| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 455941 | A. Building<br>B. Wing | 05/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 8 residents (Resident #44) reviewed for supervision. The facility failed to prevent Resident #44 from going out a window without staff awareness. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk of other resident elopements and harm the resident with injury or death. The findings include:Record review of Resident #44's admission Record revealed she was admitted to the facility on [DATE] with diagnoses including: dementia, muscle weakness, cognitive communications deficit, partial legal blindness, and need for assistance with personal care. Record review of Resident #44's [DATE] consolidated orders and MAR was documented for visual checks on resident #44's wander guard every 2 hours start date of [DATE]. Record Review of Consolidated orders for [DATE] was documented every 2 hour monitoring of residents physical location every 2 hours for exit seeking start date [DATE], and end date [DATE]. Record review of Resident #44 had consolidated orders for [DATE] and MAR was documented for visual checks on resident #44's wander guard every 2 hours start date of [DATE]. Record Review of Consolidated orders for [DATE] was documented every 2 hour monitoring of residents physical location every 2 hours for exit seeking start date [DATE], and end date [DATE]. Record review of Resident #44's Quarterly MDS dated [DATE] revealed a BIMS of 3, indicating she was severely impaired. Record review of MDS for Resident #44 was documented she required a wheelchair, she was independent with upper/lower body dressing, sit to lying and chair to chair transfer. Record review of Resident #44's comprehensive care plan date initiated [DATE] revealed Resident #1 had wandered out of facility door and was re- directed on [DATE]. Intervention was a wander guard placement to wrist, functioning every shift, if attempt to elope, divert or redirect and notify the charge nurse, and notify the MD with exit seeking behaviors. Resident #44 was at risk for falls related to impaired vision, and very poor safety awareness. Resident #44's care plan was documented she was in the courtyard unattended on [DATE] with 2 hours monitoring for locations, wear a wander guard and check device for placement.Record review of Resident #44 was found outside in courtyard between 400 and 300 halls trying to come into 400 hall door at end of the hallway by Maintenance Supervisor who was working in a room down 400 hall. Maintenance Supervisor opened door at end of 400 hall to direct Resident #44 back into building. Resident #44 was brought back into building by CNA C ambulated with one person assistance. Resident#44 didn't have her wheelchair outside with her. When asked what Resident #44 was doing outside she stated, Well [NAME] when it's a life-or-death situation you will do whatever it takes to get out. Investigation started on how Resident #44 got out of building and into secured courtyard. Skin assessment done by this ADON A with no injuries noted at this time. MD notified of incident and lab orders given. DON and administrator notified of incident. Resident #44 returned to her room where she wanted to lie down. ADON A stated upon investigation it was noted<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | resident had gotten out of building and into secured courtyard through a window in room [ROOM NUMBER]. ADON A stated Resident #44 had poor vision and impaired cognition. Upon trying to enter room [ROOM NUMBER] to investigate the situation at hand door was jammed and only able to open partially. After squeezing my way through door opening it was noted that all the drawers at base of closet were pulled out preventing door to open completely. Resident's #44 wheelchair was noted setting in front of the window. ADON A stated the window was open and screen pushed out onto ground outside of building. A fire extinguisher was noted to be missing from outside 300 hall door and noted on the opposite side of fence closest to the 400-hall exterior door. ADON A stated the gates were still latched on fence.Record review of this courtyard had a 5-feet high metal fence with gates that had latches but were not locked. There was approximately 92 feet from 300 hall window and 400 hall exit door. The weather was fair that day. (Google maps distance from 300 to 40 hall. https://www.google.com/maps/@30.2644225,-98.8819717,55m/data=!3m1!1e3?entry=ttu&g_ep=EgoyMDI2M review of Resident #44's elopement risk assessment dated [DATE] revealed she was at high risk.Record review of Resident #44's psychological visit was dated [DATE] and added 2 new medication changes. This 5 days after the incident dated on [DATE]. Observation on [DATE] at 10:15 AM during initial rounds revealed Resident #44 was in her room with door closed, after she opened the door and standing, she was confused and walking around in her room with half her clothes on. Observed on [DATE] at 11:75 AM outside between 300 hall and 400 hall, in the courtyard, had a black metal fence that had 2 gates with latches. During an interview on [DATE] at 11:73 AM Maintenance Supervisor stated he responded to the alarm and saw Resident #44 on the outside of the 400 hall exit door. Interview with the Maintenance Supervisor stated he had let Resident #44 in the door that required a code to come in. The Maintenance Supervisor stated ADON A came and assessed Resident #44. Maintenance Supervisor stated he found out that the resident went out the 300-hall room window. Resident #44 was found outside of 400 hall courtyard at approximately 4 PM by Maintenance Supervisor after she tried to get back in the building from the outside and opened the 400 hall exit door that set off an alarm. The Maintenance Supervisor stated he had alarmed the 300 hall barrier doors, limited the 300 hall room windows from opening, and limited window from opening in Resident #44's room. During an interview on [DATE] at 3 PM with CNA C stated the Maintenance Supervisor told her Resident #1 had gone down 300 hall with her wheelchair, went out the window from a 300-hall room, and walked across the courtyard to the exit door on the 400 hall where he found her. CNA C stated Resident #44 was confused, ADLs she was independent, for showers she required total assistance. CNA C stated Resident #44 mobilized with a wheelchair and wandered the halls. During an interview on [DATE] at 3:27 PM with then ADON A (previous ADON-does not work at this facility) stated she came back to facility in February 2026. ADON A stated Resident #44 was confused, she mobilized in wheelchair, resident was able to walk and usually walks in her room and moves her furniture around. ADON A stated Resident #44 was partially blind. ADON A stated she uses her walker because she gets tired of walking or standing up. ADON A stated maybe Resident #44 heard some gun shots from the dining room TV show. (this was on the other side of Resident #44's). ADON A stated Resident #44 came into her office and was asking if she was ok. ADON A stated Resident #44 was distressed. ADON A stated Resident #44 then went out of her office and about 20 minutes later she heard a door alarm, and she was going down the 400 hall. ADON A stated she saw the Maintenance Supervisor and the CNA C walking down the 400 hall with Resident #44. ADON A assessed Resident #44 and she had no injuries. ADON A notified the ADM, MD and family. ADON A stated she did have at the time of the incident. ADON A stated the Interventions were psychological services and alarm on 300 hall smoke barrier doors. Nurse assessment notified the ADM, MD and family. During an interview on [DATE] at 6:03 PM with CNA B stated she had seen Resident #44 lying down at 3 PM, and at approximately 4 PM, she saw Resident #44 walking down the 400 hall with Maintenance Supervisor and another CNA C. During an interview on [DATE] at 10:51 AM with the DON stated he was not in the facility when Resident #44 went out the window. The DON stated he was trained on exit seeking. (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The DON stated only Resident #44 had a revised elopement assessment-risk is 29 (high risk). The DON stated the new interventions that were in place after Resident #44 incident was alarms on Resident #44's windows and on the 300 hall limited opening, a psychological referral with medication changes, a urine test, that was dated [DATE] and was negative. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:25 PM. While the IJ was removed on [DATE] at 2:56 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm. IJ verification: F689 Accidents and Hazards: During an interview on [DATE] 1:75 PM with ADM stated she did not report because Resident #44 did not get out of the building. The facility took the following actions to ensure residents were adequately monitored and supervised to prevent elopement. PIR and Validation: Problem: F689 - Free of Accident Hazards/Supervision/Devices-Adequate Supervision The facility needs to take immediate action to ensure residents are adequately supervised to prevent elopement. Plan: 1)All residents will have a new elopement assessment completed, Residents identified as an as high risk for wandering and who are exit seeking will have a wander-guard applied by [DATE]. 2) All staff in facility will be in-serviced on elopement policy and safety and supervision of Residents by [DATE] by the DON or ADON with staff signatures required on sign in sheet. Staff will not be allowed to work a shift until they have completed the in-service training. New hires will be in-serviced before working a shift. The sign-in sheet will be submitted to QAPI. 3)Windows in unoccupied rooms will be secured to limit opening to prevent egress by Maintenance Supervisor by [DATE] with screws in window frames to limit opening to no more than 6 inches. Locks will be verified functional. Screens will not be considered a safety intervention. 4)Windows in resident rooms occupied by exit seeking resident will have alarm applied to window by Maintenance Supervisor by [DATE] and/or residents will be relocated as appropriate. 5) The Administrator/Designee will monitor the effectiveness of the intervention with: - Daily reviews for 14 days - Weekly reviews for 30 days - Ongoing monitoring through QAPI thereafter - This will be documented on a tracking log and submitted to QAPI 6) Maintenance Supervisor will check that all exit door locks are functioning by [DATE]. - Conduct daily checks of all window restrictors and locks for 14 days - Then weekly checks for 30 days Documentation will be maintained on a Window Safety Audit Tool and reported to the Administrator / DON and QA Committee. 7) Residents with wander-guards had their wandering care planned by [DATE]. 