

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Avir at Granbury		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Reunion Ct. Granbury, TX 76048	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on record review and interview, the facility failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, seven days a week for 5 (1/03/2026, 1/24/2026, 1/25/2026, 1/31/2026, and 3/13/2026) of 92 days reviewed for RN coverage. The facility failed to provide evidence that a Registered Nurse (RN) worked 8 consecutive hours a day, seven days a week on 1/03/2026, 1/24/2026, 1/25/2026, 1/31/2026, and 3/13/2026. This failure could place residents at risk of not having decisions made by a RN to manage residents' healthcare needs and in managing and monitoring the direct care staff. Findings included: Review of the PBJ Staffing Data Report FY Quarter 2 2026 (January 1 - March 31) revealed no RN hours were reported to CMS on 1/03/2026, 1/24/2026, 1/25/2026, 1/31/2026, and 3/13/2026. During an interview on 07/16/2026 at 8:53 a.m., the DON stated his expectation was to have RN coverage 8 hours a day. The DON stated he started working at the facility on 3/16/2026 and since then he had worked at the facility every day. He stated the previous DON's last day was on 3/13/2026 and he was unsure why there would not have been any reported RN hours prior to him starting work at the facility for 1/03/2026, 1/24/2026, 1/25/2026, 1/31/2026, and 3/13/2026. He stated there was a weekend supervisor who was a RN and he had worked at the facility to assist with making sure there was 8 hours of RN coverage on the weekends. During an interview on 07/16/2026 at 10:45 a.m., the ADMN stated she knew about an email thread with the previous ADMN telling him that he did not report RN hours appropriately. She stated she believed that the facility had RN coverage and would look through the nurse schedules and on a SharePoint site to show RN coverage hours for the days in question. During a follow up interview on 07/16/2026 at 11:24 a.m., the ADMN stated she was unable to find evidence that an RN worked 8 consecutive hours for the days in question. She stated she found a QAPI meeting where the previous ADMN put down the facility had 31 days of RN coverage in January of 2026. She stated she started working at the facility on 6/29/2026 and did not know what occurred prior to her starting to work at the facility. The ADMN did not provide a response to how not having a RN would have affected residents. Record review of facility policy, titled Staffing, Sufficient and Competent Nursing, dated August 2022 revealed: 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. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675084 If continuation sheet Page 1 of 16

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to consider the views of the resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility or to demonstrate their response and rationale for such response for 10 of 10 confidential resident council members reviewed for resident/group response. The facility failed to provide a grievance log for the January 2026, February 2026, March 2026, April 2026, May 2026, and June 2026 indicating a verbal or written response to the Resident Council addressing the grievances reported from their meetings. This failure could place residents at risk of unresolved grievances, a decreased sense of self-worth, and a decline in quality of life. Findings included: During a confidential group meeting and confidential time, 10 of 10 resident council members stated they did not feel the facility took their views and concerns into account and did not follow up when grievances and complaints were expressed. During an interview on 07/16/2026 at 4:27 PM, the ADMN stated she would expect the facility to have documentation of the grievances including resident council. She stated she would get the grievances and then the managers would discuss them in the morning meetings. She said after the grievances were discussed and completed, she would follow up with who made the grievances. She stated she started working on 06/29/2026 and did not have any documentation from January 2026 to 06/29/2026. She stated there had not been a resident council meeting since she had been the ADMN and moving forward she would make sure she followed up on the Resident Council grievances to make sure the members of the resident council were heard. Record review of facility policy titled Grievances/Complaints, Recording and Investigating revised in 2017 revealed: The administrator has assigned the responsibility of investigating grievances and complaints to the grievance officer. The grievance officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. The following information will be recorded and maintained in the log: the date the grievance/complaint was received, the name and room number of the resident filing the grievance/complaint (if available), the name and relationship of the person filing the grievance/complaint on behalf of the resident (if available), the date the alleged incident took place, the name of the person(s) investigating the incident, the date the resident, or interested party was informed of the findings, and the disposition of the grievances (i.e., resolved dispute, etc.). The Resident Grievance/Complaint Investigation Form will be filed with the ADMN within five working days of the incident. A copy of the Resident Grievance/Complaint Investigation Report Form must be attached to the Resident Grievance/Complaint Form and filed in the business office. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure foods were sealed and/or labeled properly in refrigerators, freezers and dry storage. The facility failed to ensure all food was not past expiration date. The facility failed to ensure that staff performed hand hygiene while preparing food. The facility failed to maintain proper food safety and sanitation by allowing a hot pad to fall into the tortilla soup during food preparation. The facility failed to maintain proper food safety and sanitation practices by handling ready-to-eat foods with gloves that were not changed after previous tasks. These failures could place residents that eat out of the kitchen at risk for food borne illnesses. The findings included: During an observation on 07/14/2026 between 9:27 AM and 9:48 AM the kitchen revealed: Refrigerator #11. One open plastic container with a cracked lid of chicken noodle with an open date of 07/08/2026 and a use by date of 08/07/2026. 2. One unopened package of potatoes not labeled with a food item description. Dry Storage #11. One can of cheddar cheese not dated. 2. One can of chicken noodle soup not dated. 3. One package of pasta noodles not sealed or dated. 4. One open box of powdered sugar with plastic bag holding contents not sealed. 5. One open box of creamy wheat with plastic bag holding contents not sealed or dated. 6. Three plastic containers of cereal not labeled or dated. Dry Storage #21. Three containers of mustard of a use by date of 10/20/2025. 2. Two packages of yellow cake mix without a use by date. 3. One package of chocolate frosting of a use by date of 05/15/2026. Freezer #11. One open box of frozen biscuits with plastic bag holding contents not sealed. Freezer #21. One open box of frozen broccoli with plastic bag holding contents not sealed. 2. One open box of frozen mango with plastic bag holding contents not sealed. During an observation on 07/14/2026 at 11:40 AM, the DM dropped a hot pad in the prepared soup. The cook was going to pour the remainder of the soup in the pot until questioned of cross contamination. The contaminated soup was discarded by the cook, and the cook prepared an alternative soup. During an observation on 07/14/2026 between 11:27 AM and 12:14 PM, [NAME] E failed to wash his hands after preparing puree food in the blender and preparing food on the stove. The cook used the same gloves to prepare and serve food. The cook picked up ready-to-eat items with gloved hands to plate the food items. During an interview on 07/16/2026 at 3:42 PM, [NAME] E stated that washing hands should happen with every task, between glove changes, and when touching the face. He stated the hot pad that fell into the soup and touching lettuce and tomatoes with gloved hands after doing other tasks was cross contamination that could lead to risk of illness. [NAME] E stated he unloaded the trucks and stored the food and that everything should be labeled, dated, and sealed properly. He stated the food not being sealed in the freezers could cause illness and unlabeled food could cause issues with food being old and mixed up. He stated the cook's monitored storage with the dietary manager and the failure was the need for more education. During an interview on 07/16/2026 at 3:57 PM, the DM stated items that passed their best by date should have been discarded and should have had a label on the item and dated. The DM stated that food items should be sealed and that residents could have been affected by getting food that was not flavorful or could be at-risk of illness due to freezer burn. She stated the cooks and herself were responsible for ensuring items were discarded, sealed and labeled correctly and that the failure was the need to monitor and receive more education. During an interview on 07/16/2026 at 3:59 PM, the DM stated that a hot pad should not have fallen into the soup and the soup should have been (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discarded right away. She stated that hand hygiene should happen between every task and that gloves should be changed. She stated that utensils should have been used instead of gloved hands to pick up ready-to-eat foods when switching between tasks. She stated the residents could have been affected by being at-risk of illness for cross contamination and that the failure was the need for more education. During a telephone interview on 07/16/2026 at 4:15 PM, the dietician stated that hands should have been washed between every task, especially after touching of the face and touching other items. She stated that utensils should have been used when picking up cold items while doing other tasks. She stated that the hot pad that fell into the soup was cross contamination and the soup should have been discarded immediately. She stated food that entered the kitchen should be labeled, have the entrance date and expiration date on each item, and that food should be sealed so it is not exposed to air. She stated that the negative effects were cross contamination, bacteria issues, and ruining quality of the food when exposed to air. She stated that all kitchen staff, including the DM, monitored food items, and that in-servicing was needed. The dietician stated she comes to the facility once a month and is available by phone. Record review of the facility document titled Matrix, dated 07/14/2026, revealed every resident ate out of the kitchen. Record review of facility policy titled Handwashing/Hand Hygiene dated 2025, revealed: Hand hygiene is indicated after contact with contaminated surfaces and immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene. Record review of facility policy titled Food Receiving and Storage dated 2022, revealed: Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in-first out system. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen or discarded. Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. Record review of facility policy titled Food Preparation and Service dated 2022, revealed: Gloves are worn when handling food directly and changed between tasks. Cross-contamination can occur when harmful substances, i.e., disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 07/16/2026 revealed: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement. (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD. (3) An accurate declaration of the net quantity of contents. (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. Pf (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to maintain a quality assessment and assurance committee consisting at a minimum of the required committee members of 10 of 11 meetings reviewed for QAPI. The facility failed to ensure the MD, or a representative attended the QAPI meetings in September 2025, October 2025, November 2025, December 2025, January 2026, February 2026, March 2026, April 2026, May 2026, and June 2026. This failure could place residents at risk for quality deficiencies being unidentified, no appropriate plans of action developed and implemented and no appropriate guidance developed. Findings included: Record review of sign in sheets for QAPI meetings in September 2025, October 2025, November 2025, December 2025, January 2026, February 2026, March 2026, April 2026, May 2026, and June 2026 revealed no evidence that the MD attended QAPI meeting. During an interview on 07.16.2026 at 1:00 pm the ADM stated her expectations were that the MD would attend QAPI meetings. ADM stated it would be beneficial if he attended every QAPI meeting. ADM stated she did not know why the MD had not attended the QAPI meetings. ADM stated she did not feel that this had any effect on resident care. Record review of facility's policy titled: Quality Assurance and Performance Improvement (QAPI) Program, dated Revised February 2020 Policy Statement This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Policy Interpretation and Implementation The objectives of the QAPI program are to: Provide a means to measure current and potential indicators for outcomes of care and quality of life. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. Establish systems through which to monitor and evaluate corrective actions.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 2 of 5 (CNA B & CNA C) staff and 1 of 3 (Resident #58) reviewed for infection control procedures. The facility failed to ensure CNA B and CNA C followed EBP, provided incontinent care and foley catheter care (a flexible tube inserted into the bladder for urination) appropriately, and performed hand hygiene appropriately while providing incontinent care and foley catheter care for Resident #58 on 07/14/2026. These failures could place residents at risk for the transmission of communicable diseases. Findings included: Record review of Resident #58's electronic face sheet, dated 07/16/2026, reflected a [AGE] year-old male who was admitted on [DATE] and readmitted on [DATE] with diagnosis including: retention of urine and UTI (infection in urine). Record review of Resident #58's 5-day Medicare MDS assessment, dated 05/27/2026, reflected a BIMS score of 09 indicating moderate cognitive impairment. Further review reflected he was dependent on staff for toileting hygiene and utilized an indwelling catheter for urination. Record review of Resident #58's electronic physician's order, dated 07/15/2026, reflected EBP: Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds or indwelling medical devices). Every shift for EBP Precautions. Record review of Resident #58's comprehensive care plan, dated 07/15/2026, reflected Resident is at risk for recurrent urinary tract infections related to the presence of an indwelling urinary catheter. Educate the resident and family, as appropriate, on catheter care, infection prevention, hydration, and symptoms that should be reported promptly. During an observation and interview on 07/14/2026 at 11:01 a.m., Resident #58 received incontinent care and foley catheter care from CNA B and CNA C. Both CNAs gathered supplies and entered the room with supplies in see-through plastic bag. CNA B asked Resident #58 if she could put the bag of supplies on his bedside table and he agreed. CNA B and CNA C sanitized their hands and put on gloves, no gowns were applied. Resident #58 had a foley catheter bag connected to the right side of his bed in a privacy bag. There was a EBP sign on the door and there was PPE in a bin to the right of the room with EBP sign on top. The CNAs pulled down his brief and CNA B got an incontinent wipe and wiped his left inner thigh. CNA B folded the wipe and wiped his right inner thigh. CNA B asked CNA C to get a bag out of her pocket and CNA C did. CNA C opened up the bag for soiled trash disposal. CNA C put the unused bags back into CNA B's pocket. CNA B then got another wipe and wiped the top of the penial shaft down to the scrotal area. CNA B disposed of the wipe and got another wipe to the scrotal area and kept going over the area multiple times with the same wipe touching the catheter tubing with the part of the wipe that touched the skin in the process. She disposed of that wipe and got another wipe for the catheter tubing and started wiping from the end of the shaft away from the skin down the tubing. With the same wipe she went back to the tubing and rubbed multiple times to and from the skin. She