facility policy, titled Perineal/Incontinent care, dated 12/2025, revealed .12. Removed gloves and discard into designated container. Wash and dry your hands thoroughly.

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	03/13/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the interdisciplinary team determined an individual may self-administer drugs in a safe practice for 1 of 6 residents (Resident #41) reviewed for administration of medications. The facility did not follow the facility's policy regarding Self-Administration of Medications when Resident #41 administered his nasal spray for allergy by himself. This failure could affect residents who self-administer medications by placing them at risk of not receiving their physician ordered medication treatment to meet their individual needs.The findings included: Record review of Resident #41's face sheet, dated 03/12/2026, revealed the resident was a 77-years-old male, originally admitted on [DATE], and readmitted on [DATE] to the facility with diagnosis of lack of coordination (poor muscle control that causes clumsy movement), Chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and allergy rhinitis (when a reaction occurs that causes nasal congestion, runny nose, sneezing, and itching). Record review of Resident #41's quarterly MDS assessment, dated 02/14/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity.Record review of Resident #41's comprehensive care plan, dated 02/16/2026, revealed the resident had the care plan of My resident rights will be respected and maintained through the review date. For intervention - Freedom of choice: I have the right to: make my own choices regarding personal affairs, care, benefits, and services, choose your own physician at your own expense or through a health care plan manage your own financial affairs in the leastrestrictive method, or to delegate that responsibility to another person. Record review of Resident #41's physician's order, starting date 02/20/2026, revealed the resident had the order of Nasal Mist Inhalation Aerosol Solution 0.9 % (Sodium Chloride (Inhalant)) 1 puff in nostril one time a day for allergies. Record review of Resident #41's medication administration record from 03/01/2026 to 03/31/2026 revealed the medication of Nasal Mist Inhalation Aerosol Solution 0.9 % (Sodium Chloride (Inhalant)) 1 puff in nostril one time a day for allergies was scheduled at 8:00 am. Record review of Resident #41's medication record from 02/20/2026 to 03/12/2026 revealed there was no evolution form for self-administration of medications and there was no self-administered medication record also. Observation on 03/12/2026 at 7:57 a.m. revealed Medication Aide-M administered morning medications to Resident #41, except Nasal Mist Inhalation Aerosol Solution 0.9 %. Interview on 03/12/2026 at 12:14 p.m. Resident #41 said he administered his Nasal Mist Inhalation Aerosol Solution 0.9 % to each nostril with one puff every day morning by himself, and he did it even when he was in his home. The resident said he wanted to administer the medication by himself, instead of nurses. The resident said nobody evaluated him regarding this medication, and he had this medication in his possession. Interview on 03/12/2026 at 12:21 p.m. Medication Aide-M said Resident #41 said he wanted to administer his Nasal Mist Inhalation Aerosol Solution 0.9 % to each nostril with one puff by himself, so the medication aide told it to nurses, but the medication aide said she could not remember when she told it and who she told it. Interview on 03/12/2026 at 12:17 p.m. LVN-U said nobody reported regarding Resident #41's self-administered medication of Nasal Mist Inhalation Aerosol Solution 0.9 %. The nurse stated if the resident wanted to do it by himself, nurses should have contacted his physician, evaluated his ability to do, and documented it on self-administered medication record, and the nurse said she did not know Resident #41 was administered the medication by himself until the surveyor told her. Interview on 03/13/2026 at 2:18 p.m. the DON said Resident #41 had the right to choose the self-administration of medications and he was able to do self-administration of medications, but the facility should have contacted his physician, evaluated his ability, and documented it on self-administered medication record per the facility policy. However, because of lack of communication between nurses and (continued on next page)

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	03/13/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication aide, the facility failed to follow the policy, and the failure might affect inaccurate drug administration. Record review of the facility policy, titled Self-Administration of Medications, dated 12/2025, revealed . 5. The staff and practitioner will document their finding and the choices of residents who are able to self-administer mediations. 6. For self-administering medications, the nursing staff will determine who will be responsible (the resident or nursing staff) for documenting that medication were taken. 12. Nursing staff will review the self-administered medication record on each nursing shift and they will transfer pertinent information to the medication administration record kept at the nursing station appropriately noting that the doses were self-administered.

