STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Pittsburg	123 Pecan Grove Pittsburg, TX 75686

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two of thirteen residents (Residents #3 and #8) reviewed for reasonable accommodations. The facility failed to ensure Resident #8 and Resident #38 had a call light within reach. This failure could place residents at risk of possible falls, major injuries, hospitalization, and unmet needs.Findings include: Record review of Resident #8's face sheet dated 02/10/26 reflected a [AGE] year-old male who was admitted on [DATE]. Resident #8 had diagnoses which included: senile degeneration of brain (a progressive decline in cognitive function caused by structural brain changes, not normal aging), schizoaffective disorder (a chronic mental health condition combining psychotic symptoms with mood disorders episodes), depression and anxiety disorder. Record review of Resident #8's MDS assessment, dated 12/10/25, reflected Resident #8 was usually understood and usually understood by others. Resident #8's BIMS score was a 7, which indicated severe impaired cognition. Resident #8 was dependent on toileting and shower/ bathe. Resident #8 required moderate assistance with all ADLs. Resident #8 was always incontinent to bowel and bladder. Record review of Resident #8's care plan dated 9/24/25 reflected Resident #8 was at a high risk for falls related to incontinence, unaware of safety needs related to senile degeneration of the brain. The interventions included: be sure the resident's call light was within reach, encourage the resident to use it for assistance as needed, and provide prompt response to all requests for assistance. Record review of Resident #38's face sheet dated 02/11/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included: unspecified dementia (a cognitive decline severe enough to interfere with daily life), cognitive communication deficit (an impairment in communication), extrapyramidal movement disorder (medication-induced or disease-related movement disorder affecting the brain's motor system), history of falling, muscle wasting and atrophy, difficulty in walking, muscle weakness and unspecified lack of coordination. Record review of Resident #38's MDS, dated [DATE], reflected Resident #38 was understood and was understood by others. A BIMS score was not conducted for Resident #38. Resident #38 was independent of toileting and required partial assistance with ADLs. Resident #38 was always continent of bladder and bowel. Record review of Resident #38's care plan dated 06/13/25 reflected Resident #38 was a risk for fall due to unsteady gait, decreased balance, medications, and poor safety awareness. The interventions included: call light in reach in room and answered promptly, encourage and remind her to use call light to ask for assistance. During an observation on 02/09/26 at 10:38 A.M., Resident #38 was lying in bed resting. Resident 38's call light was on the floor at the head of her bed and not within reach. During an observation on 02/09/26 11:17 AM., Resident #8 was lying in bed resting. Resident #8's call light was not within reach; it was on the other side of the room. During an observation on 02/09/26 at 2:12 P.M., Resident #8 was lying in bed asleep. Resident #8's call light was not within reach. During an observation on 02/09/26 at 2:15 P.M., Resident #38 was not in her room. Resident #38's call light was on floor at the head of the resident's bed. During an observation on 02/10/26 at 10:06 A.M., Resident #38 was lying in bed, and her call light was on the floor at the head of her bed. Resident #38's call (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	light was not within reach. During an observation on 02/10/26 at 10:08 A.M., Resident #8 was lying in bed asleep. Resident 8's call light was pinned to a cord across the room. The call light not within reach of Resident #8. During an observation on 02/11/26 at 9:34 A.M., Resident #38 was lying in bed and her call light on floor at the head of her bed. During an observation on 02/11/26 at 9:36 A.M., Resident #8 was lying in bed resting and his call light was on the opposite side of the room. Resident #8's call light was not within reach. During an interview on 02/11/26 at 9:45 A.M., CNA B said she agreed that Resident #8 and Resident #38's call lights were not accessible for the residents, and she had put the call lights where the residents could get to them. She said everyone was responsible for ensuring that the call lights were assessable for the residents. She said the negative effect of not having a call light assessable for the residents was if an emergency occurred and they needed assistance; they could not call for help. During an interview on 02/11/26 at 9:57 A.M., LVN A said the call lights should be accessible for the residents. She said everyone was responsible for ensuring that the call lights were assessable for the residents. She said a negative effect of not having the call lights assessable for a resident was if anything happened to the residents, they would not be able to call for help. During an interview on 02/11/26 at 12:00 P.M., the Assistant Director of Nursing said she expected for the residents' call lights to be within reach. She said everyone was responsible for ensuring that the call lights were accessible. She said the negative effect of the call lights not being assessable was the residents could be in need or distressed and could not call for help. During an interview on 02/11/2026 at 12:29 P.M., the Director of Nursing said she expected the call lights to be accessible and within reach at all times of the residents. She said all staff were responsible for ensuring the residents' call lights were assessable. She said the negative effect of call lights not being assessable was the residents may be unable to call for help in a reasonable manner and it may increase the risk of injury trying to assess the call light. During an interview on 02/11/2026 at 12:47 P.M., the Administrator said she expected the call lights to be accessible to the residents. She said all staff were responsible for ensuring the residents' call lights were assessable. She said the negative effect of not having the call light assessable was if a resident needed something and they could not access the call light, they cannot call for help. Record review of the facility's policy and procedure Call System, Residents dated January 2025, indicated. Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation.1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. Call system communication may be audible or visual. The system may be wired or wireless.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 14 residents reviewed for assessments. (Resident #44).The facility failed to complete an accurate resident assessment for Resident #44 by indicating the resident did not have any broken or missing teeth.This failure could place residents at risk of not having individual needs met and a decreased quality of life.Findings included:Record Review of Resident #44's face sheet, dated 11/28/2022, indicated an [AGE] year-old male admitted on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (a progressive lung disease that makes it difficult to breath), dementia (a syndrome characterized by a decline in cognitive function affecting memory, thinking, behavior and ability to perform everyday activities), hypertension (a common condition where the force of blood against the artery walls is consistently too high), Hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood, particularly low-density lipoprotein (LDL) often referred to as bad cholesterol.), Gastroesophageal reflux disease (a chronic condition where stomach acid flows back into the esophagus),pruritus (an irritating sensation that makes itch often caused by dry skin) and pulmonary embolism with acute cor pulmonale (a sudden increase in pressure in the pulmonary circulation).Record Review of Resident #44's Annual MDS assessment, dated 1/30/2025, indicated Resident #44 was understood and understood others. Resident #44 had a BIMS score of 13, which indicated his cognition was intact and was independent with ADLs. The Annual MDS did not indicate Resident #44 had missing or broken teeth.Record review of Resident #44's care plan, dated 01/30/2026, did not indicate he had any dental issues or pain.Record Review of Resident #44's MAR dated 2/1/2026-2/28/2026 indicated Resident #44 received Naproxen 220 mg 2 tablets by mouth every 8 hours as needed for pain.During an observation and interview on 2/9/2026 at 10:22 AM, Resident # 44 was sitting up in a wheelchair with observed oxygen tank in room. Resident #44 said he was independent with most activities and was no longer in therapy. He said he was having mouth pain from broken teeth and left ear pain. Resident #44 said he he had reported tooth and left ear pain months ago. He said he wanted to see a dentist because he had pain in the back of his mouth. He said he was not on a special consistency diet. Resident was observed to have broken and missing teeth.During an interview on 2/11/2026 at 8:40 AM, CNA D said Resident #44 required supervision only. She said she often checked on him to ensure he had his oxygen on. She said he was on a regular diet. CNA D said Resident #44 had never reported mouth pain to her, and she was unaware he had missing teeth. CNA D said if a resident was complaining of mouth pain, it could cause the resident to have a change in behavior, or he might eat less.During an interview on 2/11/2026 at 10:33 AM, LVN C said the nurses completed parts of the assessments for the MDS and care plans. She said the information was received from the resident. LVN C said the DON were responsible for the MDS and care plans. She said if an assessment were not captured on the MDS, it could negatively impact on the residents, and not be captured in a care plan. She said normally if something was missed, the DON would notify the nurse to get the MDS updated with the correct information. She said it could be a safety issue or a resident may have a delay in care.During an interview on 2/11/2026 at 10:59 AM, the ADON said the facility currently did not have an MDS nurse. She said the DON was responsible for the admission assessment. She said the initial assessment was completed by the nurse on duty. The ADON said the ADM, DON, and corporate staff worked together to complete the MDS. She said the MDS should match the resident's current condition. The ADON said she really did not know the duties of the MDS nurse.During an interview on 12/11/2026 at 11:27 AM, the DON said she had attempted to get Resident #44 an appointment with the visiting dental group, but they did not take his insurance, and the family would not cover the cost. She said she was getting someone to see him that day. The DON said the charge nurse was responsible for performing the initial assessment received from residents and family, and discharge paperwork from the hospital. The DON said missing teeth and (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dental issues should be documented on the MDS. She said it would be inaccurate on the MDS. She said the resident could have pain and reflect a weight loss if he quit eating certain foods, and placed him at risk for infection. The DON said the facility currently did not have a MDS nurse. She said the charge nurse were responsible for making sure the information was documented in their assessment when admitted or if there was a change in condition.During an interview on 2/11/2026 at 12:11 PM, the ADM said the facility changed EMR systems. The ADM said she expected the nurse/MDS nurse to assess the resident with accuracy on the MDS, so the care plan and interventions were individualized for the resident. She said if the assessment was not accurate, the resident may not receive proper care.Review of the facility's policy titled Resident Assessments dated March 2022 indicated, A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements.PPS assessments provide information about the clinical condition of beneficiaries receiving Part A SNF- level care in order to be reimbursed.1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements.admission assessment.Quarterly assessment.Annual assessment. Significant change in status assessment.significant correction to prior quarterly assessment.discharge assessment.2. The RAI manual (Chapter 2) provides detailed information on timing.3. A comprehensive assessment includes. completion of the Minimum Data Set (MDS), completion of the care area assessment (CAA) process.development of the comprehensive care plan. 7. All members of the care team, including licensed and unlicensed staff members, are asked to participate in the resident assessment process.8. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.9. All resident assessments completed within 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review, and revise the residents' comprehensive care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 14 residents (Residents #4, #40, and #44) reviewed for comprehensive person-centered care plans.1. The facility failed to develop and implement the comprehensive person-centered care plan for Resident #4 by not documenting he was on enhanced barrier precautions.2. The facility failed to develop and implement the comprehensive person-centered care plan for Resident #40's use of anticonvulsant medications, seizure disorder, altered diet, and impaired ADL performance.3. The facility failed to develop and implement all relevant comprehensive person-centered care plans for Resident #44's besides advanced directive and oral health.These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services.Findings include:1. Record review of Resident #4's face sheet dated 01/10/26 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included: multiple sclerosis (a chronic disease of the central nervous system), psoriasis (a skin disease that causes a rash with itchy) protein-calorie malnutrition.Record review of Resident #4's MDS assessment, dated 12/18/25, reflected Resident #4 was usually understood and usually understood by others. Resident #4's BIMS score was a 15, which indicated cognation was intact. Resident #4 was dependent on ADLs. Resident #4 was always incontinent to bowel and bladder. The 1 of 1 of unhealed pressure ulcers/ injuries at each stage: Stage 3: Full thickness tissue loss.Record review of Resident #4's care plan dated 12/16/25 reflected Resident #4 had a stage 3 pressure ulcer to the sacrum related immobility. Interventions included cleanse sacral wound with wound cleaner, pat dry, apply collagen sheet to wound bed, apply triad to peri wound, and cover with hydrocolloid dressing 3 times a week and as needed for soilage/ dislodgement. Care plan did not indicate Resident #4 was on enhanced barrier precautions, due to sacral wound.Record review of Resident #4's order summary report reflected cleanse sacral wound with wound cleanser, pat dry, apply medical grade honey fiber, and cover with bordered gauze daily and PRN for soilage/dislodgement. every evening shift for wound care, dated 02/06/26.During an interview on 02/11/26 at 9:57 AM, LVN A said she thought Resident #4's wound was cleared. She said on his orders the wound care said PRN, so she thought his wound was resolved. She said since Resident #4 had a wound, he was supposed to be on EBP. She said a negative effect of not following enhanced barrier precautions was the risk of spreading infection.During an interview on 02/11/26 at 12:00 PM, the ADON said since the facility did not have a MDS nurse, corporate was coming in the building doing MDS. She said Corporate, the Director of Nursing, and Administrator were responsible for updating the care plan. She said the negative effect of not updating the care plans could affect the residents' care the doctor ordered for them; it could make the situation worse.During an interview on 02/11/26 at 12:29 PM, the DON said she did not have an MDS nurse at that time, so any member of nursing staff, including herself, could have updated Resident #4's care plan for EBP. She said the negative effect of not updating the care plan could pose a risk of staff having a lack of knowledge that required extra precautions to prevent an increase in infection.During an interview on 02/11/26 at 12:47 PM, the Administrator said the facility did not have a treatment or MDS nurse, so she would say the infection preventionists, who was the Director of Nursing, was responsible for ensuring the EBP was on the care plan. She said the negative effect of not having the EBP of the resident's care plan would be the resident would not be receiving the proper care.2. Record review of Resident #40's face sheet, dated 2/11/2022, indicated an 80-year- old female readmitted on [DATE]with diagnoses which included Alzheimer's Disease (a brain disorder (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that destroys memory and thinking skills), Urinary Tract Infection (an infection in any part of the urinary system), Hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood, particularly low-density lipoprotein (LDL) often referred to as bad cholesterol.), and seizures (a sudden burst of electrical activity in the brain).Record review of Resident #40's Quarterly MDS, dated [DATE], indicated Resident #40 understood and was understood by others. Resident #40 had a BIMS score of 00, which indicated severely impaired cognition. Resident #40 required supervision to moderate assistance with ADLs. Resident #40 had a diagnosis of Seizure Disorder and was prescribed an anticonvulsant. The MDS indicated Resident #40 was on a mechanically altered diet.Record review of Resident #40's Care Plan, last revised on 1/30/2026 indicated the care plan did not include the resident's use of anticonvulsant medications, seizure disorder, altered diet, and impaired ADL performance.Record review of Resident #40's Order Summary Report dated 2/11/2026 indicated diagnoses including hypertension, seizures, pain, insomnia, muscle weakness. Resident #40 was on a regular, no added salt diet, pureed texture, regular liquids with whole milk and fortified food with all meals with each food item in separate bowls. The order summary report indicated Resident #40 resided on a secure unit to prevent potential injury due to wandering and elopement risk and was prescribed Levetiracetam (a medication used to help control certain types of seizures).Record review of Resident #40's MAR dated 2/1/2026-2/28/2026 indicated Resident #40 received Levetiracetam 100 mg/ml 5 ml by mouth two times daily related to seizures.During an observation on 2/9/2026 at 9:40 AM, Resident #40 was sitting in the main dining area on the secure unit playing with blocks at the table. Resident #40 was pleasantly confused, clean, and well-groomed with no signs of untimely care. Conversation was limited due to impaired thought organization.During an interview on 2/10/2026 at 11:10 AM, the RP said she had no concerns with care provided