8) Staff nurses will conduct every 1-hour visual check on residents with wander-guards going forward beginning [DATE]. This is to be documented on the Nurse Medication Administration Record in the Electronic Health Record as long as resident has wander-guard. 9) All interventions and monitoring will be tracked through the facility QAPI program. Audits will continue for a minimum of 30 days and until sustained compliance is achieved with no negative trends. Immediate Actions Taken: - Window involved in incident secured immediately - Resident assessed with no injury - All other residents assessed for elopement risk - All staff re-educated immediately Verification: Monitoring included the following: During an interview on [DATE] 1:75 PM, the ADM stated she did not report because Resident #44 did not get out of the building. Record review of Resident #20's chart revealed he had an elopement assessment completed on [DATE]. Record review of Resident #5's chart revealed he had an elopement assessment completed on [DATE]. Record review of Resident #25's chart revealed he had an elopement assessment completed on [DATE]. Record review of Resident #2's chart revealed he had an elopement assessment completed on [DATE]. Record review of Resident #58's (new admit) chart revealed he had an elopement assessment completed on [DATE]. Record review of Resident #6's chart revealed he had an elopement assessment completed on [DATE]. Record review of Resident #44's chart revealed he had an elopement assessment completed on [DATE]. Record review of Resident #45's chart revealed he had an elopement assessment completed on [DATE]. A record review of the facility's daily census for [DATE] revealed a census of 46 residents of whom 8 were assessed an elopement risk. A record review of the 46 residents revealed all were assessed for an elopement risk. A record review of the facility's Happy Feet book revealed it was kept at the nurses' (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | station. The book contained a list of residents who were assessed as elopement risks. The residents listed were supported with their demographic information and admission records. The book revealed 8 of the 46 residents were assessed as A High Risk for Elopement. The following residents were assessed as a risk for elopement: Resident #2 Resident #5 Resident #6 Resident #20 Resident #25 Resident #44 Resident #45 Resident #58 During observations on [DATE] between 5:00 to 5:11 PM with the ADON revealed the following residents had a wander guard bracelet on their persons: Resident #2 Resident #5 Resident #6 Resident #20 Resident #25 Resident #44 Resident #45 Resident #58 2) All staff in facility will be in-serviced on elopement policy and safety and supervision of Residents by [DATE] by the DON or ADON with staff signatures required on sign in sheet. Staff will not be allowed to work a shift until they have completed the in-service training. New hires will be in-serviced before working a shift. The sign-in sheet will be submitted to QAPI. A record review of the facility's employee roster revealed 50 employees were listed, of the 50 employees 23 were interviewed; 14 staff worked the 6:00 AM to 6:00 PM shift and 9 worked the 6:00 PM to 6:00 AM shift. A record review of the facility's in-service titled Policy and Procedures on Wandering and Elopement, dated [DATE], revealed, .policies and procedures to be performed while a resident is wandering and / or exit seeking; properly state the chain of command in case of occurrence; describe what is the Happy Feet book and what it contains, and it's location. Further review revealed 50 employees received the in-service training which included a review of the Wandering and Elopements policy, dated [DATE], Policy Statement The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 6:00 AM to 6:00 PM shift.During an interview on [DATE] at 4:20 PM. CNA D stated she received an in-service from the ADON on the topic of residents who wandered and had a risk for elopement. CNA D stated the training included the code for a resident who eloped was a code White and when a code white was called staff were to refer to the Happy Feet book located at the nurses' station and identify the resident who had eloped and search the facility and the surrounding areas. CNA D stated she would alert the nurse immediately if she learned a resident had eloped. CNA D stated she usually worked the 6:00 AM shift to 6:00 PM shift. During an interview on [DATE] at 4:21 PM, LVN E stated she received an in-service from the ADON on the topic of residents who wandered and had a risk for elopement. LVN E stated the training included the code for a resident who eloped was a code White and when a code white was called staff were to refer to the Happy Feet book located at the nurses' station and identify the resident who had eloped and search the facility and the surrounding areas. LVN E stated she would alert the DON immediately if she learned a resident had eloped. LVN E stated she usually worked the 6:00 AM shift to 6:00 PM shift. During an interview on [DATE] at 4:22 PM, MA F stated she received an in-service from the ADON on the topic of residents who wandered and had a risk for elopement. MA F stated the training included the code for a resident who eloped was a code White and when a code white was called staff were to refer to the Happy Feet book located at the nurses' station and identify the resident who had eloped and search the facility and the surrounding areas. MA F stated she would alert the nurse immediately if she learned a resident had eloped. MA F stated she usually worked the 6:00 AM shift to 6:00 PM shift. During an interview on [DATE] at 4:23 PM, LVN G stated she received an in-service from the ADON on the topic of residents who wandered and had a risk for elopement. LVN G stated the training included the code for a resident who eloped was a code White and when a code white was called staff were to refer to the Happy Feet book located at the nurses' station and identify the resident who had eloped and search the facility and the surrounding areas. LVN G stated she would alert the DON immediately if she learned a resident had eloped. LVN G stated she usually worked the 6:00 AM shift to 6:00 PM shift. During an interview on [DATE] at 4:30 PM, DA H stated he received an in-service from the ADON on the topic of residents who wandered and had a risk for elopement. DA H stated the training included the code for a resident who eloped was a code White and when a code white was called staff were to refer to the Happy Feet book located at the nurses' station and identify the resident who had<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | located at the nurses' station and identify the resident who had eloped and search the facility and the surrounding areas. CNA Q stated she would alert the nurse immediately if she learned a resident had eloped. CNA Q stated she usually worked the 6:00 PM shift to 6:00 AM shift. During an interview on [DATE] at 6:36 PM CNA U stated he received an in-service from the ADON on the topic of residents who wandered and had a risk for elopement. CNA U stated the training included the code for a resident who eloped was a code White and when a code white was called staff were to refer to the Happy Feet book located at the nurses' station and identify the resident who had eloped and search the facility and the surrounding areas. CNA U stated he would alert the nurse immediately if he learned a resident had eloped. CNA U stated he usually worked the 6:00 PM shift to 6:00 AM shift. During an interview on [DATE] at 6:33 PM, CNA V stated she received an in-service from the ADON on the topic of residents who wandered and had a risk for elopement. CNA V stated the training included the code for a resident who eloped was a code White and when a code white was called staff were to refer to the Happy Feet book located at the nurses' station and identify the resident who had eloped and search the facility and the surrounding areas. CNA V stated she would alert the nurse immediately if she learned a resident had eloped. CNA V stated she usually worked the 6:00 PM shift to 6:00 AM shift. 3)Windows in unoccupied rooms will be secured to limit opening to prevent egress by Maintenance Supervisor by [DATE] with screws in window frames to limit opening to no more than 6 inches. Locks will be verified functional. Screens will not be considered a safety intervention. Per POR submitted all unoccupied rooms have windows secured with screws preventing access to the courtyard. Observations on [DATE] at 3:52 PM with Maintenance Supervisor revealed: Observations on [DATE] between 3:52 PM to 4 PM in the 100 hall revealed 7 rooms that were unoccupied and had screws in the windows. No concerns. Observation on [DATE] between 4:03 PM to 4:06 PM in the 200 hall revealed 2 rooms that were unoccupied and had screws in the windows. No concerns. Observations on [DATE] between 4:11 PM to 4:21 PM on the 300 hall revealed 13 rooms that were unoccupied and had screws in the windows. No concerns. Observations on [DATE] between 4:40 PM to 4:42 PM on the 400 hall revealed 3 rooms that were unoccupied and had screws in the windows. No concerns. 4)Windows in resident rooms occupied by exit seeking resident will have alarm applied to window by Maintenance Supervisor by [DATE] and/or residents will be relocated as appropriate. Observation on [DATE] between 5:00 to 5:11 PM, with the ADON, revealed they checked, with wander guard checker device, that the wander guards are were working and not expired for Residents #20, #5, #25, #2, #6, #44, #45 and #58. Observation on [DATE] between 5:21 PM to 5:32 PM revealed all Residents #20, #5, #25, #2, #6, #44, #45 and #58's windows were checked to ensure they had an alarm. Interview on [DATE] at 8:51 PM, the DON stated he was checking windows, alarms are were functional on windows, the nursing with visual check for 1 hour checks on the wander-guards and QUAPI is scheduled for [DATE]. No other comments. 6) Maintenance Supervisor will check that all exit door locks are functioning by [DATE]. - Conduct daily checks of all window restrictors and locks for 14 days - Then weekly checks for 30 days Documentation will be maintained on a Window Safety Audit Tool and reported to the Administrator / DON and QA Committee. Exit Doors checked with Maintenance Supervisor: Interview on [DATE] between 4:32 PM to 4:43 PM with the Maintenance Supervisor revealed he checked the exit doors and windows. Observation on [DATE] at 4:32 PM revealed the exit door on the 100 hall was checked. No concerns. Observation on [DATE] at 4:29 PM revealed the exit door on the 200 hall was checked. No concerns. Observation on [DATE] at 4:30 PM revealed the exit door on the 300 hall was checked. No concerns. Observation on [DATE] at 4:35 PM revealed the exit door on the 300 hall was checked. No concerns. Observation on [DATE] at 4:43 PM revealed the front door was checked, no concerns. Record review of Window Safety Audit Tool Form revealed the Conduct daily checks of all window restrictors and locks for 14 days and the weekly checks for 30 days by the Maintenance Supervisor, was started on [DATE]. 7) Residents with wander-guards had their wandering care planned by [DATE]. Record review of Resident #20's chart revealed he had a wander-guard care plan, dated [DATE]. Record review of Resident #5's chart revealed he had a wander-guard care pl[TRUNCATED] |