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	03/13/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN (as needed) orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication for 2 (Residents #6 and #54) of 5 residents reviewed for chemical restraint, in that: 1. The facility failed to ensure Resident #6 was prescribed Lorazepam for anxiety, no longer than 14 days PRN (as needed) and no duration. 2. Resident #54 were prescribed lorazepam (a class of prescription benzodiazepine [depressant] medications that slow down the central nervous system to treat anxiety, which are intended for short-term use due to risks of dependency and addiction) to be administered as needed, indefinitely without an end date. This failure could place residents at risk of receiving unnecessary psychotropic medications. A record review of Resident #54's admission record dated 3/11/2026 revealed an admission date of 9/23/2025 with diagnoses which included generalized anxiety disorder and cerebral infarct (stroke; a medical emergency that occurs when blood flow to a part of the brain is blocked or a blood vessel in the brain bursts, preventing oxygen from reaching brain tissue). A record review of Resident #54's quarterly MDS assessment dated [DATE] revealed Resident #54 was a [AGE] year-old male admitted for long term care with ADLs. Resident #54 was assessed with a BIMS score of 14 out of a possible 15 which indicated no cognitive impairment. A record review of Resident #54's care plan dated 3/11/2026 revealed, I use as needed anti-anxiety medications related to anxiety . give anti-anxiety medications ordered by physician . anti-anxiety side effects; drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, Lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision . A record review of Resident #54's physician's orders revealed on 10/21/2025 the physician prescribed Resident #54 to receive lorazepam 0.5mg, as needed every 12 hours, indefinitely without an end date. A record review of Resident #54's medication administration record for January and February 2026 revealed Resident #54 had been administered as needed lorazepam medication several times: on 1/3/2026, 1/6/2026, 1/13/2026, and on 2/5/2026. During an interview on 3/12/2026 at 4:00 PM LVN G stated the Medical Director prescribed Resident #54 to receive lorazepam 0.5mg as needed for episodes of anxiety. LVN G stated Resident #54 had been administered the medication several times this year (2026), on 1/3/2026, 1/6/2026, 1/13/2026, and on 2/5/2026. LVN G stated Resident #54's lorazepam order began 10/21/2025 and had no end date for discontinuation. LVN G stated the order should have an end date and limited to 14-days per professional standards. LVN G stated she intended to assess Resident #54 and to report to the Medical Director and ask for an order clarification. During an interview on 3/12/2026 at 4:15 PM ADON H stated she had reviewed Resident #54's medical record and revealed the physician had prescribed an indefinite order of lorazepam for Resident #54 and could not identify where the physician had documented a rational for the indefinite (continued on next page)

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	03/13/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. ADON stated she was assigned the Pharmacy Services portion of the nursing duties and was responsible for reviewing all antipsychotic orders and would ensure orders which were administered as needed would be presented to the Physician for review to have and end date of no longer than 14-days or an end date longer than 14-days with a documented rationale for the extended end date. ADON stated she had not recognized Resident #54 had an antipsychotic order to be administered as needed without an end date. ADON stated the potential negative outcome for residents who received antipsychotic medications without an end date could be prolonged medication administration without an end date. During an interview on 3/13/2026 at 2:24 PM the DON stated her expectation for prescribed antipsychotic medications which were intended to be administered as needed was for the order to not exceed a 14-day duration. The DON stated all antipsychotic orders were reviewed at a minimum upon the date they were prescribed and monthly. The DON stated she was a member of the Interdisciplinary Team (IDT) which reviewed the orders and ensured antipsychotic medication orders which were intended to be administered as needed had an end date and was initially no longer than 14-days. The DON stated Resident #54's October 2025 order without an end date and was an oversight and the potential negative outcome for residents who received antipsychotic medications without an end date could be prolonged medication administration without an end date. A record review of the facility's Antipsychotic or Neuroleptic Medication Use policy dated December 2025, revealed, . The need to continue as needed orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the as needed order will be indicated in the order. As needed orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of the medication. document and observe, document, and report to the attending physician information regarding the effectiveness of any interventions including anti-psychotic medications. The physician shall respond appropriately by changing or stopping problematic doses or medications or clearly documenting based on assessing the situation why the benefits of the medication outweigh the risks or suspected will confirmed adverse consequences. The findings were: 1. Record review of Resident #6's face sheet, dated 03/13/2026, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis (partial muscular weakness that occurs on one side of the bed, while hemiplegia is total paralysis on one side), Alzheimer's disease (progressive disease that destroy memories and other important mental functions), and anxiety disorder (symptoms of intense anxiety or panic that are directly by a physical health problem). Record review of Resident #6's admission MDS assessment, dated 01/23/2026 reflected that she was assessed to have a BIMS score was 4 out of 15 indicating she had severe cognitive impairment. Resident #6 was assessed to not have verbal and other behavioral symptoms. However, Resident #6 was assessed to have psychiatric / mood disorder: anxiety disorder, but Resident #6 was further assessed to not be on an antianxiety medication. Record review of Resident #6's comprehensive care plan, dated 02/01/2026, reflected the resident had the care plan of The resident use PRN (as needed) anti-anxiety medications related to anxiety disorder. For intervention - Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. ANTIANXIETY SIDE EFFECTS: Drowsiness, lack of energy, (continued on next page)

