

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Avir at Pittsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 123 Pecan Grove Pittsburg, TX 75686	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident and determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 3 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1's baclofen (muscle relaxant) was administered as ordered on 10/23/2025 and 10/24/2025. This failure could place the residents at risk of not having medications available for use and medications errors. Findings included: Record review of Resident #1's face sheet dated 10/30/2025 indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included spinal stenosis (narrowing of the spinal canal with can lead to compression of the nerves and cause low back pain and discomfort), dementia (deterioration of memory, language, and other thinking abilities) and chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he understood others and was understood by others. Resident #1's MDS assessment indicated he had a BIMS score of 14, which indicated his cognition was intact. The MDS assessment indicated Resident #1 was independent for eating and hygiene and required supervision for bathing. The MDS assessment indicated Resident #1 received scheduled and as needed pain medication. Record review of Resident #1's care plan revised 09/11/2025, indicated he had a diagnosis of muscle spasms, abnormal muscle movement and was at risk for adverse reactions to medication. Interventions included providing medications as ordered. Record review of Resident #1's Order Summary Report dated 10/30/2025 indicated he had an order for baclofen 5 mg give 1 tablet orally three times a day with a start date of 04/11/2025. Record review of Resident #1's October 2025 MAR indicated baclofen 1 tablet orally three times a day at 7 AM, 1 PM, and 7:00 PM. Resident #1's MAR indicated the baclofen was not administered on: 10/23/2025 at 1 PM. 10/24/2025 at 7 AM, 1 PM, and 7:00 PM. Record review of Resident #1's progress notes indicated: 10/23/2025, Baclofen 5 mg pending arrival from pharmacy, signed by LVN A. 10/24/2025, Baclofen 5 mg pending arrival from pharmacy, signed by LVN A. During an interview on 10/30/2025 at 9:34 AM, Resident #1 said around the middle of this month (October 2025), his baclofen was not administered two days. Resident #1 said LVN A told him his medication ran out, and she had called it in. LVN A said it was not delivered because the pharmacy said it was too early to fill it. Resident #1 said LVN A told him she could not administer it from the emergency medication kit because it did not contain it. During an interview on 10/30/2025 at 11:32 AM, LVN A said sometimes the residents' medications ran out. LVN A said if they did not have a resident's medication, they checked the emergency medications to see if it was available for administration, if it was not available, the residents did not receive their medication. LVN A said if they did not have a resident's medication they should contact the pharmacy, notify the DON and doctor. LVN A said Resident #1 ran out of his baclofen the previous week, and he did not receive it for maybe one day. LVN A said she had not notified the doctor because he did not miss that many doses. LVN A said if she did not administer the baclofen, it was because it was not in the emergency medications. LVN A said she had contacted the pharmacy and notified the DON Resident #1 did not have any baclofen for administration, and she had administered it when it was delivered. LVN A said Resident #1 did not suffer any side effects from not receiving the baclofen, and he had as needed pain medications that could be administered if he needed them. LVN A said it was important to administer medications as ordered to help manage the residents' conditions. During an observation and interview on 10/30/2025 at 2:43 PM, an observation of the emergency medications was made with the DON, and there were only baclofen 10 mg tablets available. The DON said earlier in the month Resident #1 had notified her he had not received his baclofen. The DON said she called the pharmacy, and they told her they had delivered a supply for one month earlier in the month. The DON said the nurses received the medications from the pharmacy, and the nurses were supposed to verify the amount received when they signed for the medications. The DON said she searched everywhere in the facility for the baclofen and did not find it. The DON said she called the pharmacy, notified them, and they sent the medication to the facility on [DATE]. The DON said the nurses did not notify her Resident #1 did not have any baclofen and they had not administered it. The DON said she found out about the baclofen when Resident #1 notified her. The DON said if the nurses would have notified</p>		