STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455001	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Beaumont	4195 Milam St Beaumont, TX 77707

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. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure its residents were free of any significant medication errors for 2 (Resident #1 and Resident #2) of 10 residents reviewed for medications. The facility failed to hold Losartan per parameters stated in physicians' orders for a total of 8 doses in July 2025 for Resident #1. The facility failed to hold Metoprolol per parameters stated in physicians' orders for 4 doses and Clonidine per parameters stated in physicians' orders for a total of 9 doses in July 2025 for Resident # 2. These failures placed the residents at risk of harm or not receiving desired outcomes from medications not administered according to physician's orders and manufacturer's specifications.Findings Included: 1. Record review of Resident #1's face sheet indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include: Alzheimer's disease (progressive disease that destroys memory and other important mental functions), severe protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and malignant neoplasm of overlapping sites of bronchus and lung (a cancerous tumor which is located in the lungs and in the two main airways of the body that join the windpipe to each lung). Resident #1 discharged on 07/28/2025 to an acute care hospital. Record review of Resident #1's significant change in status MDS assessment dated [DATE], indicated she was severely impaired cognitively with a BIMS score of 01. She required maximal assistance with self-care and mobility. Record review of Resident #1's Comprehensive Care Plan last revised 02/15/2024, indicated she had hypertension with interventions to give antihypertensive medications as ordered and monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness and report to MD as necessary. Record review of Resident #1's physicians' orders indicated: Losartan Potassium Oral Tablet 25 mg give 1 tablet by mouth at bedtime for high blood pressure hold for SBP 110 & below & DBP 60 & below order dated 05/26/2025. Record review of Resident #1's MAR for July 2025 Blood Pressure monitoring indicated: 07/07/2025 at 7:00 p.m. BP 102/61, 07/08/2025 at 7:00 pm. BP 110/60, 07/09/2025 at 7:00 p.m. BP 110/62, 07/10/2025 at 7:00 p.m. BP 104/61, 07/17/2025 at 7:00 p.m. BP 99/67, 07/19/2025 at 7:00 p.m. BP 104/72, 07/20/2025 at 7:00 p.m. BP 105/61 and 07/25/2025 at 7:00 p.m. BP 126/58. Record review of Resident #1's MAR for July 2025 indicated Losartan was not held on: 07/07/2025 at 7:00 p.m. BP 102/61 by RN D, 07/08/2025 at 7:00 pm. BP 110/60 by LVN C, 07/09/2025 at 7:00 p.m. BP 110/62 by RN D, 07/10/2025 at 7:00 p.m. BP 104/61 by RN D, 07/17/2025 at 7:00 p.m. BP 99/67 by RN D, 07/19/2025 at 7:00 p.m. BP 104/72 by RN D, 07/20/2025 at 7:00 p.m. BP 105/61 by RN D and 07/25/2025 at 7:00 p.m. BP 126/58 by RN D. Unable to interview Resident #1, no longer resided at the nursing facility and has been admitted to an inpatient hospice facility. 2. Record review of Resident #2's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include: high blood pressure, cognitive communication deficit, anxiety and depression. Record review of Resident #2's quarterly MDS assessment dated [DATE], indicated she had active diagnoses in the last 7 days of hypertension (condition in which the force of the blood against the artery walls is too high) and she was moderately impaired cognitively with a BIMS score of 10. She used a manual wheelchair for mobility but was totally dependent on staff for mobility and assistance with transfer to and from a bed to wheelchair. Record review of Resident #2's Comprehensive Care Plan last revised 12/13/2024, indicated she had hypertension with interventions to give antihypertensive medications as ordered and monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness and report to MD as necessary. Record review of Resident #2's physician's orders indicated: Clonidine HCl Tablet 0.1 mg give 1 tablet by mouth three times a day related to hypertension HOLD IF BP < 110/60 OR PULSE <60; order dated 02/06/2022. Record review of Resident #2's physician's orders indicated: Metoprolol Tartrate Oral Tablet give 25 mg by mouth two times a day for hypertension HOLD FOR BP < 110/60. Record review of Resident #2's MAR for July 2025 Blood Pressure monitoring indicated: 07/04/2025 at 1:00 p.m. BP 100/65, 07/07/2025 at 1:00 p.m. BP 92/68, 07/08/2025 at 7:00 a.m. BP 101/60, 07/08/2025 at 1:00 pm. BP 101/60, 07/14/2025 at 7:00 a.m. BP 109/70, 07/14/2025 at 1:00 p.m. BP 109/70, 07/22/2025 at 8:00 p.m. BP 107/60, 07/27/2025 at 1:00 p.m. BP 110/54, and 07/29/2025 at 8:00 p.m. BP 106/72. Record review of Resident #2's MAR for July 2025 indicated Clonidine was not held on: 07/04/2025 at 1:00 p.m. BP 100/65 by LVN A