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| | 455941 | A. Building<br>B. Wing | 05/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**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 comprehensive person centered care plan for each resident, consistent with the resident's rights that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and ensure the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for 3 of 8 residents (Residents #42, #22 and #4) reviewed for care plans. 1. The facility failed to ensure a care plan was developed to address Resident #42's verbal suicide discussion with her caregiver. 2. The facility failed to ensure a care plan was developed to address Resident #22's discharge plans. 3. The facility failed to ensure a care plan was developed to address Resident #4's discharge plans. These failures could place residents at risk of staff not being aware of resident care plans and residents not receiving necessary care. The findings include:1.Record review of Resident #42's admission Record, dated [DATE], documented she was admitted to the facility on [DATE]. Resident #42 had diagnoses which included recurrent depressive disorder (common, serious mental health conditions characterized by persistent sad, empty, or irritable moods, accompanied by somatic and cognitive changes that significantly interfere with daily functioning) , primary generalized osteoarthritis (a common, chronic wear-and-tear degenerative joint disease caused by the gradual breakdown of cartilage, leading to pain, stiffness, and decreased mobility.), muscle weakness, restlessness and agitation, pain, Alzheimer's Disease (a progressive, irreversible brain disorder that destroys memory, thinking skills, and eventually the ability to perform daily tasks), unspecified Dementia (a general term for a progressive decline in cognitive function-including memory, language, and behavior-severe enough to interfere with daily life) and suicidal ideations (SI). Record review of Resident #42's Comprehensive MDS, dated [DATE], documented she had a BIMs score of 11/15 (moderately impaired). Resident #42's Active diagnosis was suicidal ideations. Record review of Resident #42's care plan, dated [DATE] with completed date of [DATE], did not reflect the resident's discussion of suicidal ideation. Record review of Resident #42's consolidated orders for [DATE], documented, she had orders for psychosocial services and as well as, medication management. Record review of Resident #42's progress note, dated [DATE] at 7:06 PM, note text: Upon return to the facility, caregiver reported to this nurse the resident had verbalized thoughts of wanting to commit suicide and described a potential plan involving tying a bedsheet into a noose. Caregiver also reported that both of the resident's parents died by suicide. This nurse assessed the resident privately in her room. The resident was asked if she was experiencing any concerning thoughts or thoughts of harming herself. Resident#42 denied any thoughts of self-harm. When asked directly if she had thoughts of committing suicide, the resident responded, Where did you hear that from? Resident stated, I may have mentioned that I was ready to die in a conversation I had with my recently, but I would not kill myself. I just know that my time is coming; I am old. I would not leave behind, referring to her stuffed panda. This nurse provided reassurance regarding resident safety within the facility and offered supportive listening. Resident was asked if she would like to speak with a counselor or the facility social worker. Resident responded, I would like to speak to someone all the time. I know I am here by myself, and my is trying to bring me back home; he just cannot take care of me. No additional concerns reported or observed at this time. Residents are resting in bed with call bell within reach. Record review of Resident #42's progress notes, dated on [DATE], documented Resident #42's nurse, notified the MD, recommended psychological services, notified spouse, Start 15-minute checks. Nurse notified DON on duty and Resident #42 was sent to emergency room for evaluation. Resident #42 arrived to the facility on [DATE] at 2:04 AM and started 15-minute checks for the next 24 hours, removed harmful items from room, and Resident #42 slept with no concerns. Record review of<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #42's progress notes, start date of [DATE], revealed she was checked every 15 minutes by a nurse. Record review of Resident #42's psychological services visit, dated [DATE], documented the visit was prompted by a reported incident in which the resident expressed suicidal content. She was evaluated in her room while sitting in a wheelchair with no acute physical distress noted prior to his thoughts assessment during the encounter appeared restless, agitated, and anxious. Staff reported recent incident in which the resident verbalized with an intent to harm herself using a bed sheet. However, during the evaluation of resident, she denied suicidal ideation and stated she did not want to harm herself, and said it expressed their desire to return going to her ranch. The resident remained confused and forgetful and was alert and oriented to self only. She's neatly dressed but appeared unfocused and unfortunately not located throughout duration, which limited availability order history obtained staff report no evidence of psychotic symptoms and none were observed during assessment. Despite her cognitive impairment and behavioral concerns her sleep and appetite were reported to be adequate. The mood appeals labeled with underlying anxiety, though full assessment was limited due to her cognitive status. Given the recent suicide I need suicidal statements, safety precautions have been initiated, including monitoring every 15 minutes. I'm going to be medication management will be adjusted as clinically indicated safety operations the patient is not in any acute danger to self or others however, this is the situation may change based on treatment outcomes slash worsening I'm going to go to condition, and psychosocial stressors. Observation on [DATE] at 10:26 AM revealed Resident #42 was sitting in her w/c and seemed to be confused. Resident #42 seemed to be confused of where she was and wanted to go home to the ranch. No expressions of SI.During an interview on [DATE] at 10:27 AM with the MDS nurse, stated Resident #42's care plan did not mention her SI, due to she was not aware of it. 2. Record review of Resident #22's admission Record, dated [DATE], documented a [AGE] year old, female who was admitted to the facility on [DATE]. Resident #22 had diagnoses which included epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), diabetes II (a chronic condition where high blood sugar levels result from the body's inability to properly use insulin (insulin resistance) or make enough of it. ), difficulty walking, mild cognitive impairment, cognitive communications deficit and need for assistance with personal care. Record review of Resident #22's Quarterly MDS, dated [DATE], documented her BIMs score was 12/15 (moderately impaired). Resident #22 required a walker, a wheelchair to mobilize and was independent with upper/lower body dressing. MDS stated she was responsible for MDS and care plans. MDS stated she was not aware of Resident #22's SI and would have placed it in her caer plan if she knew about it. MDS stated this would alert staff for Resident #22's SI and what to be aware of with interventions to follow up on. Record review of Resident #22's care plan, dated [DATE], revealed no discharge planning in her care plan. 3. Record review of Resident #4's admission Record, dated [DATE], documented the resident was admitted to the facility on [DATE] and re-admitted on [DATE], she was [AGE] years old Resident #4 had diagnoses which included dementia (a progressive, irreversible syndrome causing decline in memory, thinking, and behavior), need for assistance with personal care, major depressive disorder (fatigue, appetite changes, insomnia or hypersomnia, feelings of worthlessness, trouble concentrating, and suicidal thoughts) and cognitive communication deficit. Record review of Resident #4's Comprehensive MDS, dated [DATE], documented her BIMs score was 13/15 (cognitively intact). Resident #4 used a wheelchair to mobilize, and she was independent with upper/lower body dressing.Record review of Resident #4's Care plan, dated [DATE], revealed no discharge planning in her care plan. During an interview on [DATE] 6:20 PM, the MDS nurse stated she did not have a discharge plan for Resident #22 and #4 in their care plans. The MDS nurse stated she did not have a care plan for Resident #42's SI. The MDS nurse stated it was important and they should have a discharge plan and was used as a form of communication to staff on what the president's plan of care and may impede in residents' plans. No policy for care plans was provided. MDS stated it must have been a computer glitch. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 2 residents (Resident #27 and Resident #52) reviewed for quality of care.1. Resident #27 was readmitted with a cervical collar (a neck brace, a medical device used to support, stabilize, and immobilize the neck and cervical spine after injury or surgery) and did not have orders to manage or maintain the cervical collar for 40 days.2. Resident #52 was admitted with a cervical collar and did not have orders to manage or maintain the cervical collar for 6 days.This deficient practice could place residents at risk of not receiving adequate care, harm, or injuries.The findings include:1. Record review of Resident #27's admission record dated 04/17/2026 revealed he was admitted to the facility on [DATE], was discharge to the hospital on [DATE] and readmitted on [DATE] with a diagnosis of Posterior displaced type 2 dens fracture (a break at the second bone down from the skull in your neck). Record review of Resident #27's discharge MDS dated [DATE] revealed Resident #27 was a [AGE] year-old male admitted for long term care with assistive supports for activities of everyday life (ADL). Resident #27 was assessed with a BIMS score of 11 out of a possible 15 which indicated moderate cognitive impairment. Record review of Resident #27's admission nursing note dated 10/30/2025 by LVN CC revealed Resident #27 had a history of syncope [a episode when the brain does not receive enough oxygen for a short period leading to a brief loss of consciousness and can cause a fall] with resulting odontoid fracture [also known as a dens fracture, particularly affecting the cervical C2 vertebrae] and C1-C2 screw fixation [screws holding the cervical C1 and C2 vertebrae in place]. Cervical collar is in place and must be worn at all times.Record review of Resident #27's hospital records dated 03/16/2026 revealed Resident #27 was admitted for acute metabolic encephalopathy (short term reversible brain dysfunction causing altered consciousness and neurological symptoms) and had previous cervical spine surgery with hardware and screws and at discharge had a need for a cervical neck brace. Record review of Resident #27's care plan dated 04/15/2026 revealed no nursing focuses, goals, nor interventions for Resident #27's cervical collar. During an interview on 04/13/2026 at 11:18 AM CNA N stated she cared for Resident #27 who wore a neck brace. CNA N stated she had no instructions on the CNA care plan for caring for the neck brace, but she never removed the brace and would clean around the brace. During an interview on 05/02/2026 at 09:49 AM, LVN DD said she would briefly remove Resident #27's cervical collar daily to assess the surgical site on the back of his neck. LVN DD reviewed Resident #27's physician's orders in his electronic clinical record and confirmed there were no orders for the cervical collar or when it was to be removed or for how to care for the cervical collar. Observation of and interview on 05/02/2026 from 10:03 AM to 10:11 AM, revealed Resident #27 was wearing a hard cervical collar with pads on the inside of the collar and on the outside were Velcro straps on the side of the cervical collar so it could be removed. Resident #27 said he was wearing the cervical collar because he broke his neck when he had a fall at home, and he woke up in the hospital he had the cervical collar on his neck. Resident #27 stated he had worn another cervical collar in the past but has had his current cervical collar for 2 to 3 months. Resident #27 said when he saw his physician he asked if he could take it off to clean it and he was told to keep it on, .but I have taken it off a time or two to clean my neck. Resident #27 said that he had not gotten any sores or irritations from wearing the collar and he will put a washcloth between his neck and the collar to clean his neck. When asked if the CNAs or nurses had removed his collar, Resident #27 said that he didn't know if it was a nurse or a CNA who removed it but when they did, they have taken it off long enough to do whatever they needed to do, and they make sure that I don't move my head. During a telephone interview on 05/02/2026 at 3:38 PM, Physician FF stated she was the on-call physician and was covering for Resident #27's Physician EE, but she was not familiar with<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #27's care. Physician FF said she was contacted on 05/02/2026 about Resident #27 and gave the orders for Resident #27's cervical collar to be worn and to be checked by the nurses.Record review of Resident #27's physician's orders summary dated 05/02/2026 revealed two orders, with a start date of 05/02/2026 at 10:45 AM, for a cervical collar may be worn; and for 2 nurses to inspect skin under c-collar [cervical collar] for any skin issues once a day. During an interview on 05/02/2026 at 4:23 PM, RN E said she was the nurse who readmitted Resident #27 on 03/23/2026, and he was wearing a cervical collar at that time. RN E said she didn't remember if the hospital discharge records had orders for his cervical collar or for how to care for the collar. RN E said she had contacted Resident #27's Physician EE for clarification on a medication order when he was readmitted , but she didn't remember getting clarification orders for his cervical collar. RN E stated clarification orders should have been obtained the day of a readmission or admission; and there should be orders for any medical devices which included cervical collars. 2. Record review of Resident #52's admission record dated 04/14/2026 revealed an admission date of 04/10/2026 with a diagnosis of displaced posterior arch fracture of first cervical vertebra (a break to the first spinal bone which supports the head). Record review of Resident #52's admission MDS admission assessment dated [DATE] revealed Resident #52 was a [AGE] year-old male admitted from a short-term hospital for long term care and his BIMS score was 9 out of 15 indication his cognitive skills for daily decision making were moderately impaired. Record review of Resident #52's hospital records dated 04/08/2026 revealed, Assessment / Plan: [AGE] year-old man with history of chronic kidney disease, . had ground level fall . found to have a right C1 burst fracture. continue C-Collar at all times for at least 12 weeks, possibly 6 months, but will need to be re-evaluated at clinic. Please provide patient with a second pair of pads for hygiene. Included in Resident #52's hospital records were education material on a cervical spine fracture and how to care for the cervical collar.Record review of Resident #52's physician's summary orders dated 05/02/2026 revealed the physician order on 04/16/2026 for C-collar [cervical collar] to be worn at all times, every day and night, but there were no orders for cervical collar care, instructions for how to care for the collar nor orders for skin care and or monitoring skin. Record review of Resident #52's care plan dated 04/13/2026 revealed no focus, no goals, nor no interventions for Resident #52's cervical collar. During an observation and interview on 04/13/2026 at 11:00 AM revealed Resident #52 in his bed. Resident #52 wore a cervical collar. Resident #52 stated he was told never to remove his brace but could briefly remove the brace to have hygiene care. Resident #52 stated some of the staff provided care by washing the skin around his collar. During an interview on 04/13/2026 at 11:03 AM CNA D stated she was the CNA for Resident #52 who wore a cervical collar. CNA D stated she had no instructions for caring for Resident #52's cervical collar on Resident #52's CNA care plan. CNA D stated she would not remove the collar per Resident #52's instructions but would clean Resident #52's skin around his cervical collar. During an interview on 04/16/2026 at 6:10 PM RN AA stated she was the charge nurse for Resident #27 and Resident #52. RN AA stated she had been the RN charge nurse since December 2025. RN AA stated Resident #27 and Resident #52 both wore cervical collars for support with their cervical spine fractures. RN AA reviewed both residents' physicians' orders and recognized neither had orders for their cervical collars. During a telephone interview on 05/02/2026 at 3:58 PM, Resident 27's Physician GG stated the nurses had contacted her about getting an order for Resident #27's cervical collar but could not remember when it was. Physician GG said she remembers seeing in Resident #27's hospital paperwork instructions for the cervical collar, how to care for the collar, and for the collar to be worn for a minimum of 6 weeks, then it would be re-evaluated. Physician GG said Resident #27's cervical collar should be always left on except when it was briefly removed to clean around his neck. During an interview on 05/02/2026 at 4:34 PM, the ADON said when a resident was admitted or readmitted , the nurse would verify the physician's orders and if the resident was admitted with a medical device, brace or cervical collar the nurse should ensure there was an order for the medical device. The ADON said the harm of not having orders for a cervical collar or for care of<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the cervical collar could result in proper care not being provided to the resident.During an interview on 05/02/2026 at 5:10 PM, the Administrator said when a resident was admitted or readmitted with a medical device such as a cervical collar, the nurse would contact the resident's physician to verify the orders received from the receiving facility; and if there were no orders for the cervical collar, the nurse wound obtain an order from the resident's physician. The Administrator stated the harm of not having an order for the cervical collar could result in the nursing staff not providing the proper care of the collar.Record review of the Physician Orders policy, revised February 2025, revealed The purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services.5. Physician orders are essential for the comprehensive care of the residents. These orders encompass various aspects, including leave of absence, evaluations, medications and treatment regimen, and therapy.consultations with other physicians; dietary plans; activity instructions; x-rays; laboratory work; .and any other orders as needed.11. admission orders-the licensed nurse will verify admission or readmission order with the physician or physician extender for all residents admitting or readmitting. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on record reviews and interviews, the facility failed to use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility's reviewed for registered nurse (RN) services. The facility failed to have an RN on 11 dates during the period reviewed 11/1/2025 through 4/15/2026. This failure could place residents at risk of not having the services of an RN.Based on interview and record review the facility failed to ensure, except when waived, the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility's reviewed for registered nurse (RN) services. The facility failed to have an RN on 11 dates during the period reviewed from 11/1/2025 through 4/15/2026. This failure could place residents at risk of not having the services of an RN. The findings include: A record review of the facility's RN timecards for the period dated 11/1/2025 through 4/15/2026 revealed 11 dates with no RN coverage. The review revealed the following dates without the services of an RN: 11/15/2025, Saturday.11/16/2025, Sunday.12/27/2025, Saturday.12/28/2025, Sunday.12/29/2025, Monday.2/28/2026, Saturday3/1/2026, Sunday.3/14/2026, Saturday.3/15/2026, Sunday.3/29/2026, Sunday.4/13/2026, Monday. During an interview on 4/16/2026 at 4:00 PM, the DON stated the 11 dates identified where the facility did not have the services of an RN were correct. The DON stated the potential negative outcome for residents could be they would not have the services of an RN's critical thinking skills. A record review of the facility's Staffing, Sufficient and Competent Nursing, dated August 2022, revealed Policy Statement: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Sufficient Staff. A registered nurse provides services at least 8 hours every 24 hours seven days a week. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours, if the events that caused the allegation did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 8 residents (Resident #44) reviewed for abuse and neglect. The facility failed to report to the State Survey Agency that Resident #44 went out a window without staff awareness. This deficient practice could place residents at risk by not reporting hazards and can affect residents' safety. The findings include:Record review of Resident #44's admission Record revealed a female who was admitted to the facility on [DATE]. Resident #44, was [AGE] years old, had diagnoses which included: dementia ( a progressive decline in mental ability severe enough to interfere with daily life, caused by physical changes in the brain), muscle weakness, cognitive communications deficit, partial legal blindness, and need for assistance with personal care. Record review of Resident #44's March 2026 consolidated orders and MAR was documented for visual checks on Resident #44's wander guard every 2 hours, start date of 5/7/2025. Record review of Resident #44's Consolidated orders for April 2026 was documented every 2-hour monitoring of resident's physical location every 2 hours for exit seeking start date 3/19/2026, and end date 4/11/2026. Record review of Resident #44's consolidated orders for April 2026, and MAR documented visual checks on Resident #44's wander guard every 2 hours start date of 5/7/2025. Record review of Resident #44's Consolidated orders for April 2026 was documented every 2 hours monitoring of the resident's physical location every 2 hours for exit seeking start date 3/19/2026, and end date 4/11/2026. Record review of Resident #44's Quarterly MDS, dated [DATE], revealed a BIMS of 3, which indicated she was severely impaired. Resident #44 required a wheelchair, she was independent with upper/lower body dressing, sit to lying and chair to chair transfer. Record review of Resident #44's comprehensive care plan, date initiated 3/19/2026, revealed Resident #1 wandered out of the facility door and was re- directed on 5/7/2025. Intervention was a wander guard placement to the wrist, functioning every shift, if attempt to elope, divert or redirect and notify the charge nurse, and notify the MD with exit seeking behaviors. Resident #44 was at risk for falls related to impaired vision, and very poor safety awareness. Resident #44's care plan documented she was in the courtyard unattended on 3/19/2026 with 2 hours monitoring for locations, wearing a wander guard and check device for placement. Record review of progress note dated 3/19/2026 3:55 PM Resident #44 was found outside in the courtyard between 400 and 300 halls trying to enter into the 400 hall door at the end of the hallway by the Maintenance Supervisor, who was working in a room down 400 hall. The Maintenance Supervisor opened the door at end of 400 hall to direct Resident #44 back into the building. Resident #44 was brought back into the building by CNA C, the resident ambulated with one person assistance. Resident #44 didn't have her wheelchair outside with her. When asked what Resident #44 was doing outside she stated, Well [NAME] when it's a life-or-death situation you will do whatever it takes to get out. The Investigation started on how Resident #44 got out of building and into the secured courtyard. Skin assessment done by this ADON A with no injuries noted at this time. MD notified of incident and lab orders given. The DON and administrator notified of incident. Resident #44 returned to her room where she wanted to lie down. ADON A stated upon investigation it was noted the resident had gotten out of building and into the secured courtyard through a window in room [ROOM NUMBER] (another resident room). ADON A stated Resident #44 had poor vision and impaired cognition. Upon trying to enter room [ROOM NUMBER] to investigate the situation at hand, the door<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455941 | A. Building<br>B. Wing | 05/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was jammed and only able to open partially. After squeezing my way through door opening it was noted that all the drawers at base of closet were pulled out preventing doors from opening completely. Resident's #44 wheelchair was noted sitting in front of the window. ADON A stated the window was opened and the screen pushed out onto the ground outside of building. A fire extinguisher was noted to be missing from outside 300 hall door and noted on the opposite side of fence closest to the 400-hall exterior door. ADON A stated the gates were still latched on fence.Record review google maps revealed this courtyard had a 5-feet high metal fence with gates that had latches but were not locked. There was approximately 92 feet from 300 hall window and 400 hall exit door. The weather was fair that day. (Google maps distance from 300 to 40 hall. https://www.google.com/maps/@30.2644225,-98.8819717,55m/data=!3m1!1e3?entry=ttu&g_ep=EgoyMDI2M review of Resident #44's elopement risk assessment, dated 5/7/2025, revealed she was at high risk.Record review of Resident #44's psychological visit, dated 3/24/2026, and added 2 new medication changes. This was 5 days after the incident, dated 3/19/2024. Observation on 4/12/2026 at 10:15 AM during initial rounds revealed Resident #44 was in her room with the door closed, after she opened the door and stood, she was confused and walking around in her room with half her clothes on. Observed on 04/15/2026 at 11:725 AM outside between 300 hall and 400 hall, in the courtyard, had a black metal fence that had 2 gates with latches. During an interview on 04/15/2026 at 11:73 AM, the Maintenance Supervisor stated he responded to the alarm and saw Resident #44 on the outside of the 400 hall exit door. The Maintenance Supervisor stated he let Resident #44 in the door that required a code to come in. The Maintenance Supervisor stated ADON A came and assessed Resident #44. The Maintenance Supervisor stated he found out the resident went out of the 300-hall room window. Resident #44 was found outside of the 400 hall courtyard at approximately 4 PM by the Maintenance Supervisor after she tried to get back in the building from the outside and opened the 400 hall exit door that set off an alarm. The Maintenance Supervisor stated he had alarmed the 300 hall barrier doors, limited the 300 hall room windows from opening, and limited windows from opening in Resident #44's room. The Maintenance Supervisor stated he reported the incident to ADON A. During an interview on 04/15/2026 at 1:75 PM, the ADM stated she did not report the incident because Resident #44 did not get out of the building. ADM stated she was responsible in reporting allegations to the STATE. ADM stated she did bring to corporate and they decided this incident was not responsible. During an interview on 04/15/2026 at 3 PM, CNA C stated the Maintenance Supervisor told her Resident #1 had gone down 300 hall with her wheelchair, went out the window from a 300-hall room, and walked across the courtyard to the exit door on the 400 hall where he found her. CNA C stated Resident #44 was confused, ADLs she was independent, for showers she required total assistance. CNA C stated Resident #44 mobilized with a wheelchair and wandered the halls. During an interview on 4/15/2026 at 3:27 PM with then ADON A (previous ADON-does not work at this facility) stated she came back to the facility in February 2026. ADON A stated Resident #44 was confused, she mobilized in a wheelchair, the resident was able to walk and usually walked in her room and moved her furniture around. ADON A stated Resident #44 was partially blind. ADON A stated she used her walker because she got tired of walking or standing up. ADON A stated maybe Resident #44 heard some gun shots from the dining room TV show. (this was on the other side of Resident #44). ADON A stated Resident #44 came into her office and was asking if she was ok. ADON A stated Resident #44 was distressed. ADON A stated Resident #44 then went out of her office and about 20 minutes later she heard a door alarm, and she was going down the 400 hall. ADON A stated she saw the Maintenance Supervisor and the CNA walking down the 400 hall with Resident #44. ADON A assessed Resident #44 and she had no injuries. ADON A notified the ADM, MD and family. ADON A stated she did have her wheelchair at the time of the incident. ADON A stated the interventions were psychological services and alarm on 300 hall smoke barrier doors. Nurse assessment notified the ADM, MD and family. During an interview on 04/15/2026 at 6:03 PM, CNA B stated she saw Resident #44 lying down at 3 PM, and at approximately 4 PM, she saw Resident #44 walking down the 400 hall (continued on next page) |

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| | 455941 | A. Building<br>B. Wing | 05/02/2026 |

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| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | with the Maintenance Supervisor and another CNA C. During an interview on 4/16/2026 at 10:51 AM, the DON stated he was not in the facility when Resident #44 went out the window. The DON stated he was trained on exit seeking. The DON stated only Resident #44 had a revised elopement assessment-risk of 29 (high risk). The DON stated the new interventions that were in place after Resident #44 incident were alarms on Resident #44's windows and the 300 hall limited opening, a psychological referral with medication changes, a urine test, that was dated 3/19/2026 and was negative.DON stated they follow the abuse, neglect policy for reporting inclines with harm, and not sure why they (quapi/corporate) decided not to report. Record review of the facility's policy, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, documented -All reports of resident abuse, neglect, are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported.Policy Interpretation and Implementation, Reporting Allegations to the Administrator and Authorities 1. If Resident Abuse Neglect, Exploitation, if resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law and HHSC putting guidelines.2. Administrator for the individuals making location immediately reports his or her suspicion to the following persons or agencies. a. The State license/certification agency responsible for survey/licensing the facility.3. Immediately is defined as b. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.6. Allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions if any are needed for the protection of residence. |

