

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455643	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Avir at Bay City		STREET ADDRESS, CITY, STATE, ZIP CODE 700 12th St Bay City, TX 77414	
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. Based on observations, interviews, and record reviews the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions in accordance with professional standards for 4 of 8 medication carts reviewed for medication storage in that: Medication Carts #1, #2, #3 and #4 contained medications that did not have an open date written on the bottles. The failure to date opened medications placed residents at risk for receiving expired, contaminated, or ineffective medications which could result in medication errors, infection, delayed treatment or adverse drug outcome. Findings: On 2/25/2026 at 10:20 a.m., during a medication storage observation of Medication Cart #1 located on the 400 Hall, in the presence of the DON and RN I, the following medications were observed without a documented date indicating when the medications were opened: Valproic acid solution 250/5ml. (used to treat various types of seizure disorders). Dayquil, Severe Cold and flu (used to treat nose stuffiness, relieve coughing, and ease pain and fever). Nystatin powder 1,000,000iu. (it is used to treat skin infections caused by yeast). Zinc oxide pastes skin protectant with menthol. (is used to protect, soothe and heal the skin, also used in the prevention and treatment of skin breakdown). Triple antibiotic ointment (it is used to help prevent bacterial infection in minor skin injuries). Prevent Silicone cream. (skin protectant that temporarily protects and helps relieve chapped or cracked skin) On 2/25/2026 at 10:51 a.m., during a medication storage observation of Medication Cart #2 located on the 300 Hall, in the presence of the DON and LVN J, the following medications were observed without a documented date indicating when the medication was opened: Two Albuterol Sulfate Inhalation Aerosol 90mcg per activation (used to treat or prevent bronchospasm, or narrowing of the airways in the lungs, relaxes muscles in the airways and increases air flow to the lungs). Valproic acid solution 250/5ml (used to treat various types of seizure disorders). All day Allergy, Cetirizine Hydrochloride (used to treat cold or allergy symptoms such as sneezing, itching, watery eyes, or runny nose). Promethazine/Codeine solution (is a combination medicine used to treat cold or allergy symptoms such as runny nose, sneezing, and cough). ConvaTec Stomahesive Paste 2-ounce tube (used in filling uneven skin surface around the stoma to create a secure seal, preventing leakage and irritation). On 2/25/2026 at 11:03 a.m., during a medication storage observation of Medication Cart #3 located on the 500 Hall, in the presence of the DON and MA L, the following medications were observed without a documented date indicating when the medication was opened: Collagenase Santyl ointments 250 units/30g (is used to treat severe burns or skin ulcers in adults. Santyl helps remove dead skin tissue and aid in wound healing). Silver sulfadiazine cream, USP 1% (is commonly used to treat and prevent wound infections in people with severe burns). Albuterol sulfate inhalation solution 2.5mg/3ml (used to treat or prevent bronchospasm, or narrowing of the airways in the lungs, relaxes muscles in the airways and increases air flow to the lungs). Ammonium Lactate cream 12% (is used to treat dry, scaly, itchy skin). Zinc Oxide 20% cream. (is used primarily to protect, soothe and heal the skin, also used in the prevention and treatment of skin breakdown). Fluticasone Propionate Nasal spray, USP. 50mcg per (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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spray (is used to treat nasal congestion, sneezing, runny nose, and itchy or watery eyes caused by seasonal or year-round allergies). Miebo drops 1.3gm/ml (is a prescription eye drop used to treat the signs and symptoms of dry disease). Nitroglycerin 0.4mg/hr. (skin patch) is used to prevent attacks of chest pain). Pantoprazole Sodium 40mg delayed release oral suspension. (used to treat certain stomach and esophagus problems (such as acid reflux). It works by decreasing the amount of acid your stomach makes. Famotidine tablet 10mg (is used to prevent and relieve heartburn due to acid indigestion). Two packets of Alendronate sodium tablets, USP 70mg (is a medication that strengthens bones and reduces the risk of fractures by slowing bone loss). Mucus relief, Guaifenesin 400mg (is used as an expectorant to relieve chest congestion by thinning and loosening mucus, making it easier to cough up). Brimonidine tartrate/Timolol Maleate ophthalmic solution 0.2%/0.5% 5ml (is an eye drop used to treat increase pressure in the eye). Two packets of Linzess capsules (is used to treat certain types of constipation. Constipation is a condition in which you may have fewer bowel movements than expected, or you may have stools that are hard, dry, lumpy, or painful or difficult to pass). Bisacodyl 5mg, stimulant laxative enteric coated tablets (is a laxative that stimulates bowel movements). Cyclosporine ophthalmic emulsion, 0.05% (is used to treat chronic dry eye syndrome by increasing tear production and reducing inflammation in the eyes). On 2/25/2026 at 11:18 a.m., during a