by the facility. She said Resident #40 was doing well with her medications and they were helping her. She said she was notified of potential side effects of medications, and she received updates on her care.During an interview on 2/11/2026 at 10:33 AM, LVN C said Resident #40 was encouraged to elevate her feet while she was sitting. She said she required her meals to be set up, and she was able to feed herself. LVN said Resident #40 was on a regular, no added salt pureed texture diet with regular liquids and she resided on the secure unit. LVN C said staff documented changes in condition and new physician orders on the 24-hour report. She said she reviewed the care plan. LVN C said the resident's diagnoses should be on the care plan to know why care was being performed. She said the care plan was based off the reports and assessments. LVN C said the interventions were different for each resident and should match what was going on with the resident. LVN C said the DON was responsible for the MDS and care plans. She said if a care plan and MDS was inaccurate, it could negatively impact the resident because the staff would not know what to monitor the resident for.During an interview on 2/11/2026 at 10:59 AM, the ADON said the care plan was created and started with the DON. She said it was a group effort. The ADON said the residents' diagnoses, interventions such as fall mats, dialysis, medications, code status and diet should be on the care plan. The ADON said the staff have a care plan meeting that was held on Thursdays, but she was not sure when the care plan meetings were held since the new corporate company took over. The ADON said the care plan should be updated when there was a significant change. The ADON said the DON and ADM were responsible for updating the care plan.During an interview on 2/11/2026 at 11:21 AM, the DON said Resident #40's care plan should have goals and interventions specific to her needs related to diagnoses and medications. She said the IDT was responsible for making sure the interventions and goals were updated. She said by not having the care plan updated, the staff may not provide the resident with resident centered care.During an interview on 2/11/2026 at 11:21 AM, the ADM said the care plan information was pulled from the MDS. She said she expected the MDS nurse and nurse to assess the residents with accuracy on the MDS so the care plan and interventions were individualized for each resident. She said if the assessment was not accurate, the resident might not receive proper care. 3. Record Review of Resident #44's face sheet, dated 11/28/2022, indicated an [AGE] year-old male admitted (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (a progressive lung disease that makes it difficult to breath), dementia (a syndrome characterized by a decline in cognitive function affecting memory, thinking, behavior and ability to perform everyday activities), hypertension (a common condition where the force of blood against the artery walls is consistently too high), Hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood, particularly low-density lipoprotein (LDL) often referred to as bad cholesterol.), Gastroesophageal reflux disease (a chronic condition where stomach acid flows back into the esophagus),pruritus (an irritating sensation that makes itch often caused by dry skin) and pulmonary embolism with acute cor pulmonale (a sudden increase in pressure in the pulmonary circulation).Record Review of Resident #44's Annual MDS, dated [DATE], indicated Resident #44 was understood and understood others. Resident #44 had a BIMS score of 13, which indicated he was cognitively intact and was independent with ADLs. The Annual MDS indicated Resident #44 had hypertension, Gastroesophageal reflex, hyperlipidemia, dementia, and Chronic Obstructive Pulmonary Disease. The MDS indicated resident was on an antiplatelet. The care areas triggered on the annual MDS were visual function and nutritional status.Record review of Resident #44's care plan, dated 01/30/2026, indicated full code status with interventions to encourage resident to verbalize and express wishes regarding personal decisions, ensure any questions were posed by the resident or representative regarding advanced care planning were answered timely and executed accordingly. There were no care plans related to Chronic Obstructive Pulmonary Disease, pain, or antiplatelet medication. The only Care areas triggered were visual function, nutritional status on the Annual MDS dated [DATE].Record review of Resident #44's order summary dated 2/9/2026 indicated diagnoses included Chronic Obstructive Pulmonary Disease, hyperlipidemia, dementia, hypertension , gastroesophageal reflux disease , pruritus , and pulmonary embolism with acute cor pulmonale (a sudden increase in pressure in the pulmonary circulation). Resident #44 was on a regular diet, with no added salt with regular liquids. The order summary report indicated that resident was prescribed antiplatelet (a medication used to prevent blood clots and reduce risk of heart attack and stroke), required oxygen and nebulizer treatments for Chronic Obstructive Pulmonary Disease.Record Review of Resident #44's MAR dated 2/1/2026-2/28/2026 indicated Resident #44 received the following medications:Aspirin 81 mg daily for pulmonary embolism with acute cor pulmonaleOxygen 2-4 liters via nasal cannula as needed for shortness of breath and maintain pulse oximeter (a non-invasive electronic device typically placed onto finger to measure the oxygen saturation level of the blood and heart rate) greater than 88 %.Umeclidinium-Vilanterol Inhalation Aerosol Powder 62.5-25 mcg/act 1 puff inhaled daily for Chronic Obstructive Pulmonary Disease.Albuterol nebulizer 0.083 % 1 vial inhaled via nebulizer every 4 hours as needed for shortness of breath related to Chronic Obstructive Pulmonary Disease.Naproxen 220 mg 2 tablets by mouth every 8 hours as needed for pain.During an observation and interview on 2/9/2026 at 10:22 AM, Resident # 44 was sitting up in a wheelchair with observed oxygen tank in room. Resident #44 said he was independent with most activities and was no longer attending therapy. Resident #44 said he was having mouth pain from broken teeth and left ear pain. He said he wanted to see a dentist because he had pain in the back of his mouth. He said he was