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|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in response to allegations of abuse, neglect, exploitation, or mistreatment must have evidence that all alleged violations were thoroughly investigated for 1 of 8 residents (Resident #44) reviewed for abuse and neglect. The facility failed to investigate that Resident #44 went out a window without staff awareness. This deficient practice could place residents at risk of harm and other resident elopements. The findings include:Record review of Resident #44's admission Record revealed she was admitted to the facility on [DATE] with diagnoses including: dementia, muscle weakness, cognitive communications deficit, partial legal blindness, and need for assistance with personal care. Record review of Resident #44's March 2026 consolidated orders and MAR was documented for visual checks on resident #44's wander guard every 2 hours start date of 5/7/2025. Record Review of Consolidated orders for April 2026 was documented every 2-hour monitoring of resident's physical location every 2 hours for exit seeking start date 3/19/2026, and end date 4/11/2026. Record review of Resident #44 had consolidated orders for April 2026, and MAR was documented for visual checks on resident #44's wander guard every 2 hours start date of 5/7/2025. Record Review of Consolidated orders for April 2026 was documented every 2-hour monitoring of resident's physical location every 2 hours for exit seeking start date 3/19/2026, and end date 4/11/2026. Record review of Resident #44's Quarterly MDS dated [DATE] revealed a BIMS of 3, indicating she was severely impaired. Record review of MDS for Resident #44 was documented she required a wheelchair, she was independent with upper/lower body dressing, sit to lying and chair to chair transfer. Record review of Resident #44's comprehensive care plan date initiated 2/6/2026 revealed Resident #1 had wandered out of facility door and was re- directed on 5/7/2025. Intervention was a wander guard placement to wrist, functioning every shift, if attempt to elope, divert or redirect and notify the charge nurse, and notify the MD with exit seeking behaviors. Resident #44 was at risk for falls related to impaired vision, and very poor safety awareness. Resident #44's care plan was documented she was in the courtyard unattended on 3/19/2026 with 2 hours monitoring for locations, wearing a wander guard and check device for placement. Record review of Resident #44 was found outside in courtyard between 400 and 300 halls trying to come into 400 hall door at end of the hallway by Maintenance Supervisor who was working in a room down 400 hall. Maintenance Supervisor opened door at end of 400 hall to direct Resident #44 back into building. Resident #44 was brought back into building by CNA C ambulated with one person assistance. Resident#44 didn't have her wheelchair outside with her. When asked what Resident #44 was doing outside she stated, Well [NAME] when it's a life-or-death situation you will do whatever it takes to get out. Investigation started on how Resident #44 got out of building and into secured courtyard. Skin assessment done by this ADON A with no injuries noted at this time. MD notified of incident and lab orders given. DON and administrator notified of incident. Resident #44 returned to her room where she wanted to lie down. ADON A stated upon investigation it was noted resident had gotten out of building and into secured courtyard through a window in room [ROOM NUMBER]. ADON A stated Resident #44 had poor vision and impaired cognition. Upon trying to enter room [ROOM NUMBER] to investigate the situation at hand door was jammed and only able to open partially. After squeezing my way through door opening it was noted that all the drawers at base of closet were pulled out preventing doors from opening completely. Resident's #44 wheelchair was noted sitting in front of the window. ADON A stated the window was open and screen pushed out onto ground outside of building. A fire extinguisher was noted to be missing from outside 300 hall door and noted on the opposite side of fence closest to the 400-hall exterior door. ADON A stated the gates were still latched on fence. Record review of this courtyard had a 5-feet high metal fence with gates that had latches but were not locked. There was approximately 92 feet from 300 hall window and 400 hall exit door. The weather was fair that day. (Google maps distance from 300 to 40 hall.<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | https://www.google.com/maps/@30.2644225,-98.8819717,55m/data=!3m1!1e3?entry=ttu&g_ep=EgoyMDI2M Record review of Resident #44's elopement risk assessment dated [DATE] revealed she was at high risk. Record review of Resident #44's psychological visit was dated 3/24/2026 and added 2 new medication changes. This was 5 days after the incident dated 3/19/2024. Observation on 4/12/2026 at 10:15 AM during initial rounds revealed Resident #44 was in her room with door closed, after she opened the door and standing, she was confused and walking around in her room with half her clothes on. Observed on 04/15/2026 at 11:75 AM outside between 300 hall and 400 hall, in the courtyard, had a black metal fence that had 2 gates with latches. During an interview on 04/15/2026 at 11:73 AM Maintenance Supervisor stated he responded to the alarm and saw Resident #44 on the outside of the 400 hall exit door. Interview with the Maintenance Supervisor stated he had let Resident #44 in the door that required a code to come in. The Maintenance Supervisor stated ADON A came and assessed Resident #44. Maintenance Supervisor stated he found out that the resident went out of the 300-hall room window. Resident #44 was found outside of 400 hall courtyard at approximately 4 PM by Maintenance Supervisor after she tried to get back in the building from the outside and opened the 400 hall exit door that set off an alarm. The Maintenance Supervisor stated he had alarmed the 300 hall barrier doors, limited the 300 hall room windows from opening, and limited window from opening in Resident #44's room. During an interview on 04/15/2026 at 1:75 PM, the ADM stated she did not report the incident because Resident #44 did not get out of the building. ADM stated she was responsible in reporting allegations to the STATE. ADM stated she did bring to corporate and they decided this incident was not responsible. During an interview on 04/15/2026 at 3 PM with CNA C stated the Maintenance Supervisor told her Resident #1 had gone down 300 hall with her wheelchair, went out the window from a 300-hall room, and walked across the courtyard to the exit door on the 400 hall where he found her. CNA C stated Resident #44 was confused, ADLs she was independent, for showers she required total assistance. CNA C stated Resident #44 mobilized with a wheelchair and wandered the halls. During an interview on 4/15/2026 at 3:27 PM with then ADON A (previous ADON-does not work at this facility) stated she came back to facility in February 2026. ADON A stated Resident #44 was confused, she mobilized in wheelchair, resident was able to walk and usually walks in her room and moves her furniture around. ADON A stated Resident #44 was partially blind. ADON A stated she uses her walker because she gets tired of walking or standing up. ADON A stated maybe Resident #44 heard some gun shots from the dining room TV show. (this was on the other side of Resident #44's). ADON A stated Resident #44 came into her office and was asking if she was ok. ADON A stated Resident #44 was distressed. ADON A stated Resident #44 then went out of her office and about 20 minutes later she heard a door alarm, and she was going down the 400 hall. ADON A stated she saw the Maintenance Supervisor and the CNA walking down the 400 hall with Resident #44. ADON A assessed Resident #44 and she had no injuries. ADON A notified the ADM, MD and family. ADON A stated she did have at the time of the incident. ADON A stated the Interventions were psychological services and alarm on 300 hall smoke barrier doors. Nurse assessment notified the ADM, MD and family. During an interview on 04/15/2026 at 6:03 PM with CNA B stated she had seen Resident #44 lying down at 3 PM, and at approximately 4 PM, she saw Resident #44 walking down the 400 hall with Maintenance Supervisor and another CNA C. During an interview on 4/16/2026 at 10:51 AM with the DON stated he was not in the facility when Resident #44 went out the window. The DON stated he was trained on exit seeking. The DON stated only Resident #44 had a revised elopement assessment-risk is 29 (high risk). The DON stated the new interventions that were in place after Resident #44 incident was alarms on Resident #44's windows and on the 300 hall limited opening, a psychological referral with medication changes, a urine test, that was dated 3/19/2026 and was negative. Record review of the facility's policy, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2001, documented -All reports of resident abuse, neglect, are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported.Policy Interpretation and (continued on next page) |

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| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implementation, Reporting Allegations to the Administrator and Authorities:Investigating Allegations7. All allegations are thoroughly investigated. The administrator initiates investigations.8. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations.9. The Administrator provides supporting documents and evidence related to the alleged incidents to the individual in charge of the investigation.13. That individual conducting the investigation of a minor; and we use the documentation and evidence, k. Reviews all events leading up to the alleged incident, and l. Documents the investigation completely and thoroughly.Follow up report:move in five business days of the incident, the administrator will provide a follow-up investigation report. |