medication storage observation of Medication Cart #4 located on the 500 Hall, in the presence of the DON and LVN K, the following medications were observed without a documented date indicating when the medication was opened: Collagenase Santyl ointments 250 units/30g (is used to treat severe burns or skin ulcers in adults, also used to help remove dead skin tissue and aid in wound healing). Albuterol sulphate inhalation sodium, 0.083% 3ml (is used to treat or prevent narrowing of the airways in the lungs, relaxes muscles in the airways and increases air flow to the lungs). Antimicrobial skin and wound gel. Triple antibiotic ointment (is used to help prevent bacterial infection in minor skin injuries). Triad Hydrophilic wound dressing (is used to manage moisture-prone wounds and protect peri wound skin from irritation and maceration). Dakin's solution (is a diluted sodium hypochlorite solution, is primarily used for cleaning and disinfecting wounds to prevent or treat infections). Therahoney gel (is used to help wound heal, helps debride - remove dead tissue) naturally. Antidiarrheal - Loperamide HCL tablets 2mg (used to treat loose stool or to reduce the amount of stool). On 2/25/2026 at 10:25 a.m., an interview was conducted with RN I. RN I stated that she did not know which staff member opened the medications without documenting an opened date. When asked about the potential consequences of failing to document an opened date, RN I stated that without an opened date, it may result in the administration of an expired medication. RN I further stated that administration of an expired medication could negatively affect a resident's health condition. On 2/25/2026 at 10:51 a.m., an interview was conducted with LVN J. LVN J acknowledged that, in accordance with facility policy and safe medication administration practices, all medications were required to be dated upon opening. LVN J stated she did not know which staff member opened the medications without documenting the opened date. She stated that she discovered the medications had already been opened without a date and indicated there was no way to determine when they were opened. LVN J stated she would discard the medications and ensure that replacement medications were dated at the time of opening. When asked about the potential risk to residents if medications were opened and not dated, she stated that without an opened date, staff would not be able to determine when the medication has expired. LVN J further stated that administering expired medications could cause residents to become ill. She explained that once medications expire, their strength and effectiveness may be reduced, which could result in harm to residents. On 2/25/2026 at 11:03 a.m., an interview was conducted with MA L. MA L Acknowledged responsibility for not ensuring that opened medications contain a documented date open. She confirmed that facility policy required staff to document the dates when medications were opened. MA L stated she did not know which staff member opened the medications without documenting the opened date. MA L further stated that if medications were not dated upon opening, there was a risk that residents could receive (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to document evidence of receiving or refusal of influenza or pneumococcal immunization for 5 of 5 residents reviewed for immunizations (Resident#12, Resident #2, Resident #39, Resident #7, and Resident #5). The facility failed to document evidence in the electronic medical record the offering or the refusal of the influenza and pneumococcal immunization status for Resident #12 and Resident #2. The facility failed to document evidence in the electronic medical record the offering or the refusal of the pneumococcal immunization status for Resident #7, Resident #39, and Resident #5. The failures could place residents at risk of contracting viral illness, influenza or pneumococcal disease, or of not being informed of the benefits and risk which could cause respiratory complications and lead to potential adverse health outcomes. Record review of Resident #12's face sheet dated 2/26/2026 revealed a [AGE] year-old female admitted into the facility on 2/12/2026 with diagnoses that included Unspecified Atrial Fibrillation (irregular heart beat), Type 2 diabetes mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), Hypertensive Heart Disease with heart failure (a condition where the pressure inside the blood vessels is too high leading to heart strain and the heart can't pump blood effectively). Record review of Resident #12's electronic record revealed no documented evidence of the facility offering or the refusal of influenza or pneumococcal vaccines. Record review of Resident #2's face sheet dated 2/26/2026 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (a group of diseases affecting the lungs), Essential Hypertension (a type of high blood pressure that does not have a known cause), and Type 2 Diabetes Mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels). Record review of Resident #2's Comprehensive MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. Section O of Resident #2's Comprehensive MDS dated [DATE] indicated that he was not up to date with both influenza and pneumococcal vaccinations and had declined the offer of both the influenza and pneumococcal vaccines. Record review of Resident #2's electronic