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	03/13/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clumsiness, slow reflexes, Slurred speech, Confusion and disorientation, Depression, Dizziness, lightheadedness, Impaired thinking and judgment, Memory loss, forgetfulness, Nausea, stomach upset, Blurred or double vision. PARADOXICAL SIDE EFFECTS (effects of a chemical substance, such as a medical drug, that is opposite to what would usually be expected): Mania, Hostility and rage, Aggressive or impulsive behavior, Hallucinations. Record review of Resident #6's physician's orders, start dated 01/20/2026, reflected the resident had the order of LORazepam Oral Tablet 0.5 MG (Lorazepam) - Give 1 tablet by mouth every 4 hours as needed for ANXIETY -Start Date- 01/20/2026. Record review of Resident #6's medication administration record from 03/01/2026 to 03/31/2026 revealed Resident #6 did not receive Lorazepam 0.5 mg. Interview with LVN-G on 03/13/2026 at 9:47 a.m., revealed it was confirmed Resident #6 had an order for Lorazepam oral tablet 0.5 mg for anxiety disorder as needed when the resident had anxiety, but the resident did not receive it because when the resident had anxiety, verbal redirections were effective. Interview with the MDS Coordinator on 03/13/2026 at 10:32 a.m., revealed it was confirmed that because Resident #6 did not receive her Lorazepam oral tablet 0.5 mg as needed for anxiety, the resident's MDS assessment coded as No antianxiety. Interview with the DON on 03/13/2026 at 11:15 a.m., revealed it was confirmed Resident #6 had an order for Lorazepam Tablet 0.5 MG - Give 1 tablet by mouth every 4 hours as needed for ANXIETY, and the order should have only been for 14 days. The DON stated she did not know why the order was written over 14 days and did not have duration, as overuse could place Resident #6 at risk for taking unnecessary medications. The DON said she was responsible for overseeing antipsychotic medications daily and currently monitored it at random, and it might affect Resident #6 by her receiving unnecessary medications without re-evaluations.

