STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675144	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Burleson	600 Maple St Burleson, TX 76028

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility did not provide drugs and related services needed by each resident for 1of 1 medication storage rooms and 1 of 3 medication carts (Medication Cart A) reviewed for medication storage. The facility failed to ensure:- expired medication administration supplies was removed from the medication storage room- opened resident medications was dated on the date they were opened. This failure could place residents at risk for ineffective treatments, infections, or not receiving the therapeutic benefit of the medication.Observation on 9/22/25 at 2:45 PM of the E Hall Nurse medication cart revealed the following medications were opened for use and did not have a date indicating when they were opened: 1 Albuterol 90 MCG Inhalers opened and not dated. 1 Albuterol 90 MCG Inhalers opened and not dated. 1 partial bottle labeled Acetic Acid 0.25% opened and not dated. The bottle was also leaking. 1 partial bottle of Hydrogen Peroxide Solution 32 oz opened and not dated. Observation on 9/22/25 at 3:00 PM of the medication storage room revealed the following medication administration supplies were expired: 6 Central line medication catheter dressing kits expired on the following dates:o 4 expired 8/31/25o 2 expired 6/30/25. In an interview on 9/23/25 at 3:11 PM, MA B stated, expired supplies should be discarded properly because they could make residents sick. She stated everyone that goes into the medication room or medication carts was responsible for discarding them. She stated using an expired dressing kit could cause skin problems or infections for the residents. In an interview on 9/23/25 at 3:13 PM, LVN A stated that expired supplies and undated medications should be given to the DON to be destroyed. She stated it is important not to use them after the expiration date, because they could cause allergic reactions or infections. She stated nurses, medication aides, and the DON was responsible for doing this. She stated using a central line dressing kit after it expired could cause an infection. In an interview on 9/23/25 at 3:18 PM, the ADON stated expired supplies, and undated medications should be discarded. She stated this was important because they could lose their effectiveness and for infection control. She stated nurses was responsible for discarding expired items and that she and the DON was responsible for following up on that. She stated an expired central line dressing kit could cause a resident to get an infection. In an interview on 9/23/25 at 3:20 PM, the ADM stated that expired supplies should be disposed. He stated this was important for safety reasons and the nurses, DON, and ADON was responsible for disposing of expired/undated items. He stated using an expired central line dressing kit could cause an infection and that opened Albuterol inhalers should be dated to determine how long they would be good. A record review of facility policy titled, Medication Storage in The Facility, dated June 9, 2025, reflected the following: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed and disposed of. When the original seal of a manufacturer's container is initially broken, the container will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the container will be 30 days from opening unless regulations require different dates. All expired medications will be removed from active supply and destroyed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food storage, food safety, and nutrition services for 1 of 1 kitchen. The facility failed to ensure food items were labeled and/or dated. This failure could place residents at risk of foodborne illness by being served expired food. Findings Included: Observation on 9/21/2025 at 9:13 AM of the cooler revealed the following:1 sheet cake prepared in the pan sitting on top of boxes uncovered and not dated.1 bag of shredded lettuce sitting on a shelf open and undated. In an interview on 9/21/2025 at 9:13 AM, the DM stated the sheet cake was just cooked this morning, and the staff had placed it in the freezer to cool down and the bag of lettuce was just opened. The DM stated the staff forgot to place a date on it. She said normally anything that is placed in the refrigerator or freezer would be covered and dated. The DM stated it was her responsibility to make sure items was dated and to check the refrigerator and freezer daily. The DM stated not covering items could lead to contamination leading to food borne illness. In an interview on 09/23/2025 1:57 PM, the ADM stated dietary aides and cooks was responsible for covering and dating items that go into the freezer and refrigerator. He stated the dietary manager was responsible for doing daily monitoring of the refrigerator and freezer for expired undated and uncovered items. He stated the ADM does a weekly walk through and inspects the kitchen. He is also responsible for monitoring the kitchen for dated and covered items. He stated consequences for not covering and dating items in the refrigerator could be food borne illness and resident safety. Record review of the facility's food storage policy dated October 01, 2018, reflected the following: Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.