not on a special consistency diet.During an interview on 2/11/2026 at 8:40 AM, CNA D said Resident #44 was supervision only. She said she checked on him to ensure he had his oxygen on. She said he was on a regular diet. CNA D said Resident #44 had never reported mouth pain to her, and she said she was unaware he had missing teeth. CNA D said if a resident was complaining of mouth pain, it could cause the resident to have a change in behavior, or he might eat less.During an interview on 2/11/2026 at 10:33 AM, LVN C said she completed the head-to-toe assessment on her residents. She said she was not aware Resident #44 had any mouth pain. LVN C said Resident #44 only had his code status on his care plan and said that it was an insufficient care plan. She said he should have more diagnoses and interventions on his care plan. LVN C said the orders for the residents should be on the care plan. She said orders such as diet, code status, and diagnoses would be on the care plan, so the staff knew (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why care was being performed. LVN C said the DON was responsible for the initial assessment and the care plan was based off the reports of the initial assessment. LVN C said the interventions were different for each resident and should match what was going on with the resident. She said the resident's diet, nutrition, interventions for diagnoses, and medications were on the care plan. She said if an area of concern was not captured on the MDS, the care area might not get entered on the care plan. LVN C said the DON was responsible for the MDS and care plans. LVN C said it could negatively impact a resident if the care plan were not in place or revised because the nursing staff would not know what to monitor, cause safety issues and a resident could have a delay in care.During an interview on 2/11/2026 at 10:59 AM, the ADON said she was not aware he needed to see a dentist and could be insurance issue. The ADON said the facility currently does not have a MDS nurse and the DON was putting in the orders and baseline care plan. The ADON said the care plans were created by the DON but said it was a group effort. The ADON said a resident's diagnoses, interventions, medications, code status, and diet should be on the care plan so the nurse staff would know how to care for the residents. She said the care plan should be revised when there was a significant change in condition or during the IDT meetings and during QAPI meetings. She said the DON and ADM were responsible for updating and revising the care plan. She said if the care plan was not initiated or revised, the residents may not receive the care they need resulting in a life-threatening outcome.During an interview on 12/11/2026 at 11:27 AM, the DON said she had attempted to get Resident #44 an appointment with the visiting dental group, but they did not take his insurance, and the family would not cover the cost. She said she was getting someone to see him today. The DON said Resident #44 should have goals and interventions specific to his needs. She said the facility had been on a different EMR system and the staff had to reenter all the residents' care plans. The DON said the facility currently did not have an MDS nurse, and corporate had been assisting with the MDS assessments. The DON said the charge nurse was responsible for performing the initial assessment based on information received from residents, family, and discharge paperwork from the hospital. The DON said the MDS triggered the care plan. She said she expected the care plans to be updated and revised as changes occurred. She said she also expected the care plan to be individualized. She said the Interdisciplinary Team was responsible for ensuring the interventions and goals were updated quarterly and when there were changes. She said not having a care plan in place could result in residents not receiving individualized care. During an interview on 2/11/2026 at 12:11 PM, the ADM said the facility changed EMR systems. The ADM said she expected the care plan to be revised and updated. She said the care plan was important so the staff would know how to provide care for the residents. She said she expected the staff to review the care plan at least one time each shift and for the care plan to be revised if a resident had a change in condition. She said the nurses, MDS nurse, and the IDT were responsible for ensuring the care plan were updated and accurate. The ADM said the staff go over updates in their morning meetings. She said if the care plan and assessment were not updated or accurate, the resident might not receive the care they need. Record review of the facility's policy titled Care Plans, Comprehensive Person-Center dated March 2022 indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The interdisciplinary team in conjunction with the resident.7.The comprehensive, person-center care plan includes measurable objectives and timeframes.describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being.residents goals upon admission and desired outcomes.builds on resident strengths.reflects currently recognized standards of practice for problem areas and conditions.9. Care plan interventions are chosen after data gathering.10. Assessments of residents are ongoing, and care plans are revised as information about the residents' condition changes.The interdisciplinary team reviews and updates the care plan when.significant change in condition.when the desired outcome is not met.at least quarterly, in conjunction with the required MDS assessment.

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	675037	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Pittsburg	123 Pecan Grove Pittsburg, TX 75686