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|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible, for 1 of 8 residents (Resident #55) reviewed for urinary retention (the inability to fully empty the bladder, resulting in urine being held back even when the bladder feels full. It can be a sudden, painful, and dangerous inability to urinate requiring emergency care or a long-term condition with difficulty urinating or a weak stream.) Resident #55 had a need for straight in / out urinary catheterization (a flexible tube designed to drain urine from the bladder, which is inserted and removed immediately after the bladder is empty) 4 times a day and LVN Z performed the procedure late by 1 1/2 hours. This failure could place residents at risk for urinary retention, pain, and / or infection.Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible, for 1 of 8 residents (Resident #55) reviewed for incontinence. (the inability to fully empty the bladder, resulting in urine being held back even when the bladder feels full. It can be a sudden, painful, and dangerous inability to urinate requiring emergency care or a long-term condition with difficulty urinating or a weak stream.) The facility failed to perform a urinary catheter on time for Resident #55 who had a need for straight in / out urinary catheterization (a flexible tube designed to drain urine from the bladder, which is inserted and removed immediately after the bladder is empty). This failure could place residents at risk for urinary retention, pain, and/or infection.Findings included: A record review of Resident #55's admission record, dated 4/14/2026, revealed an admission date of 4/11/2026 with diagnoses which included urinary tract infection (UTI, a common infection caused by bacteria entering the urinary system, typically affecting the bladder and urethra) and urinary retention. A record review of Resident #55's admission MDS, dated [DATE], revealed an [AGE] year-old male admitted from a short-term hospital stay. A record review of Resident #55's hospital records, dated 4/10/2026, revealed Resident #55 had a UTI, was started on antibiotics, and supported for urinary retention, . Assessment and plan: [AGE] year-old male with a past medical history of . benign prosthetic hyperplasia (BPH a common enlargement of the prostate gland in older men. The prostate grows, squeezing the urethra and causing bothersome urinary symptoms like incomplete bladder emptying.) . Chronic urinary retention: home in/out catheterization -- continue so here. A record review of Resident #55's physician's orders revealed the physician had prescribed for Resident #55 to receive straight in/out urinary catheterizations four times a day at 3:00 AM, 9:00 AM, 3:00 PM and again at 9:00 PM, to support his BPH and history of UTIs. During observations on 4/14/2026 from 2:05 PM until 4:00 PM, Resident #55 was in his room, attended physical therapy, and returned to his room. Observations revealed LVN Z had not provided care for Resident #55. During an observation on 4/14/2026 at 4:00 PM, LVN Z was in an office speaking with the ADON. During an interview on 4/14/2026 at 4:15 PM, Resident #55 stated he had not received his 3:00 p.m. urinary catheterization. During an interview on 4/15/2026 at 4:00 PM, LVN Z stated she performed an in and out catheter for Resident #55 on 4/14/2026 on or about 4:30 PM. LVN Z stated she was unaware that Resident #55 had a physicians' order which called for him to have an in and out catheter four times a day at specific times. LVN Z stated Resident #55's orders were updated and she had not reviewed the new orders. LVN Z stated the previous order called for Resident #55 to receive an in and out urinary catheter four times a day; however, the times were not specified. LVN Z stated she was unaware that Resident #55 was scheduled to have an in and out catheter at 3:00 PM and performed the catheterization around 4:30 PM. LVN Z stated the potential negative outcome to residents would be that they may not receive the therapeutic effects of their physicians' orders and a potential for<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | inaccurate records. During a joint interview on 4/15/2026 at 5:00 PM, the Administrator and the DON stated their expectation was for nursing staff to follow physicians' orders and to review physicians' orders prior to taking their shift on the floor for each resident and following those orders. The Administrator and the DON stated the potential negative outcome could be residents would not receive the therapeutic effects of their physicians' orders. A policy was not requested and not provided. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations interviews, and record reviews, the facility failed to ensure that its Residents were free of any significant medication errors for 1 of 6 residents (Resident #22) reviewed for significant medication errors. On 4/15/2026 LVN G administered Resident #22's insulin, via an injection pen, and did not follow the manufactures' administration instructions. This failure could place residents at risk for not receiving the therapeutic effects of their medications.Based on observations, interviews, and record reviews, the facility failed to ensure that its residents were free of any significant medication errors for 1 of 6 residents (Resident #22) reviewed for significant medication errors. On 4/15/2026 LVN G administered Resident #22's insulin, via an injection pen, and did not follow the manufactures' administration instructions. This failure could place residents at risk of not receiving the therapeutic effects of their medications.Findings included: A record review of Resident #22's admission record, dated 4/17/2026, revealed an admission date of 1/10/2026, with diagnosis of type II diabetes mellitus (a chronic condition characterized by high blood sugar levels caused by insulin resistance (cells not using insulin properly and insufficient insulin production by the pancreas). A record review of Resident #22's quarterly MDS assessment, dated 1/15/2026, revealed Resident #22 was a [AGE] year-old female admitted for LTC ADL supports, medication administration, for her type II diabetes. A record review of Resident #22's physicians' orders, dated 4/14/2026, revealed the physician prescribed for Resident #22 to receive insulin aspart before meals and again at bedtime, . Inject as per sliding scale: if 150 - 200 = 2 units; . subcutaneously (directly underneath the skin, specifically within the fatty tissue) before meals and at bedtime related to type 2 diabetes mellitus . A record review of the Resident #22's 3ml insulin aspart 100units/ml injection pen manufactures website https://www.novo-pi.com/novolog.pdf ; accessed 4/15/2026, titled Highlights of Prescribing Information revealed, Instructions For Use: 3 milliliter insulin pen prefilled pen 100 units per milliliter. Introduction: please read the following instructions carefully before using your injection pen. (brand name) injection pen is a disposable single patient use dial-a-dose insulin pen. You can select doses from 1 to 60 units in increments of 1 unit . Attaching the needle: . Screw the needle tightly onto your injection pen. Giving the airshot before each injection: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your injection pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. During an observation and interview on 4/15/2026 at 11:37 AM, LVN G assessed Resident #22's blood sugar level at 163 and prepared Resident #22's 3ml insulin aspart injection pen, 100ml/ml, by applying a needle to the injection pen and set the dosage to 2 units and administered the insulin to Resident #22 without an air shot of 2 units prior to administering Resident #22's insulin dose. LVN G stated she was unaware of priming/ air shot the injection pen and had not performed the procedure prior to administering Resident #22 insulin. LVN G stated she would review the manufactures instructions for the injection pen. During an interview on 4/15/2026 at 4:00 PM, the DON stated the expectation for insulin injection administration with injection pens was to follow manufactures instructions for use which included priming the needle for accurate dosing. The DON stated the potential risk for residents if the injection pen was not primed could be a small under dosage of insulin. A record review of the facility's policy titled, Insulin Administration, dated September 2014, revealed, Purpose: to provide guidelines for the safe administration of insulin to residents with diabetes. Preparation: . the type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. the nursing staff will have access to specific instructions from the manufacturer, if appropriate, on all forms of insulin delivery systems prior to their use. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455941 | A. Building<br>B. Wing | 05/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews and record review, the facility failed to ensure- Food safety requirements. The facility must store, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 (1 kitchen) in that: The nourishment room, in hall 100, had 2 food items that were open and not dated. This could affect all residents that keep food in the nutrition room and could result in food borne illness The Findings:Observations on 4/15/2026 at 8:49 AM in the 100 hall nourishment room, in the refrigerator had a weenie wrap that was opened with no date. The 2nd food item in the refrigerator had a chicken express box that was opened, with no date. This contained 2 small containers of eaten mashed potatoes, and 1 piece of chicken that was eaten. During an interview on 4/15/2026 at 8:33 AM with the MDS nurse confirmed the weenie wrap that was open with no date and the chicken express box that was opened, with no date. Interview on 4/15/2026 4:47 PM with ADM stated the food was removed from the refrigerator. The ADM stated this could cause a food borne illness, if not properly labeled. ADM did not provide a policy, before exit. |

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| | 455941 | A. Building<br>B. Wing | 05/02/2026 |

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| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that were complete; accurately documented; readily accessible; and systematically organized, for 1 of 6 residents (Resident #55) reviewed for accurate records. LVN Z inaccurately documented care for Resident #55. This failure could place residents at risk for inaccurate records.Based on observations, interviews, and record reviews, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 of 6 residents (Resident #55) reviewed for medical records. LVN Z inaccurately documented care for Resident #55. This failure could place residents at risk for their needs not being met accurately.Findings included: A record review of Resident #55's admission record, dated 4/14/2026, revealed an admission date of 4/11/2026 with diagnoses which included urinary tract infection (UTI, a common infection caused by bacteria entering the urinary system, typically affecting the bladder and urethra) and urinary retention. A record review of Resident #55's admission MDS dated [DATE] revealed Resident #55 was a [AGE] year-old male admitted from a short-term hospital stay. A record review of Resident #55's hospital records dated 4/10/2026 revealed Resident #55 had a UTI and was started on antibiotics and supported for his urinary retention, . Assessment and plan: [AGE] year-old male with a past medical history of . benign prosthetic hyperplasia (BPH a common enlargement of the prostate gland in older men. The prostate grows, squeezing the urethra and causing bothersome urinary symptoms like incomplete bladder emptying.) . Chronic urinary retention: home in / out catheterization -- continue