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	03/13/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 20 Residents (Resident #82) whose records were reviewed. The facility failed to ensure Resident #82's baseline care plan included the resident's dialysis status, wound care, and the use of oxygen. This deficient practice could affect any resident and contribute to residents not having their needs met based on their assessment.The findings were:Record review of Resident #82's face sheet, dated 03/13/2026, revealed that the resident was a 74-years-old female and admitted to the facility on [DATE] with diagnosis of pulmonary embolism (sudden blockage in a lung artery), peripheral vascular disease (reduced circulation of blood to a body part other than the brain or heart), and dependence on renal dialysis (require dialysis treatment of chronic kidney diseases or acute kidney injury). Record review of Resident #82's admission MDS assessment revealed the assessment was in progress on 03/13/2026 because the resident was admitted to the facility on [DATE]. Record review of Resident #82's physician order, start dated 03/07/2026, revealed the resident had the order of [Resident #82] to have dialysis every Monday, Wednesday, and Friday at chair time 2:45 PM - pick up at 1:45 PM. Every shift every and Woundcare: left lower leg: Clean wound using gauze and vashe solution. Allow wound bed to soak with vashe saturated gauze for approximately 5 minutes. Clean with damp vashe gauze for peri-wound 4-6 centimeters beyondwound edges circumferentially (from inside to the outside). Pat dry. Apply xeroform gauze to wound bed, cover with abdominal pad, lightly wrap with kerlix gauze, secure with tape. Daily & if needed/soiled. Every day shift for wound care. Further record review of Resident #82's physician orders revealed there was no physician order related to oxygen. Observation on 03/12/2026 at 10:09 a.m. revealed Resident #82 had 3 liters oxygen per minute via nasal cannular and received wound care from the wound care nurse. Interview on 03/12/2026 at 10:09 a.m. with Resident #82 said she had dialysis on every Monday, Wednesday, and Friday. Record review of Resident #82's baseline care plan, dated 03/07/2026, revealed the resident did not have the baseline care plans of dialysis, wound care, and oxygen. Interview on 03/13/2026 at 9:27 a.m. LVN-U stated Resident #82 was receiving oxygen therapy, dialysis, and wound care since she was admitted to the facility on [DATE]. Interview on 03/13/2026 at 10:35 a.m. the MDS Coordinator stated Resident #82's baseline care plan did not reflect the resident's oxygen therapy, dialysis, and wound care, and it was MDS Coordinator's mistake to make sure the baseline care plan reflect the oxygen therapy, dialysis, and wound care. The MDS Coordinator said Resident #82's baseline care plan should have reflected the resident's oxygen, dialysis, and wound care because Resident #82 was receiving oxygen therapy, dialysis, and wound care since she was admitted to the facility on [DATE], and if the baseline care did not reflect those areas, staff might not provide proper care to the resident. Interview on 03/13/2026 at 2:18 p.m. the DON said the MDS Coordinator should have reflected Resident #82's oxygen, dialysis, and wound care on the resident's baseline care plan because Resident #82 was receiving oxygen therapy, dialysis, and wound care since she was admitted to the facility on [DATE] to make sure the resident received proper care. Record review of the facility policy, titled Care plan - baseline, dated 12/2025, revealed 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.

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	03/13/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident and identify the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 20 Residents (Residents #46 and #4) whose records were reviewed for resident needs. 1. The facility failed to ensure Resident #46's care plan reflected the care for the resident's bowel incontinence. 2. The facility failed to ensure Resident #4's care plan was revised and updated after the resident's gastrostomy feeding tube status was changed from continuous feeding to bolus feeding (a way to send formular through feeding tube using a catheter syringe) only at bedtime. The deficient practice could place residents at risk of not receiving proper care and services.The findings were: 1. Record review of Resident #46's face sheet, dated 03/13/2026, revealed the resident was a-91-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of cerebral infarction (disrupted blood flow to the brain due to problem with the blood vessels that supply it), muscle weakness, and hemiplegia and hemiparesis (partial muscular weakness that occurs on one side of the bed, while hemiplegia is total paralysis on one side). Record review of Resident #46's quarterly MDS assessment, dated 12/22/2025, revealed the resident's BIMS score was 0 out of 15 which indicated the resident had severe cognitive impairment and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to transfer for chair-to-bed and toilet, and the resident was always incontinent to bowel and bladder. Record review of Resident #46's comprehensive care plan, dated 09/09/2024, revealed the resident had the care plan of I have bladder incontinence related to hemiplegia and hemiparesis. For interventions - Observe/document for signs and symptoms related to urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Further record review of the care plan did not have any care related to bowel incontinence. Interview on 03/13/2026 at 9:44 a.m. LVN-G stated Resident #46 was always incontinent to bowel and bladder, so the staff should provide incontinent care to bowel and bladder for the resident. Interview on 03/13/2026 at 10:28 a.m. the MDS Coordinator said Resident #46's comprehensive care plan should have reflected the resident's bowel incontinence care because she was always incontinent of bowel, and missing the bowel incontinence care in the care plan was her mistake and it might affect the resident by not receiving proper care. 2. Record review of Resident #4's face sheet, dated 03/13/2026, revealed the resident was a-90-years-old female and admitted to the facility on [DATE] with diagnosis of cerebral infarction (disrupted blood flow to the brain due to problem with the blood vessels that supply it), dysphagia (difficulty in swallowing), and gastrostomy status (surgical opening into stomach for nutritional support or gastric decompression). Record review of Resident #4's quarterly MDS assessment, dated 01/05/2026, revealed the resident's BIMS score was 3 out of 15 which indicated the resident had severe cognitive impairment and had feeding tube for nutrition. Record review of Resident #4's physician order, started date on 02/27/2026, revealed the resident had the order of Enteral Feed Order at bedtime give 2 bolus (each can 250 cubic centimeters) of Fibrersource 1.2 to provide 600 kilocalories/54gram/protein/404ml free water. Record review of Resident #4's comprehensive care plan, dated 10/08/2025, revealed the resident had the care plan of I require tube feeding related to Dysphagia. Intervention - Fibersource 1.2 at 55ml/hour for 22 hours Flush with 80 milliliters water every 4 hours AND in the morning for Tube Feeding Orders Downtime for 2 hours disconnect at 6am and reconnect at 8am. Interview on 03/13/2026 at 9:22 a.m. LVN-U said Resident #4 was eating foods and medications by mouth, and the physician changed order from (continued on next page)