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 13 residents (Resident #12) reviewed for quality of care.1. The facility failed to change the oxygen tubing and water reservoir for Resident #12's oxygen concentrator.2. The facility failed to ensure that oxygen filters were clean for Resident #12's oxygen concentrator.These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care.Findings included:Record review of Resident #12's face sheet, dated 10/13/25 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included Chronic Obtrusive Pulmonary Disease (a progressive lung condition that blocks airflow, making it hard to breathe, and includes emphysema (damaged air sacs) and chronic bronchitis (inflamed airways), Hypokalemia (muscle weakness, cramps, fatigue, and constipation, along with heart palpitations, abnormal heart rhythms, lightheadedness, numbness, tingling, and sometimes confusion or frequent urination), Schizophrenia (a chronic, severe brain disorder that causes individuals to interpret reality abnormally, often resulting in hallucinations, delusions, and disorganized thinking).Record review of Resident #12's quarterly MDS assessment, dated 11/24/25, revealed Resident #12 had a BIMS score of 10, which indicated moderately impaired cognitionResident #12 required assistance or supervision with ADLs.Record review of Resident #12's care plan reflected a problem initiated on 11/18/2025 indicating that, Impaired gas exchange related to. Resident will maintain optimal gas exchange as evidenced by oxygen saturation within baseline for the resident, and alert, responsive mentation or no further reduction in mental status.Administer oxygen therapy as ordered.Record review of an order for Resident #12, dated 12/14/25, reflected that staff were to, Check oxygen concentrator filter for placement and clean filter every week or as needed.Record review of an order for Resident #12, dated 12/14/25, reflected that staff were to, Change oxygen tubing/water every week and as needed.During an observation and interview on 2/9/26 at 10:30 a.m. Resident #12 said he liked to use the black oxygen concentrator. He said he didn't like using the white oxygen concentrator in his room. He said the white one belonged to his old roommate, but she wasn't there at that time. He said he never used the white oxygen concentrator but regularly uses the black one. It was observed that the black concentrator electric cord was plugged into the wall, and the oxygen tubing and water reservoir was dated 12/22/25. It was observed that both oxygen concentrators had dirty filters and the machine itself was dirty.During an observation on 2/10/26 at 9:45 a.m. Resident #12 had two oxygen concentrators in his room. a black oxygen concentrator with a dirty filter, oxygen tubing dated 12/22/25, and an oxygen reservoir dated 12/22/25. The black oxygen concentrator was plugged into the wall's electrical outlet. The white oxygen concentrator was not plugged into the electrical outlet and not in use. Both concentrators had dirty filters. The oxygen tubing of the white concentrator was within date per orders. During an interview on 2/11/2026 at 10:20 a.m., LVN C said that it was the responsibility of nurses to change residents' oxygen tubing, water reservoir, and filters as ordered. She said that residents could be placed at risk of respiratory infections if they did not have their tubing, filters, or water reservoir changed regularly.During an interview on 2/11/26 at 11:25 a.m., the Director of Nurses said that it was the responsibility of facility nurses to ensure that resident's oxygen tubing was changed per orders and labeled with the new date. She stated that oxygen filters should be cleaned or replaced as ordered. She stated that residents could be placed at risk for respiratory infections if their oxygen tubing was not changed properly.During an interview on 2/11/26 at 11:36 a.m. with the Administrator, she said that it was the responsibility of nursing staff to change the oxygen tubing and filters for oxygen concentrators as it was ordered. She said that residents could be placed at risk for respiratory infections if they were not supplied with clean oxygen tubing. Record review of facility's policy titled Oxygen Administration revised in October of 2010 revealed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. The date and time that the procedure was performed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to store all drugs and biologicals in locked compartments for 1 of 13 residents reviewed for pharmacy services. (Resident #26)The facility failed to ensure wound care treatment chemicals were not improperly stored in Resident #26 room.This failure could place residents at risk for adverse reactions.Findings included:Review of Resident # 26's face sheet, dated, 11/02/2022, reflected a [AGE] year-old male who was admitted on [DATE]. Resident #26 had diagnoses which included Parkinsonism (an umbrella term for a neurological syndrome characterized by motor symptoms like tremor, bradykinesia (slowness), rigidity, and postural instability), Vitamin Deficiency (occurs when the body does not get enough essential nutrients, leading to impaired function and potential long-term health issues), and Anxiety Disorder (a group of mental health conditions characterized by persistent, excessive, and irrational fear or worry that interferes with daily life).Review of Resident #26's Quarterly MDS assessment, dated 12/04/2025, reflected the resident had a BIMS score of 14, which indicated his cognition was intact. Resident #26 was independent with most of his ADLs.During an observation and interview on 2/9/26 at 1:51 p.m. Resident #26 had a bottle of liquid chemical wound cleanser in his room. He said it was for his neck and that he had a wound previously on his neck that needed skin cleanser. During an observation on 2/10/26 at 10:40 a.m. the bottle of liquid chemical wound cleanser remained in Resident #26's room. During an interview on 2/11/2026 at 10:20 a.m., LVN C said that wound care chemicals should be kept in the treatment cart or the medication cart. She said that residents should not have that left in their room as residents could be placed at risk of drinking the chemicals or getting the chemicals in their eyes or ears. She said that it was everyone's responsibility to ensure that potentially harmful chemicals were stored properly and out of reach of residents.During an interview on 2/11/26 at 11:25 a.m. with the DON, she said that wound care chemicals, or any type of medication or chemical, should be kept in the medication cart or the medication supply room. She said that every staff that entered residents' rooms were responsible to ensure prohibited items are not in the residents' rooms. She said that there could be a high risk of serious injury or harm if a resident misused a medication or chemical.During an interview on 2/11/26 at 11:36 a.m., the Administrator said that medications should not be left in a resident's room. She said that all staff were responsible for making sure residents did not have medications or chemicals in their room. She said that residents could be placed at risk of harm if they used the medication or chemical wrong.Record review of the facility's policy dated July of 2017 titled Safety and Supervision of Residents revealed, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Our facility-oriented approach to safety addresses risks for groups of residents.Implementing interventions to reduce accident risks and hazards shall include the following: Communicating specific interventions to all relevant staff; Assigning responsibility for carrying out interventions; Providing training, as necessary; Ensuring that interventions are implemented; and Documenting interventions.