disposed of the wipe and asked CNA C to help resident roll to his left side. CNA C helped him roll to his side. CNA B got another wipe and began to scrub his buttock area that had cream on it multiple times with same wipe. CNA B disposed of wipe and got another wipe and wiped multiple times with same wipe getting skin clean from cream that CNA B stated was to help prevent rash. CNA B stated the nurse put on the cream and Resident #58's skin was looking better from the rash. CNA B (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed the soiled brief and rolled the soiled draw sheet up to the resident's left side. CNA B did not remove gloves or perform hand hygiene and gathered clean brief. CNA B placed the clean brief on top of clean draw sheet and pushed under Resident #58's left side. CNA B helped Resident #58 roll to his back and to his right. CNA B removed the soiled draw sheet and unfolded the clean draw sheet flat under the resident. CNA B reached into her pocket for a see-through plastic bag for the soiled linen without removing her gloves or performing hand hygiene. CNA B put the bags that were unused back into her front left pocket with dirty gloved hand. Resident #58 rolled back onto his back and was covered with sheet and blanket. CNA B and CNA C removed their gloves and sanitized their hands with hand sanitizer before leaving the room with the soiled linen and trash in bags. During an interview on 07/14/2026 at 11:11 a.m., CNA C stated she had been trained on infection control and that it was not appropriate to wipe an area with the same wipe multiple times. She stated she should have worn a gown during catheter care and just forgot to put one on. She stated she should have changed gloves and performed hand hygiene to help prevent infection spread when going from dirty to clean environments. During an interview on 07/14/2026 at 11:11 a.m., CNA B stated it was appropriate to use the same wipe multiple times since she folded it. CNA B stated it was not okay to rub the area back and forth with the same part of the wipe. She stated she should have worn a gown during catheter care and did not remember to put one on. She stated she had been trained on infection control. During an interview on 07/14/2026 at 4:02 p.m., LVN D stated the EBP sign meant staff should wear PPE including gown and gloves when performing foley catheter care. She stated she had been trained on infection control at least yearly on computer and then in-services as needed. She stated she did not know why staff may not have used PPE during foley catheter care. She stated staff originally would learn what EBP was on hire and that all staff had been trained. She stated using a wipe multiple times could cause infection spread from one area to the other. She stated gloves should be changed from going from dirty to clean area and hands sanitized to help reduce infection spread. During an interview on 07/16/2026 at 10:20 a.m., the DON stated that staff should be looking at EBP signs and wearing gowns when providing high contact care such as incontinent care for a resident. He stated all staff were trained on EBP and infection control including hand hygiene. He stated he expected staff to change their gloves and perform hand hygiene when they were moving from a dirty to clean area like placing clean linen and brief or reaching into their pocket. He stated staff should not be going over the same skin multiple times with the same wipe and should not be touching the catheter tubing with the same wipe that was used to wipe the resident's skin. He stated not wearing the PPE could potentially cause infection spread. He stated not performing hand hygiene and reusing the same wipe over multiple areas could potentially cause infection spread. He stated he monitored that nursing staff were following infection control protocol multiple times a day as he monitored them performing care to the residents. He stated he felt that staff were just nervous and forgot to follow infection control protocols during observation. Review of facility policy titled, Handwashing/Hand Hygiene, dated 01/2025, reflected Indications for Hand Hygiene 1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. Review of facility policy titled, Enhanced Barrier Precautions, dated 03/2024, reflected 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 (continued on next page)		

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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 observation, interviews and reviews, the facility failed to ensure that the MDS assessment accurately reflected the resident's status for 1 of 12 (Resident #39) residents reviewed for accuracy of assessments. The facility failed to accurately code the presence of a condom (external) urinary catheter for Resident #39 on 2 consecutive quarterly assessments on 04/27/2026 and 05/04/2026. This deficient practice could place residents at risk for inadequate care and services to meet their needs based on inaccurate MDS assessments. Findings included: During record review of Resident #39's electronic face sheet, dated 07/15/2026, revealed a [AGE] year-old male, admitted on [DATE], with diagnoses of flaccid hemiplegia affecting left nondominant side (inability to use his left arm), acute kidney failure, weakness, psychotic disorder (a set of symptoms involving a loss of touch with reality), stroke (a medical emergency when blood flow to the brain is interrupted), depression (persistent sadness, loss of interest and physical fatigue), anxiety (feelings of fear, tension and worry), heart failure (heart muscle is too weak or stiff to pump blood