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 1 of 6 residents (Resident #1) reviewed for laboratory services. The facility failed to ensure Resident #1's Comprehensive Metabolic Panel, also known as CMP (a blood test that checks for a wide range of substances in your blood, including proteins, enzymes, electrolytes, and minerals), Complete Blood Count also known as CBC (a blood test that measures amounts and sizes of your red blood cells, hemoglobin, white blood cells and platelets), carcinoembryonic antigen also known as CEA (blood test measures the level of a specific protein in the blood, primarily used to monitor certain types of cancer), Thyroid-Stimulating Hormone also known as TSH (blood test to assess level of thyroid stimulating hormone and thyroid function and metabolism) and Thyroxine test also known as T4 (blood test that helps diagnosis thyroid conditions) was drawn every 14 days as ordered. This failure could place residents at risk of not receiving lab services as ordered and not managing medications at a therapeutic level.Finding included: Record review of Resident #1's face sheet indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include: Alzheimer's disease (progressive disease that destroys memory and other important mental functions), severe protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and malignant neoplasm of overlapping sites of bronchus and lung (a cancerous tumor which is located in the lungs and in the two main airways of the body that join the windpipe to each lung). Resident #1 discharged on 07/28/2025 to an acute care hospital. Record review of Resident #1's significant change in status MDS assessment dated [DATE], indicated she was severely impaired cognitively with a BIMS score of 01. She required maximal assistance with self-care and mobility. Record review of Resident #1's comprehensive care plan last revised 04/23/2025, indicated she had potential nutritional problem related to low body weight, cancer, and protein calorie malnutrition with interventions of health shakes with meals, magic cup, house supplement, liquid protein and obtain and monitor lab/diagnostic work as ordered, and report results to MD and follow up as indicated. Record review of Resident #1's physician's orders indicated: Obtain CBC w/diff, CEA, CMP, T4, and TSH every 14 day(s) for 6 occurrences start order dated 05/30/2025 and end date 08/08/2025. Record review of Resident #1's electronic health record lab results indicated that her CBC w/diff, CEA, CMP, T4, and TSH was due on 05/30/2025, 06/13/2025, 06/27/2025, 07/11/2025, 07/25/2025 and 08/08/2025. Her CBC w/ diff was obtained on 05/30/2025, 06/12/2025, 07/01/2025, and 07/25/2025. No indication that CBC w/ diff was obtained on 06/27/2025, and 07/11/2025 as ordered by physician. Her CEA was obtained on 05/30/2025 and 06/12/2025. No indication CEA was obtained on 06/27/2025, 07/11/2025, and 07/25/2025 as ordered by physician. Her CMP was obtained on 05/30/2025, 06/12/2025, 06/26/2025, 07/21/2025, and 07/25/2025. No indication CMP was obtained on 07/11/2025 as ordered by physician. Her TSH and T4 was obtained on 05/30/2025, 06/12/2025, 07/01/2025, and 07/25/2025. No indication TSH and T4 was obtained on 06/27/2025 and 07/11/2025 as ordered by physician. During an interview on 08/11/2025 at 3:05 p.m. and 3:20 p.m., LVN E and LVN G said when the nurses received an order for a lab, they would enter it in their electronic medical record system as a lab order and into a lab request electronic system. She said the two systems communicated and the request would generate a lab results entry into the medical records identifying that the labs were ordered and when obtained the results uploaded into the medical records. She said it was the responsibility of the nurse to go into the electronic medical record system periodically throughout the shift to check for lab and x-ray results, review results and report to the NP/MD if applicable. During an interview on 08/11/2025 at 5:05 p.m. and 5:35 p.m., LVN C and LVN H said when receiving orders from a physician via phone, fax or paper, the order was entered into the electronic medical record. They said if a lab was included on the order, the order must be entered into the electronic lab request system to notify the lab of the request. They said the lab system has a place to include date due and if reoccurring event, so one time ordered labs would have the specific date identified but if reoccurring labs would identify dates and that it was a reoccurring event. They said labs due were discussed during shift change and they print a copy of the lab request and place it at the nurses' station to identify any labs coming due and/or results pending. They said it was their responsibility to go into electronic medical records system several times during the shift to check