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs for 1 of 13 residents (Residents #26) reviewed for receiving meals as prescribed.The facility failed to honor Resident #26's food preference of large portions according to his care plan and meal ticket.This deficient practice could place residents at risk of not receiving their meal to meet their needs for allergy aversions, unwanted weight loss, and meal textures and/or consistencies.Findings included:Review of Resident # 26's face sheet, dated, 11/02/2022, reflected a [AGE] year-old male who was admitted on [DATE]. Resident #26 had diagnoses which included Parkinsonism (an umbrella term for a neurological syndrome characterized by motor symptoms like tremor, bradykinesia (slowness), rigidity, and postural instability), Vitamin Deficiency (occurs when the body does not get enough essential nutrients, leading to impaired function and potential long-term health issues), and Anxiety Disorder (a group of mental health conditions characterized by persistent, excessive, and irrational fear or worry that interferes with daily life).Review of Resident #26's Quarterly MDS assessment, dated 12/04/2025, reflected the resident had a BIMS score of 14, which indicated his cognition was intact. Resident #26 did not have a weight loss or a weight gain.Review of Resident #26's Comprehensive Care Plan, with a problem initiated on 01/13/2026 reflected Resident #26 had unplanned/unexpected weight loss related to recent hospitalization following elective surgery. The goals was for the resident's weight to return to the baseline range by review date. An intervention was for Resident #26 to have large portions with all meals.Record review of Resident #26's lunch meal ticket dated 2/10/26 revealed that Resident #26 was to receive a large portion of food. Record review of Resident #26's weight records show that they did not have a significant weight loss.During an interview and observation on 2/9/26 at 1:51 p.m., Resident #26 said that he was upset with the portion size of his food. He said that the portions were too small. He said the taste was fine, but he required a larger sized portion of food. Resident #26 took out his phone and showed the surveyor pictures of past food without dates. The first photo showed a single fried egg and a biscuit. The second photo showed two slices of bread with a single slice of bologna with no condiments or cheese. During an observation and interview on 2/10/26 at 1:45 p.m., Resident #26 stated that he did not get double portioned food. He stated that he sometimes recieved double portions of his food but rarely. He said he requested double portions, and his meal ticket said double portions. He said that he was not satiated from the portion size of his food, and he knew that he would have to constantly remind the kitchen staff he receives double portions. He said he had taken a picture of his lunch today to show the surveyor his regular sized portion. Resident #26 showed the surveyor a photograph of today's lunch, chicken spaghetti green beans and garlic toast. Shown in the photo was a half slice of bread, a regular sized portion of spaghetti, and a regular sized scoop of green beans. During an interview on 2/11/26 at 10:32 a.m. the Dietary Manger said that it was a mistake that Resident #26 did not have large portions on his lunch meal on 2/10/26. She said that residents, whose meal ticket stated large portions, would receive a larger portion of food than normal portions. She said that residents could be placed at risk of weight loss if they were not given a larger portion when they requested them.During an interview on 2/11/26 at 11:25 a.m., the DON said that residents that required large portions shouldn't be given the normal portion size. She said that residents who received the wrong portion of food could be placed at risk for weight loss and a diminished quality of life. She said that it was the responsibility of kitchen staff and nurses to ensure that food quantity was served as ordered and care planned.During an interview on 2/11/26 at 11:36 a.m., the Administrator said that residents that received large portions should not be given a smaller portion of food. She said it was the responsibility of kitchen staff and nursing staff to ensure that residents that (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were ordered or requested large portions, received their large portions. She said that residents could be placed at risk of weight loss and diminished quality of life if given the wrong portion size of food.Record review of the facility's Resident Right Policy, dated October 2017 revealed that the purpose of the policy was, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.the multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional and psychosocial factors that affect eating and nutritional intake and utilization.A resident-centered diet and nutrition plan will be based on this assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 1 of 13 residents (Residents #4) reviewed for infection control practices. The facility failed to ensure LVN A and CNA B applied enhanced barrier precautions when they washed Resident #4's hair on 02/10/26. This failure could place residents at risk for cross contamination and the spread of infection. Findings include: Record review of Resident #4's face sheet dated 01/10/26 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included: multiple sclerosis (a chronic disease of the central nervous system), psoriasis (a skin disease that causes a rash with itchy), and