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	03/13/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuous feeding to bolus feeding only at bedtime on 02/27/2026. Interview on 03/13/2026 at 10:24 a.m. the MDS Coordinator said Resident #4's comprehensive care plan regarding her feeding tube should have been revised and updated because the resident had bolus feedings only at bedtime, instead of continuous feeding, since 02/27/2026, and it was her mistake. The MDS Coordinator said not updating care plan might affect the resident could not receive proper care.Record review of the facility policy, titled Care plans, comprehensive, dated 12/2025, revealed . 8. The comprehensive, person-centered care plan will describe the servibeing.t are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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	03/13/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #37) of 4 residents reviewed for incontinence care. When CNA-V was providing incontinent care to Resident #37 on 03/12/2026, CNA-V cleaned the perineal area with multiple passes of one wipe. The failure could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections.The findings included: Record review of Resident #37's face sheet, dated 03/13/2026, reflected the resident was a [AGE] year-old male originally admitted on [DATE] and readmitted to the facility on [DATE] with the following diagnoses of lack of coordination (poor muscle control that causes clumsy movement), urinary tract infection (an infection in any part of the urinary system, such as bladder), and obstructive and reflux uropathy (urinary tract disorder due to a structural or functional obstruction of urinary flow). Record review of Resident #37's quarterly MDS assessment, dated 01/31/2026, reflected that he was assessed to have a BIMS score was 6 out of 15 indicating he had severe cognitive impairment. Resident #37 was assessed he had indwelling urinary catheter and frequently incontinence to bowel. Record review of Resident #37's comprehensive care plan, dated 11/01/2024, reflected the resident had the care plan of I have Indwelling Catheter related to obstructive and reflux uropathy and bowel incontinence. For intervention - clean catheter and peri-area with each incontinence episode. Observation on 03/12/2026 at 4:13 p.m. revealed CNA-V opened Resident #37's old and dirty brief, cleaned the resident's right and left groin areas, and cleaned the resident's genital area and indwelling urinary catheter with multiple pass of one wipe. The CNA then cleaned the resident's buttock areas. Interview on 03/12/2026 at 4:29 p.m. CNA-V stated when she was providing incontinent care to Resident #37, she cleaned with multiple passes of one wipe when cleaning the resident's penis and buttock area because she was very nervous. CNA-V said she should have used a new wipe with each stroke to prevent infection. Interview on 03/12/2026 at 6:00 p.m. the DON said CNA-V should have used a new wipe with each stroke to prevent infection. Record review of the facility policy, titled Perineal/Incontinence Care, revised 12/2025, revealed . 10. For a male resident: . (3) Continue to wash the perineal area including the penis, scrotum and inner thigh. Do not reuse the same washcloth or water to clean the urethra.