effectively), and pain. During record review of Resident #39's Quarterly MDS Assessment, dated 04/27/2026, revealed in Section C - Cognitive Patterns, subsection C0500, a BIMS score of 13 out of 15, indicating mild cognitive impairment. Section H - Bowel & Bladder, subsection H0100 Appliances, A. Indwelling (inside the body) and B. External were entered indicating Resident #39 had an indwelling and external urinary catheter. Resident #39's Quarterly MDS Assessment, dated 05/04/2026, revealed in Section H - Bowel & Bladder, subsection H0100 Appliances, Z. None of the Above was entered. During record review of Resident #39's comprehensive care plan dated 07/28/2025, revealed Problem: Resident requires an external catheter (condom Catheter) R/T personal preference and dignity concerns. During an observation on 07/14/2026 at 2:45 p.m., a urine collection bag was noted hanging under Resident #39's bed frame in a privacy bag. During an interview on 07/14/2026 at 2:45 p.m., Resident #39 stated he wore a condom (external) urinary catheter to keep his clothing and bed linens dry. He stated he required staff assistance with changing the catheter. During an interview on 07/16/2026 at 3:16 p.m., the DON stated Resident #39 used a condom catheter and the MDS should have been coded to indicate the catheter. He stated he did not know why the catheter was not coded correctly, corporate staff completed the MDS. The DON stated his expectation was for the MDS to accurately reflect the resident's status. Record review of the Policy titled Resident Assessment date revised March 2026, stated in part. 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: a. OBRA required assessments - conducted for all residents in the facility: (1) admission Assessment (Comprehensive); (2) Quarterly Assessment; (3) Annual Assessment (Comprehensive); (4) Significant Change in Status Assessment (SCSA) (Comprehensive); (5) Significant Correction to Prior Comprehensive Assessment (SCPA) (Comprehensive); (6) Significant Correction to Prior Quarterly Assessment (SCQA); and (7) Discharge Assessment (return anticipated and return not anticipated). b. PPS required assessments - conducted (in addition to the OBRA required assessments) for residents for whom the facility receives Medicare Part A SNF benefits: (1) 5-day Assessment; (2) Interim Payment Assessment; and (3) Part A PPS Discharge Assessment. 2. The RAI User's Manual (Chapter 2) provides detailed information on timing and submission of assessments. 3. A comprehensive assessment includes: a. completion of the Minimum Data Set (MDS); b. completion of the care area assessment (CAA) process; and c. development of the comprehensive care plan.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to refer residents with newly evident or possible serious mental illness or a related condition for PASRR evaluation for 1 of 18 resident (Resident #9) reviewed for PASRR. The facility failed to follow up with the LA for PASRR level II determination when Resident #9's PASRR level I screening reflected she was positive for mental illness This failure placed residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings included:Record review of Resident #9's electronic face sheet dated 7.16.2026 revealed [AGE] year-old male admitted to the facility 05.14.2026 with the diagnoses of bipolar disorder (mental health condition), Major Depressive Disorder, Morbid Obesity (chronic disease of severely overweight). Post Traumatic Stress Disorder Record review of Resident #9's PASRR Level I Screening dated 5.14.2026 Section C PASRR screening was negative for Primary Diagnosis of Dementia, Mental Illness, Intellectual Disability, and Developmental Disability. Record review of Resident #9's physician orders dated 7.16.2026 revealed Depakote two times a day, Sertraline daily, may be seen by psychiatric and psychological services to evaluate and treat as needed, Amantadine at bedtime, Fluoxetine daily, Prazosin at bedtime. Record review of Resident #9's Quarterly MDS dated 06.23.2026 revealed Section C-Cognitive Patterns BIMS score-15 (cognitively intact). Section I-Active Diagnosis Seizure Disorder or Epilepsy, Bipolar Disorder, Post Traumatic Stress Disorder. Record review of Resident #9's Care Plan dated 7.13.2026 revealed Resident is at risk for adverse drug effects due to use of psychotropic medications for treatment of depression. There was no evidence in the care plan that the bipolar diagnosis was being addressed. During an interview on 07.16.2026 at 3:20 pm, the DON stated his expectations were that all residents PASRR information be accurate. The DON stated if a resident had a diagnosis that could potentially qualify them for specialized services the PE should be completed and sent to the LA (local authority). The DON stated he did not feel this failure affected the residents care. The DON stated this failure occurred due to human error. Record review of facility's policy titled: PASRR dated 01.20.2026:The aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID) or Developmental Disability (DD)/Related Conditions (RC) to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD. The facility's Admissions Coordinator or designee will ensure the referring entity provides a copy of the PL 1 upon admission.2. LIDDA submits PL1 in portal3. LIDDA performs PE withing 72 hours of receipt of PL1.4. LIDDA submits PE on Portal within 7 days of receipt of PL 1.The MDS coordinator or designee will input all other PL1s into the online portal on admission. This includes negative preadmission PL1s and PL1s for resident who qualify for exempted or expedited services.		