record did not reveal documented evidence of Resident #2's refusal of the influenza or pneumococcal vaccines. Record review of Resident #7's face sheet dated 2/26/2026 revealed a [AGE] year-old male was originally admitted into the facility on 6/24/2025 and readmitted on [DATE] with diagnoses that included Paraplegia (a condition where the legs are unable to move due to damage to the spinal cord), Heart Failure (a condition where the heart is unable to pump enough blood to meet the body's needs, leading to fatigue and shortness of breath), Type 2 Diabetes Mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), and Essential Hypertension (a type of high blood pressure that does not have a known cause). Record review of Resident #7's quarterly MDS dated [DATE] revealed a BIMS score of 12 which indicated moderate cognitive impairment. Section O of Resident #7's quarterly MDS indicated that Resident #7 was not up to date with pneumococcal vaccination and declined the offer of the pneumococcal vaccination. Record review of Resident #7's electronic record did not reveal documented evidence of Resident #7's refusal of the pneumococcal vaccine. Record review of Resident #39's face sheet dated 2/26/2026 revealed a [AGE] year-old female originally admitted into the facility on 1/20/2021 and readmitted on [DATE] with diagnoses that included Polyneuropathy (a condition involving damage to the peripheral nervous system affecting sensory and motor functions), Dementia (a general term for a range of conditions affecting memory, thinking, and social abilities), and Heart Failure (a condition where the heart is unable to pump enough blood to meet the body's needs, leading to fatigue and shortness of breath). Record review of Resident #39's quarterly MDS dated [DATE] revealed a BIMS score of 7 which indicated severe cognitive impairment. Section O of Resident #39's quarterly MDS dated [DATE] indicated Resident #39 was not up to date on her (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to implement their policy to ensure residents were offered, received, or refused Covid-19 immunization, for 3 of 5 residents who were reviewed for immunization compliance. (Resident #12, Resident #7, and Resident#2). The facility failed to document in Resident #12, Resident #7, and Resident #2's electronic medical records for having received or having had not received the Covid-19 immunization due to medical contraindication or refusal. This failure could place residents at risk of not being informed of complications and potential adverse health outcomes. Record review of Resident #12's face sheet dated 2/26/2026 revealed a [AGE] year-old female admitted into the facility on 2/12/2026 with diagnoses that included Unspecified Atrial Fibrillation (irregular heart beat), Type 2 diabetes mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), Hypertensive Heart Disease with heart failure (a condition where the pressure inside the blood vessels is too high leading to heart strain and the heart can't pump blood effectively). Record review of Resident #12's electronic record revealed no documented evidence that revealed her immunization status for Covid-19. Record review of Resident #7's face sheet dated 2/26/2026 revealed a [AGE] year-old male was originally admitted into the facility on 6/24/2025 and readmitted on [DATE] with diagnoses that included Paraplegia (a condition where the legs are unable to move due to damage to the spinal cord), Heart Failure (a condition where the heart is unable to pump enough blood to meet the body's needs, leading to fatigue and shortness of breath), Type 2 Diabetes Mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), and Essential Hypertension (a type of high blood pressure that does not have a known cause). Record review of Resident #7s quarterly MDS dated [DATE] revealed a BIMS score of 12 which indicated moderate cognitive impairment. Record review of Resident #7's electronic medical record revealed no documented evidence that revealed Resident #7's immunization status Covid-19. Record review of Resident #2's face sheet dated 2/26/2026 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (a group of diseases affecting the lungs), Essential Hypertension (a type of high blood pressure that does not have a known cause), and Type 2 Diabetes Mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels). Record review of Resident #2's Comprehensive MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. Record review of Resident #2's electronic medical record revealed no documentation that revealed Resident #2's immunization status against Covid-19. Interview with the ADON on 2/26/2026 at 9:32 am revealed she was the infection preventionist for the facility and was responsible for immunization compliance along with the DON. The ADON stated that a resident's immunization status should be listed in the immunization tab of the electronic record but sometimes is in the notes section. The ADON stated that all residents are offered immunizations for influenza, pneumococcal, and covid on admission. The ADON stated on 2/26/2026 a Covid Clinic took place at the facility in January 2025. The ADON stated that at that time, the facility used an electronic medical record software called the Matrix system which is no longer being utilized in the facility. The ADON stated that the facility now used a newer electronic medical record