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	03/13/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who need respiratory care were provided with such care, consistent with professional standards of practice for 2 (Resident #57 and #82) of 9 residents reviewed for respiratory care. 1. Resident #57's nebulizer mask for breathing treatment was not covered in a plastic bag when it was not being used on 03/10/2026. 2. Resident #82 was receiving oxygen therapy without a physician's order. This failure could place residents at risk of illness, respiratory complications and accidents.The findings included: 1. Record review of Resident #57's face sheet, dated 03/13/2026, revealed the resident was a 100-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of lack of coordination (poor muscle control that causes clumsy movement), atrial fibrillation (irregular and often very rapid heart rhythm), and atherosclerotic heart disease (caused by plaque buildup in arterial walls). Record review of Resident #57's quarterly MDS assessment, dated 01/21/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and the resident was receiving oxygen therapy. Record review of Resident #57's comprehensive care plan, dated 10/15/2025, revealed the resident had the care plan of I have as needed Oxygen Therapy related to history of Ineffective gas exchange. For intervention - OXYGEN SETTINGS: OXYGEN at 2 liter per minute via nasal cannular OR FACE MASK TO MAINTAIN oxygen saturation GREATER THAN 90% FOR short of breath as needed. Record review of Resident #57's physician order, starting date 01/02/2026, revealed the resident had the order of Ipratropium-Albuterol Solution 0.5-2.5 (3) Milligram/3miliiters 3 ml inhale orally every 8 hours as needed for short of breath or Wheezing via nebulizer. Observation on 03/10/2026 at 10:05 a.m. revealed Resident #57 was sleeping on the bed with oxygen 2 liters per minute via a nasal cannular. Further observation revealed there was a nebulizer on the nightstand at the bedside, and the mask connected to the nebulizer was on the nightstand without covering in a plastic bag. Interview on 03/10/2026 at 11:25 a.m. the ADON said Resident #57's mask connected to the nebulizer on the nightstand was not covered in a plastic bag, and it should have been covered in a plastic bag when it was not used to prevent possible infection. Interview on 03/13/2026 at 2:18 p.m. the DON said Resident #57's mask connected to a nebulizer for breathing treatment should have been covered in a plastic bag when it was not used to prevent infection. 2. Record review of Resident #82's face sheet, dated 03/13/2026, revealed that the resident was a 74-years-old female and admitted to the facility on [DATE] with diagnosis of pulmonary embolism (sudden blockage in a lung artery), peripheral vascular disease (reduced circulation of blood to a body part other than the brain or heart), and dependence on renal dialysis (require dialysis treatment of chronic kidney diseases or acute kidney injury). Record review of Resident #82's admission MDS assessment revealed the assessment was in progress on 03/13/2026 because the resident was admitted to the facility on [DATE]. Observation on 03/12/2026 at 10:09 a.m. revealed Resident #82 had 3 liters of oxygen per minute via nasal cannular. Interview on 03/12/2026 at 10:09 a.m. with Resident #82 said she had oxygen since she came to the facility. Record review of Resident #82's baseline care plan, dated 03/07/2026, revealed the resident did not have the baseline care plans of oxygen. Record review of Resident #82's physician order, starting dated 03/07/2026, revealed there was no physician's order related to oxygen. Interview on 03/13/2026 at 9:27 a.m. LVN-U stated Resident #82 was receiving oxygen therapy since she was admitted to the facility on [DATE], and the nurse did not know there was no physician's order regarding the resident's oxygen therapy LVN-U said she would contact the resident's physician and get the order immediately because oxygen should have been administered with the physician's order. Interview on 03/13/2026 at 2:18 p.m. the DON said Resident #82 needed to have oxygen therapy due to her respiratory status, and the DON did not know what reason no physician order regarding the resident's oxygen therapy was, and facility nurse might make mistakes regarding putting the oxygen (continued on next page)

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	03/13/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order into the system. If the resident did not have oxygen order, the resident might have inappropriate care or lack of care. Record review of the facility policy, titled Department (Respiratory Therapy) - prevention of infection, dated 12/2025, revealed . 7. Store the circuit in plastic gag, marked with date and resident's name, between uses.