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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 observation, interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #55) reviewed for care plans. The facility failed to ensure Resident #55 had a care plan in place to address his smoking status. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. Findings included: During record review of Resident #55's electronic face sheet, dated 07/14/2026, revealed a [AGE] year-old male, admitted on [DATE], with diagnoses of stroke, right side paralysis, rheumatoid arthritis (a chronic disease that causes the immune system to attack the lining of the joints), schizophrenia (a brain disorder that causes individuals to struggle with distinguishing reality from imagination), seizures, and blindness. During record review of Resident #55's admission MDS Assessment, dated 06/23/2026, revealed in Section C - Cognitive Patterns, subsection C0500, a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #55's admission MDS Assessment, dated 06/23/2026, revealed in Section J - Health Conditions, subsection J1300 - Current Tobacco Use, 0 indicating No was selected. During an observation on 07/15/2026 at 10:38 a.m., Resident #55 was in the designated smoking area smoking a cigarette. During record review of Resident #55's comprehensive care plan dated 06/18/2026 and reviewed/revised 07/14/2026, revealed tobacco use was not addressed on the care plan. During an interview on 07/16/2026 at 1:55 p.m., LVN A stated the social worker, administrator and department heads were responsible for creating and updating care plans. She stated the DON was responsible for monitoring care plan accuracy. LVN A stated staff utilized the care plans to make sure proper care was provided. She stated the smoking status of a resident should be care planned so that staff were aware. She stated R # 55 was a smoker. LVN A stated she did not know why a resident's smoking status would not be included in the care plan. During an interview on 07/16/2026 at 2:08 p.m., NA B stated he reviewed the resident's care plans, so he would know their needs. He stated resident needs should be on the care plan. NA B stated failure to include individualized needs on the care plan could result in poor resident care. He stated he was aware that R #55 was a smoker. During an interview on 07/16/2026 at 2:28 p.m., the DON stated the MDS Coordinator and IDT were responsible for the care plans, but he was ultimately responsible for accuracy and completeness. The DON stated his expectations were for the care plans to be accurate. He stated incomplete or inaccurate care plans may have a negative psychosocial effect on a resident. The DON stated the reason resident's need may not be included in their care plan would be human error and it was overlooked. During an interview on 07/16/2026 at 3:16 p.m., the Admn stated the DON and regional nurse were responsible for care plans. She stated nursing staff input was welcome. She stated consequences of failing to produce an accurate care plan could affect how staff approached care and communication the residents. The Admn stated the smoking status should be on the care plan. She stated the reason it could have been missed was human error. She stated her expectations were for anything to do with resident care be included on the care plan for staff to follow. Review of facility's policy titled Care Plans - Comprehensive Person Centered revised March 2022, revealed: Policy statement A 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. Policy interpretation and (continued on next page)		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implementation7. The person-centered care plan:a. includes measurable objectives and timeframes.b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.		