software program called Point Click Care {PCC}. The ADON stated that immunizations that were administered or refused were not transferred over into the PCC. The ADON stated that this was still a work in progress. When asked to provide any documentation of covid vaccine administration or refusal of for Resident #12, Resident #7, and Resident #2, the ADON stated she could not locate the information. The ADON stated that another Covid Clinic would be scheduled but was waiting until there were multiple residents who needed the immunization. When asked what (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was the number that was needed before a Covid Clinic could take place, the ADON was unable to give a specific number of residents. When asked what the risk were associated with not assessing immunization compliance for Covid, the ADON stated the resident could be vaccinated twice for the same illness, the residents could have gotten sick with a preventable disease, or the resident could have received vaccinations that were contraindicated. Interview with the DON on 2/26/2026 at 1:01 pm revealed that overall immunizations was an area that needed attention for compliance. The DON stated that the system change from Matrix to PCC was causing a problem with documentation of covid vaccine administrations and refusals. The DON stated that sometimes residents were already immunized against Covid prior to admission, and but records were not consistently updated in the electronic medical record. The DON stated it was a work in progress. The DON stated the risk of not having up to date immunization records for residents could possibly lead to preventable illness, or unnecessary vaccinations . Record review of facility policy titled Coronavirus Disease (COVID-19) -Vaccination of Residents dated 2001 revised May 2023, revealed in part. The resident's medical record includes documentation that indicates at a minimum. signed consent. #2 prior vaccination or refusal.		

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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 the facility failed to review and revised the person-centered comprehensive care plan for 1 (Resident #22) of 5 residents reviewed for comprehensive care plan revisions. The facility failed to update Resident #22's care plan to reflect the status of Resident #22's NPO status. This failure could place residents at risk of not receiving the appropriate care and interventions they need. Record review of Resident #22's face sheet dated 2/26/2026 revealed a [AGE] year old male admitted to the facility originally on 8/7/2024 and readmitted on [DATE] with diagnoses that included Parkinson's Disease (a progressive movement disorder of the nervous system that worsens over time), Dysphagia Oropharyngeal phase (the inability to swallow food or drink), and Unspecified Dementia (a decline in cognitive function affecting memory, thinking, behavior, and the ability to perform everyday activities). Record review of Resident #22's Order Summary dated 2/26/2026 revealed a dietary order of a NPO diet with a start date of 2/18/2026. Resident #22 had a current order of Jevity 1.5 ml at 69 ml per hour via a gastrostomy tube (a feeding tube that goes through the skin of the belly into the stomach for feedings) stationary pump. Record review of Resident #22's most recent comprehensive care plan obtained 2/25/2026 revealed that Resident #22 was at risk for aspiration (when food, liquid, or other material accidentally gets into your windpipe and lungs) and listed interventions that included monitoring oral intake and reporting to the MD as needed for signs and symptoms of aspiration. Additionally, interventions included to encourage Resident #22's intake of nutritional supplements between meals. Record review of a nursing progress note dated 2/17/2026 revealed that Resident #22 was readmitted to facility and was NPO. Interview with the MDS nurse on 2/25/2026 at 11:59 am revealed she was responsible for all resident care plans. The MDS nurse stated that Resident #22's care plan did not accurately reflect the care needed that Resident #22 required. The MDS nurse stated that the entire facility required new care plans due to the new software system and that it was a heavy load. The MDS nurse stated that Resident #22's care plan did not reflect the recent change to NPO that was given after Resident #22's most recent hospitalization. The MDS stated that the risk of not having a care plan that reflected the current needs of the residents could lead to missed services and interventions that could lead to a resident not receiving the appropriate care they need. Interview with ADON on 2/26/2026 at 9:15 am revealed that she was not responsible for care plans and stated the MDS nurse was responsible for creating and updating care plans. Interview with the DON on 2/26/2026 at 1:01 pm revealed that she did not know too much about care plans nor does she create or revise them. The DON stated the MDS nurse was responsible for updating care plans to reflect any significant changes in the care of the residents. Record review of the facility policy statement, undated, and titled Comprehensive Assessments revealed in part. assessments are used to develop, review and revise the resident's comprehensive care plan. The facility policy statement did not specifically address the revision of comprehensive care plans.		