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	03/13/2026

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 of 20 residents (Residents #41) reviewed for food and nutrition services. The facility failed to ensure Resident #41's personal refrigerator, located in his room, did not have a small plastic cup that was not dated or labeled. This failure could place the residents at risk for food borne illness.The findings include: Record review of Resident #41's face sheet, dated 03/12/2026, revealed a 77-years-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #41 had diagnoses which included lack of coordination (poor muscle control that causes clumsy movement), Chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and allergy rhinitis (when a reaction occurs that causes nasal congestion, runny nose, sneezing, and itching). Record review of Resident #41's quarterly MDS assessment, dated 02/14/2026, revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive was intact. Resident #41 required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating. Record review of Resident #41's comprehensive care plan, dated 02/16/2026, revealed I have a nutritional problem or potential for nutritional problem related to Protein-Calorie Malnutrition. For intervention - Monitor/document/report to physician for signs and symptoms of dysphagia (difficulty in swallowing): Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Observation on 03/10/2026 at 10:11 a.m. revealed in Resident #41's room, there was one small refrigerator. Inside the refrigerator, there was one plastic container with some food, and the container did not have a label and was not dated. Interview on 03/10/2026 at 10:12 a.m., Resident #41 said the resident's family member might bring the food, but he did not know what it was and when the resident's family member would bring it. Interview on 03/10/2026 at 11:27 a.m., the ADON stated in Resident #41's room, there was one small refrigerator. Inside the refrigerator, there was one plastic container with some food, and the container did not have any label or date. The ADON said it looked like chicken salad, and the facility nurses should have labeled and dated the container when the resident's family brought the food from outside to prevent possible food illness, and night nurses should have checked the resident's refrigerator every night. Interview on 03/13/2026 at 2:18 p.m., the DON said the facility nurses should have labeled and dated the container when the resident's family brought the food from outside to prevent possible food illness. Record review of the facility's policy, titled Foods Brought by Family/Visitors, dated 12/2025, revealed . 7. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Container will be labeled with the resident's name, the item and the use by date.

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	03/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices, on each resident that were complete and accurately documented for 1 of 20 residents (Resident #4) reviewed for accuracy and completeness of clinical records. The facility failed to ensure Resident #4 had physician orders that documented the could have liquid protein supplements by mouth instead of via gastrostomy tube. This failure could place residents at risk for incorrect medication administrations due to misinformation by incomplete and inaccurate medical record. Findings include: Record review of Resident #4's face sheet, dated 03/13/2026, revealed a 90-years-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included cerebral infarction (disrupted blood flow to the brain due to problem with the blood vessels that supply it), dysphagia (difficulty in swallowing), and gastrostomy status (surgical opening into stomach for nutritional support or gastric decompression). Record review of Resident #4's quarterly MDS assessment, dated 01/05/2026, revealed the resident's BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Resident #4 had feeding tube for nutrition. Record review of Resident #4's physician order, start date on 09/24/2025, revealed the resident had the order of Liquid Protein in the morning for supplement Give 30milliters every day via gastrostomy tube to provide 15 gram protein/100kilocalories. Further record review of the physician orders revealed the resident was receiving all medications by mouth. Interview on 03/13/2026 at 9:22 a.m., LVN-U stated Resident #4's order of Liquid Protein in the morning for supplement Give 30ml every day via gastrostomy tube to provide 15 gram protein/100kcals was incorrect and inaccurate because the resident was receiving all food and medications by mouth as ordered, and the resident was receiving only bolus feeding via gastrostomy tube at bedtime. The nurse said she did not know what reason the order had still via gastrostomy tube, instead of by mouth. Interview on 03/13/2026 at 2:19 p.m., the DON said Resident #4's order of Liquid Protein in the morning for supplement Give 30 miliiters every day via gastrostomy tube to provide 15 gram protein/100kcals was incorrect and inaccurate because the resident was receiving all food and medications by mouth as ordered. The DON said when the facility nurses changed orders regarding Resident #4's medications from via gastrostomy tube to by mouth, nurses did not change only this order of Liquid Protein in the morning for supplement. The DON stated an inaccurate medical record might affect inaccurate care to the resident due to confusion. Record review of the facility's policy, titled Charting and documentation, dated 12/2023, revealed All services provided to the resident or any changes in the resident's medical or mental conditions, shall be documented in the resident's medical record.