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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. Based on observation, and interview, and record review, the facility failed to store drugs and biologicals in locked compartments during medication storage inspection for 1 (West Hall Medication Cart) of 3 medication carts reviewed for storage. The facility failed to ensure the [NAME] Hall Medication Cart was locked and secured while unattended. This failure could place residents at risk of drug diversion. Findings included: During an observation on 07/15/2026 at 12:43 p.m., the [NAME] Hall Medication Cart sitting by entrance to the hallway was unlocked. There were two residents sitting in wheelchairs at the nurses' station by the unlocked medication cart. No nurse was observed on the hall. The top drawer of the medication cart had OTC medications including diphenhydramine (generic Benadryl for allergies) and acetaminophen (generic Tylenol for fever or pain). The top drawer had prescription antiemesis (for nausea) topical medication and prescription eye drops. There were alcohol swabs in the top drawer. Next drawer down from top had gloves and prescription tablets in bubble packaging. The second from top drawer had prescription breathing treatments, liquid Maalox (for indigestion) and over the counter topical cream. Bottom drawer had lancet sharps insulin needles, and disinfecting wipes. There was a locked drawer that had narcotic medication in it. During an interview on 07/15/2026 at 12:50 p.m. the DON stated his expectation would be for the medication cart to be locked when a nurse was not present. He stated the nurses were responsible for locking their own carts and he monitored that they locked the carts when he was walking down the halls. He stated that not locking the cart could potentially cause residents to ingest medications that were not theirs or hurt themselves or others with sharp items. He stated that LVN A was responsible for the [NAME] Hall Medication Cart. During an interview on 07/15/2026 at 1:27 p.m., LVN A stated the medication carts should be locked when not attended. She stated she had to go help a resident that fell and forgot to lock her cart in the moment. She stated not locking the cart could cause residents to have access to medications and sharps that could hurt them or others. Record Review of facility policy Medication Labeling and Storage dated February 2023 revealed, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Medication Storage. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the menu was followed for 3 (Resident #5, Resident #25, and Resident #48) of 18 residents reviewed for food and nutrition services. The facility failed to ensure Resident #5, Resident #25, and Resident #48 received items listed on the lunch menu on 7/14/2026. This failure could place residents at risk of poor intake, chemical imbalance, and/or weight loss. Findings included: Record review of Resident #5's electronic face sheet, dated 07/16/2026, reflected an [AGE] year-old male admitted on [DATE] and most recent readmission on [DATE] with diagnoses including: unspecified protein-calorie malnutrition (insufficient intake or absorption of protein and calories leading to impaired body function and tissue loss). Record review of Resident #5's Quarterly MDS assessment, dated 06/11/2026, reflected a BIMS score of 12 indicating moderate cognitive impairment. Further review reflected Resident #5 did not have weight loss in the last 6 months. During an observation and interview on 07/14/2026 at 12:43 p.m., Resident #5 was sitting at a table in the dining room. He did not receive tortilla soup and received tomato soup. Resident #5 stated he was not told that the soup would be different. Record review of Resident #25's electronic face sheet, dated 07/16/2026, reflected a [AGE] year-old male admitted on [DATE] with diagnoses including: type 2 diabetes mellitus (excess blood sugar levels related to body not producing enough insulin). Record review of Resident #25's Quarterly MDS assessment, dated 06/26/2026, reflected a BIMS score of 15 indicating intact cognition. Further review reflected Resident #25 did not have weight loss in the last 6 months. During an observation and interview on 07/14/2026 at 1:01 p.m., Resident #25 received his lunch tray in his room. The ticket stated that he was to receive tortilla soup and he received tomato soup. Resident #25 stated he would not eat tomato soup because he does not like cooked vegetables. He stated he was not informed that he would not get tortilla soup. He covered the soup and began to eat other items on his tray. Record review of Resident #48's electronic face sheet, dated 07/16/2026, reflected a [AGE] year-old male admitted on [DATE] with diagnosis of anemia (low blood iron levels). Record review of Resident #48's Quarterly MDS assessment, dated 06/11/2026, reflected a BIMS score of 06 indicating severe cognitive impairment. Further review reflected Resident #48 did not have weight loss in the last 6 months. During an observation and interview on 07/14/2026 at 12:43 p.m., Resident #48 was sitting at a table in the dining room. He was served tomato soup. In a confidential group interview at an undisclosed date at an undisclosed time, 10 of 10 group members stated the facility kitchen would change the menu frequently. They stated they did not get notified when a menu change had occurred until they received their food and saw that the items were not what they expected. They stated that they would like to know what was going to be served prior to meal service. During an observation on 07/14/2026 at 12:02 p.m., the lunch menu on the dining room wall outside of the kitchen had the menu items: Tortilla Soup, Soft Beef Taco, Refried Beans, Shred Lettuce & Chop Tomato, Chocolate Brownie, and Beverage. During an interview on 07/16/2026 at 8:57 a.m., the DM stated she expected for residents to get all of the menu items. She stated there was a problem with the soup during lunch service on 7/14/2026 