protein-calorie malnutrition. Record review of Resident #4's MDS assessment, dated 12/18/25, reflected Resident #4 was usually understood and usually understood by others. Resident #4's BIMs score was a 15, which indicated cognition was intact. Resident #4 was dependent on ADLs. The 1 of 1 of unhealed pressure ulcers/ injuries at each stage, during the look-back period: Stage 3: Full thickness tissue loss. Record review of Resident #4's care plan dated 12/16/25 reflected Resident #4 had a stage 3 pressure ulcer to the sacrum related to immobility. There was no care plan related to EBP. Record review of Resident #4's order summary report reflected an order for wound treatment, dated 02/06/26. During an observation on 02/10/26 at 10: 21 AM, LVN A started to wash Resident #4's hair with gloves on, but did not apply gown. During an observation on 02/10/26 at 10:22 AM, CNA B assisted LVN B with washing Resident #4's hair by holding his head with gloves on. CNA B did not apply a gown. Resident #4 had a sign in room and PPE for EBP. During an interview on 02/12/26 at 9:25 AM with Resident #4, he said when staff changed him, gave him a bed bath, and did his wound care, they did not put on their gowns. He said they just put on those gowns yesterday, because state was there. During an interview on 02/11/26 at 9:45 AM, CNA B agreed, she was supposed to have worn a gown yesterday when she was assisting with washing Resident #4's hair. She said staff were supposed to wear the gown and gloves, because Resident #4 had a wound. She said a negative effect of not wearing the gown would be an infection control issue. During an interview on 02/11/26 at 9:57 AM, LVN A said she thought Resident #4's wound was cleared. She said on his orders the wound care said PRN, so she thought his wound was resolved. She said since Resident #4 had a wound, he was supposed to be on EBP. She agreed, she should have worn PPE such as a gown while providing care for him. She said she should wear a gown and gloves to protect herself and others. She said a negative effect of not following enhanced barrier precautions was the risk of spreading infection. During an interview on 02/11/26 at 12:00 PM, the ADON said she expected staff to follow the enhanced barrier precaution procedure. She said she was responsible for ensuring PPE was in the resident's room, and in-servicing the staff on EBP. She said not following enhanced barrier precautions could put the resident and everyone at risk for infection. During an interview on 02/11/26 at 12:29 PM, the DON said she expected staff to wear gown and gloves while providing high contact care to residents on enhanced barrier precautions. She said any staff member entering the resident's room to provide high contact care was responsible for applying PPE and following EBP. She said the negative effect of not following enhanced barrier precautions increased the risk of infections for the residents and they were already comprised. During an interview on 02/11/26 at 12:47 PM, the Administrator said she expected for the staff to know who was on EBP and to apply PPE. She said the staff was responsible for following the EBP. She said a negative effect of not following EBP staff could transfer an infection to residents or cause cross contamination. Record review of the facility's policy and procedure Enhanced Barrier Precautions dated March 2024, indicated. Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. 1.Enhanced barrier precautions EBPs) are used (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as an infection prevention and to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact care activities that provide opportunities for transfer of MDROs to staff hands and clothing. 2.EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 3. Example of high-contact resident care activities requiring the use of gown and gloves for EBPs include:. d. providing hygiene. 4. EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with CDC targeted or epidemiologically important MDRO, including. 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. A. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. 10. Staff are trained prior to caring for residents on EBPs.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, record review and interview, the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 3 of 3 days reviewed (02/06/26, 02/07/26 and 02/08/26) for nursing services. The facility failed to post the required current daily staffing information on 02/06/26, 02/07/26 and 02/08/26. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included: During an observation on 02/09/26 at 8:48 AM, nurse staffing data was posted on a wall on entrance of the facility, easily visible, and was dated 02/05/26. During an interview on 02/11/26 at 12:00 PM, the ADON said she was responsible for updating the staff posting. She said usually updating the staff posting sign was the first thing she did in the morning, but she did not work on the weekend, so it had not been changed since Friday. She said when state entered the facility on Monday (02/09/26) the staffing post was dated 02/05/26. She said the staffing post was to show the accurate number of staff to take care of the residents in the facility. During an interview on 02/11/26 at 12:29 PM, the Director of Nursing said the ADON was responsible for updating the nurse staffing posting and it should be updated daily, where everyone could see it. She said generally, the ADON left the updated staff posting for the 10-6 nurse on the weekend to update the posting. She said the risk of not posting nurse staffing information was that no one would be aware of how many direct nursing staff were in the facility. During an interview on 02/11/26 at 12:47 PM, the Administrator said the ADON was responsible for updating the nurse staffing posting. She said the nurse staff posting should be updated every day and corrected if there was a change. She said the nurse staff posting was to inform anyone who entered the building the number of staff the facility had to take care of the residents. She said the risk of not posting nurse staffing information was staff, visitors, and residents would not know how many staff were in the facility. During an interview on 02/11/2026 at 12:55 PM., the Administrator said there was no policy to address the staffing post.