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	08/19/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained for 1 of 7 residents (Resident #1) reviewed for controlled medications. The facility did not have documentation on Resident #1's July 2025 and August 2025 MARs indicating she was administered her Lorazepam (controlled antianxiety medication) prn when it was signed out on the controlled medication count sheet. The controlled medication count sheet did not indicate the medication doses were wasted. This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. Findings included: Record review of the physician orders for August 2025 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included acute respiratory failure (a serious condition that makes it difficult to breathe on your own), generalized anxiety disorder (persistent and excessive worry that interferes with daily activities), and autistic disorder (autistic disorder-a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication and includes limited and repeated patterns of behavior). Resident #1 had an order dated 07/15/25 for Lorazepam 1mg via g-tube every 8 hours as needed for anxiety/agitation for 90 Days. Record review of the current MDS dated [DATE] indicated Resident #1 rarely/never made herself understood, sometimes understood others, had short term and long term memory problems, had severely impaired cognitive skills for daily decision making, had active diagnosis of anxiety, and did not take any antianxiety medication during the lookback period. Record review of the controlled medication count sheet for Resident #1 indicated the Lorazepam 1mg had one tablet removed:* on 07/21/25 at 10:00 p.m.;* on 07/29/25 at 06:00 p.m.;* on 07/31/25 at 09:00 p.m.;* on 08/13/25 at 06:00 p.m.; and* on 08/15/25 at 08:00 p. m Record review of the July 2025 MAR indicated there was no documentation Resident #1 received a Lorazepam 1mg tablet on 07/21/25, 07/29/25, or 07/31/25. Record review of the Nurse Notes indicated there was no documentation of Resident #1 receiving a Lorazepam 1mg tablet on 07/21/25, 07/29/25, or 07/31/25. Record review of the August 2025 MAR indicated there was no documentation Resident #1 received a Lorazepam 1mg tablet on 08/13/25 or 08/15/25. Record review of the Nurse Notes indicated there was no documentation of Resident #1 receiving a Lorazepam 1mg tablet on 08/13/25 or 08/15/25. During an observation on 08/21/25 at 01:30 p.m., Resident #1 was sitting in her wheelchair in the common area at the nurse station. She was calm without agitation. An interview was attempted but the resident was not able to answer questions appropriately. During an interview on 08/19/25 at 02:00 p.m., LVN A reviewed the controlled medication count sheet and the July and August 2025 MARs. She said it appeared Resident #1's Lorazepam was signed out on the count sheet but there was no documentation of the medication being administered to the resident on the MARs for the dates the medication was signed out. During an interview on 08/19/25 at 02:15 p.m. the ADON reviewed the controlled medication count sheet and the July and August 2025 MARs. She said it would appear Resident #1's Lorazepam was not given to the resident but was signed out on the count sheet. She said she could not verify the resident had been administered the medication based on the July and August 2025 MARs. She said it could possibly be a drug diversion. During an interview on 04/24/25 at 02:30 p.m., the Administrator and DON reviewed Resident #1's controlled medication count sheet and the July and August 2025 MARs and acknowledged Lorazepam was signed out on the count sheet but there was no documentation of the medication being administered to the resident on the MARs for the dates the medication was signed out. They also reviewed the Nurse Notes which did not have any documentation of the medication being administered to the medication. They said the adverse outcome could be a drug diversion.Record review of the Administering Medications policy revised April 2019 indicated the following: .22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.