and the remaining tortilla soup had to be disposed of. She stated that was why some residents did not get the tortilla soup. She stated she did not tell the residents or the nursing staff that there was going to be a switch in menu items. She stated the kitchen staff looked at the resident's food tickets and if there were no food preferences about tomato soup listed, those residents received the tomato soup. She stated someone who did not like cooked vegetables should (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have gotten tomato soup and did not know why Resident #25 had gotten the tomato soup instead of something else. She stated that she wrote down the substitution of tomato soup for tortilla soup on the substitution log for the dietitian to review on her next visit to the facility. She stated she did not notify the dietitian about the substitution when it occurred. She stated the residents not being told about substitutions could make them unhappy. She stated sometimes she needed to make substitutions due to items not being available, but that issue had been corrected now that the new ADMN had increased the dollar amount per day for each resident and she could get all of the items needed for food service on the food delivery truck. During a telephone interview on 07/16/2026 at 4:05 p.m., the dietitian stated ideally the menu should be followed. She stated if a food item had to be substituted, she would expect for the residents to be notified of the substitution. She stated she was unsure if she had been notified of the substitution of tomato soup for the tortilla soup. She stated negative effect would depend on the soup recipe and if the tortilla soup was broth based then it should have been replaced with another broth based soup to be equivalent. She stated the menu should match what was being served but the ticket may not match if there was a food substitution. She stated the DM was responsible for making sure food served matched the menu. She stated she had just started supervising the facility and came to the facility monthly. She stated she was always available on the phone when needed. She stated she did monitor some of food service when she was present among doing other tasks such as reviewing resident records and diet orders. Record review of facility policy, titled Menu Planning, dated 2003, revealed 5. Menus will be posted in areas that are accessible to patients/residents and at heights where all individuals can easily view them. 6. Temporary changes in the menu will be noted on the menu substitution sheets and posted so that facility staff are aware of changes.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's QAPI committee failed to implement an appropriate action plan to address identified quality deficiencies for 1 of 1 facility. The QAPI committee failed to implement the corrective actions outlined on the Plan of Correction, dated 12/12/2025, for deficient practice F727. This failure could place residents at risk for substandard quality of care due to the failure of the facility to take action on an identified problem affecting resident safety, respiratory treatment, and employee training. Findings included: Record review of a CMS 2567, dated 12/05/2025, reflected that based on interview, and record review, a deficient practice was cited at F727 (RN 8 hours a day seven days a week) during the 12/05/2025 SSA recertification survey. Interview and record review reflected the facility failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, seven days a week for 1 of 1 (11/01/2025, 11/02/2025, 11/08/2025, 11/29/2025, and 11/30/2025) month reviewed for RN coverage. Record review of the facility's Plan of Correction, dated 9/5/2024, which was submitted in response to the 7/31/2024 SSA CHOW survey reflected the facility's plan as 1. The facility has corrected the issue by hiring a weekend Registered Nurse to ensure compliance with CMS and or HHSC requirements for RN coverage. 2. Resident of the facility could be affected by this deficient practice. 3. Systemic changes to prevent recurrence, the facility has hired a new RN weekend supervisor. The new weekend RN supervisor started on 12/12/25. Facility now has RN coverage eight hours a day, seven days per week. The DON or designee will monitor compliance by reviewing the staffing schedule daily. The audit for RN coverage will be held during morning meetings Monday through Friday for the first four weeks, then once per month for one month. 4. The matter of not having RN coverage eight hours per day will be brought before the QAPI committee for the next two months, if no further issues arise, the matter will be considered resolved. Review of the PBJ Staffing Data Report FY Quarter 2 2026 (January 1 - March 31) revealed no RN hours were reported to CMS on 1/03/2026, 1/24/2026, 1/25/2026, 1/31/2026, and 3/13/2026. During an interview on 07/16/2026 at 11:24 a.m., the ADMN stated she started working for the facility on 06/29/2026. She stated she was able to look up the QAPI meeting in January where the previous ADMN documented that there was RN coverage 31 days in January 2026. She stated she could not provide evidence that an RN was working eight consecutive hours on 1/03/2026, 1/24/2026, 1/25/2026, 1/31/2026, or 3/13/2026. She stated she would expect that the plan of correction to be followed and reviewed during the QAPI meetings to monitor that the issue had been resolved. Review of the facility's policy titled, Quality Assurance and Performance Improvement Changes to QAPI Program, dated February 2023, reflected 1. The QAPI committee oversees implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee. 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performance measurement; c. identifying and prioritizing quality deficiencies; d. systematically analyzing underlying causes of systemic quality deficiencies; e. developing and implementing corrective action or performance improvement activities; and f. monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.		