so here. A record review of Resident #55's physician's orders revealed the physician had prescribed for Resident #55 to receive straight in / out urinary catheterizations 4 times a day at 3:00 AM, 9:00 AM, 3:00 PM and again at 9:00 PM, to support his BPH and history of UTI's. During observations on 4/14/2026 from 2:05 PM until 4:00 PM revealed Resident #55 in his room, attended physical therapy, and returned to his room. observations revealed LVN Z had not provided care for Resident #55. During an observation on 4/14/2026 at 4:00 PM revealed LVN Z was in an office speaking with the ADON. During an interview on 4/14/2026 at 4:15 PM Resident #55 stated he had not received his 3 PM urinary catheterization. During an interview on 4/15/2026 at 4:00 PM LVN Z stated she had performed an in and out catheter for Resident #55 on 4/14/2026 on or about 4:30 PM. LVN Z stated she was unaware that Resident #55 had a physicians' order which called for him to have an in and out catheter 4 times a day at specific times. LVN Z stated Resident #55's orders had been updated and she had not reviewed the new orders. LVN Z stated the previous order called for Resident #55 to receive an in and out urinary catheter 4 times a day however the times were not specified. LVN Z stated therefore she was unaware that Resident #55 was scheduled to have an in and out catheter at 3:00 PM and therefore performed the catheterization around 4:30 PM. LVN Z stated that she erred on the documentation of the in and out catheter and documented that she performed the procedure at 3:30 instead of 4:30 PM. LVN Z stated the potential negative outcome to residents was they may not receive the therapeutic effects of their physicians orders and a potential for inaccurate records. During a joint interview on 4/15/2026 at 5:00 PM the Administrator and the DON stated their expectation was for nursing staff to follow physicians' orders and to review physicians' orders prior to taking their shift on the floor for each resident and following those orders. The Administrator and the DON stated the potential negative outcome could be residents would not receive the therapeutic effects of their physicians' orders. The Administrator and the DON stated they expected nursing staff to document accurately the correct dates, correct times, correct residents, correct documentation for procedures. The administrator stated the potential negative outcome for residents would be<br>(continued on next page) |

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| | 455941 | A. Building<br>B. Wing | 05/02/2026 |

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| Avir at Enchanted Rock | 210 West Windcrest St<br>Fredericksburg, TX 78624 |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | inaccurate reports. A record review of the facility's Charting and Documentation policy dated July 2017, revealed, Policy statement: All services provided to the resident, progress towards the care plan goals, or any changes in the resident medical, physical, functional or psychosocial condition, shall be documented in the resident medical record. The medical record should facilitate communication between the interdisciplinary team regarding the residents' condition and response to care. Policy interpretation and implementation: . Documentation in the medical record will be objective, complete, add accurate. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and record reviews, 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 2 of 6 residents (Residents #26 and #27) reviewed for infection prevention measures. RN BB assessed Residents #26's blood sugar with a glucometer (a portable device used to measure blood sugar levels; A drop of blood obtained via a lancing device is placed on the edge of the strip which was inserted into the meter) and did not disinfect the glucometer with an appropriate blood borne pathogen (germs or infectious agents and include viruses, bacteria, fungi, and parasites) disinfectant; and then proceeded to assess Resident #27's blood sugar with the same glucometer used for Resident #26. This failure could place residents at risk for blood borne pathogen infections.Based on observations, and record reviews, 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 2 of 6 residents (Residents #26 and #27) reviewed for infection control. RN BB assessed Residents #26's blood sugar with a glucometer (a portable device used to measure blood sugar levels; A drop of blood obtained via a lancing device is placed on the edge of the strip which was inserted into the meter) and did not disinfect the glucometer with an appropriate blood borne pathogen (germs or infectious agents and include viruses, bacteria, fungi, and parasites) disinfectant; and then proceeded to assess Resident #27's blood sugar with the same glucometer used for Resident #26. This failure could place residents at risk for blood borne pathogen infections.Findings included: 1. A record review of Resident #26's admission record, dated 4/17/2026, revealed an admission date of 7/29/2024 with a diagnosis of type II diabetes (a disorder characterized by high blood sugar resulting from the body's inability to use insulin properly and, over time, a failure to produce enough insulin). A record review of Resident #26's quarterly MDS assessment dated [DATE] revealed Resident #26 was a [AGE] year-old female admitted for LTC and assessed with a BIMS score of 12 which indicated moderate cognitive impairment. A record review of Resident #26's care plan, dated 4/17/2026, revealed, The resident has diabetes mellitus, date initiated 8/5/2024 . The resident will have no complications related to diabetes through the review date . A record review of resident #26's physicians orders, dated 4/16/2026, revealed the physician prescribed, on 3/2/2026, for nursing staff to assess Resident #26's blood sugar levels prior to meals and at bedtime. 2. A record review of Resident #27's admission record, dated 4/17/2026, revealed an admission date of 3/23/2026 with a diagnosis of type II diabetes. A record review of Resident #27's admission MDS assessment, dated 3/16/2026, revealed Resident #27 was a [AGE] year-old male admitted for LTC and supported with his diabetes. A record review of Resident #27's care plan, dated 4/16/2026, revealed, The resident has diabetes . the resident will have no complications related to diabetes through the review date . A record review of resident #27's physicians' orders, dated 4/16/2026, revealed the physician prescribed, on 2/27/2026, for the resident to receive insulin lispro (a fast-acting human insulin analog used to treat type 1 and type 2 diabetes by controlling blood sugar spikes, particularly after meals) prior to meals by first assessing Resident #27's blood sugar levels. A record review of the Texas HHSC's website:https://www.hhs.texas.gov/sites/default/files/documents/glucometer-use-care-quality-control.pdfacces 4/16/2026, titled Tips for Glucometer Use and Care revealed, Steps in Use: . Disinfect the glucometer according to manufacturer recommendations.a. Properly disinfect glucometers to prevent spread of diseases like Hepatitis B, Hepatitis C, and HIV. Even when devices are used by a single person only, consider the potential for contamination during storage and disinfect accordingly. *Note: DO NOT assume that a glucometer was cleaned after the last use.c. Follow the manufacturer's recommended chemical contact (dwell) time, before using the meter.*Note: DO NOT USE ALCOHOL to disinfect a<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | glucometer, as this is not adequate for disinfection to prevent cross contamination, and it can damage equipment. A record review of the glucometers manufactures website https://www.medline.com/media/catalog/Docs/MKT/LITe22140_MAN_EvenCare%20G2_19W4233811.pdfAcc 4/16/2026, titled Blood Glucose Monitoring System Healthcare Professional Operator's Manual revealed, Operator's Manual and In-Service Guide: . Important: Users need to adhere to standard precautions when handling or using this device. All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals. A new pair of clean gloves should be worn by the user before testing each patient. Cleaning and Disinfecting: Important; DO NOT use glass cleaners or household cleaners on the meter.Materials needed:. Gloves A validated disinfecting wipe .The following products are validated for disinfecting the (Brand name) Meter: (Brand name) Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number: 56392-8) (Brand name) Disinfecting, Deodorizing, Cleaning Wipes with Quaternary Ammonium and Alcohol (EPA Registration Number: 59894-10) (brand name) Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12) (Brand name) Bleach Germicidal Bleach Wipes (EPA Registration Number: 37549-1). During an observation on 4/15/2026 at 11:20 AM, RN BB assessed Resident #26 for his blood sugar level, with a glucometer, and cleansed the glucometer with alcohol wipes and then assessed Resident #27, with the same glucometer, for his blood sugar level and cleansed the glucometer with alcohol wipes. During an interview on 4/15/2026 at 11:32 a.m., RN BB stated she had one glucometer to check residents' blood sugar levels. RN BB stated she used alcohol wipes to cleanse the glucometer prior to use, after use, and in between residents. RN BB stated she used alcohol wipes to cleanse the glucometer instead of the Germicidal blood borne wipes because the facility was out of wipes. RN BB stated she had not reported the lack of germicidal blood borne pathogen wipes to the DON. RN BB stated the potential negative outcome to residents could be the spread of blood borne pathogens. During an interview on 4/16/2026 at 4:00 p.m., the DON stated the expectation for nurses when assessing residents' blood sugar levels was for nurses to disinfect the glucometer with the approved germicidal disinfecting wipes and not alcohol wipes, in between resident uses. The DON stated he was not notified there were no germicidal wipes and and stated the facility did have the correct germicidal wipes to disinfect the glucometers and if RN BB had searched and or requested for the wipes she would have received the wipes. The DON stated the failure to disinfect the glucometer with the approved disinfectant wipes for blood borne pathogens could be the spread of blood borne pathogens. A record review of the facility's Obtaining a Finger Stick Glucose Level policy dated October 2011, revealed, Purpose: the purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Equipment and supplies: the following equipment and supplies will be necessary when performing this procedure: . Clean the glucometer with germicidal wipes /or bleach and water solution diluted with a 1 to 9 ratio before initial use, after final use, and between each resident following manufacturer recommendations. |