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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 interview and record review, the facility admitted an individual with a positive PL1 without a complete PE and PASRR determination for 1 of 12 residents (Resident #1) reviewed for PASARR services. The facility failed to ensure a PASARR screening was completed correctly for Resident #1. Resident #1 was marked No for mental illness. This deficient practice could place residents at risk for not obtaining the services needed to treat their mental health diagnoses. The findings include:Record review of Resident #1's admission sheet, dated 09/21/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included anxiety (feeling of uneasiness or worry) diagnosed on [DATE], bipolar (extreme mood swings) diagnosed on [DATE] and depression (mood disorder that causes a persistent feeling of sadness) diagnosed on [DATE]. Record review of Resident #1's Quarterly MDS assessment, dated 09/02/2025, revealed Resident #1 had a BIMS score of 14, which indicated intact cognitive response. Resident #1's mood indicators were present which included little interest or pleasure in doing things, feeling down, depressed, or hopeless. The MDS also documented bipolar (extreme mood swings) and depression (mood disorder that causes a persistent feeling of sadness) as active diagnoses. Record review of Resident #1's care plan, dated 06/17/2025, noted the resident used an anti-depressant medication. The goal was Resident #1 Resident will not exhibit signs of drug related side effects or adverse drug reaction. The approach was Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension (high blood pressure), or anticholinergic symptoms (group of side effects that block the action of the medication). Quantitatively (measure by quantity) and objectively document the resident's mood. Try non-pharmacological interventions before initiating drug therapy. Record review revealed Resident #1's PASARR Level I dated 08/02/2024 revealed that for the question that stated, is there evidence or an indicator this is an individual with a mental illness? was marked as no. During an interview with Resident #1 on 09/23/2025 at 09:33 a.m., Resident #1 said she was diagnosed with her mental disorder a long time ago. She said she had mental illnesses prior to coming to the facility. She said she does take medication for her mental illness, and she sees a phycologist. She also said that she had her own therapist that she was seeing before she entered the facility that she still sees. She said she did not get any other services for her mental health. She said she would like specialized services if she qualified for them. During an interview with SW on 09/23/2025 at 12:37 p.m., revealed that the SW had been trained on PASARR. She said the policy was that the facility had to have a PASARR for all residents before the resident was admitted . She said the hospital or the person doing the referral was responsible for completing a PASARR. She also said if the residents were positive the facility would be sent to LA. She said normally the CCM would ensure accuracy of the PASARR, but the facility did not have a CCM, so she had been ensuring the PASARR's was correct when a resident is admitted . She said she ensures they are correct by looking at the resident's medical records and their diagnosis. She said the process was to get the PASARR to review it, review the resident's medical records, review the diagnosis and if positive then send it to the LA. She said if a resident had a new diagnosis the facility would do a new PASARR, and the resident would be reevaluated by the LA to see if they qualify for specialized services. She said right now the ADM was responsible for submitting a positive PASARR to the LA. She said if the PASARR is not marked correctly the resident could miss services for which they are potentially eligible. She said normally the CCM monitored to ensure all residents had a PASARR, she said right now she thought it was the ADM. She said the PASARR specialist at corporate office would ensure competency of PASARR. She said when the new CCM starts, they would do the training with the PASARR specialist for cooperating office. She said she did not know why Resident #1's PASARR was marked incorrectly. During an interview with the ADM on 09/23/2025 at 12:48 p.m., revealed he had been trained on PASARR. He (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the policy was the facility needed a PASARR filled out before a resident was admitted to the facility. He said the hospital or referring party was responsible for completing the PASARR. He said that the CCM was normally responsible for ensuring the PASARRs was correct but until the facility got a new CCM, he was responsible. He said that he had a PIP on PASARR to ensure they was completed correctly and sent to the LA when a resident was positive. He said the PASARR process was to get the PASARR, review the resident's hospital diagnosis list, medical records, and do family interviews to ensure the PASARR is completed correctly. He said usually the CCM was responsible for ensuring that PASARR was referred to the LA when a resident was positive. He said if a resident was positive before admission usually the LA would meet with the resident prior to admission if the PASARR was known to be positive before admission. He said he is responsible for ensuring competency in PASARR. He said he used the HHS learning portal for PASARR and had the SW review it. He said if the PASARR was not done correctly the residents would not get the necessary services they need. He said he did not know why Resident #1's PASARR was marked incorrectly. During an interview with the CPS on 09/23/2025 at 3:17 p.m., revealed that she had been trained on PASARR. She said that the policy was the facility needed a PASARR before a resident was admitted to the facility regardless of payor source. She said normally it would be the CCM who would be responsible for ensuring the PASARR was correct, however the facility did not have one, so the SW and ADM was doing the PASARRs. She said that she helped the facility if they needed it. She said that the facility would look at the resident's clinical records from the hospital and match it up to make sure the PASARR was correct. She said the process was to get the PASARR, review the clinical admission documents and talk to the family about the residents' mental and intellectual disabilities. She said if a resident was diagnosed after admission the facility would review the new diagnosis and see if the resident was positive for mental illness or Intellectual disability and if the resident was not positive at admission the facility would complete a new PASARR level one and then do the PASARR evaluation and submit it to the LA. After submitting to the LA, the LA would set up a meeting to evaluate the residents and see if the residents qualified for specialized services. She said the CCM was responsible for monitoring all residents who had a correct PASARR and then she would double check. She said the facility monitored the PASARRs through a TEAMS channel that had the admissions in an excel file that was reviewed daily. She said that not having the PASARR filled out correctly could affect PASARR specialized services for a resident that might be eligible. She said Resident #1's PASARR was not correct because the hospital did not mark the mental illness. She said she did not know why the previous PASARR coordinator did not catch the mistake. Record review of the PASARR positive resident list provided by the facility on 09/21/2025 revealed Resident #1 was not on the list. Record review of the PASARR Guidelines revised on 7/2023 revealed It is the intent of the facility to meet and abide by all State and Federal regulations that pertain to resident Preadmission and Screening Resident Review (PASARR) Rules. If admission is NOT Exempted Hospital Discharge or Expedited (Self/family/Doctor referral, Psych Hospital, Home, Home with Hospice, Homeless Shelter, Jail): ˆThe PL1 is FAXED to LIDDA/LMHA prior to admissionˆ The Social Worker/designee monitors the Simple LTC portal for the PEˆ The Social Worker/designee Prints out the PE form, reviews the PE Recommendations with the IDT. PE to be printed and filed in the medical record.ˆ IDT will determine if the individual will or will not be admitted to the facility,ˆ The Social Worker/designee will Certify on the Simple LTC Portal that the facility can or cannot provide or support the Specialized Services recommended on the PE.ˆ The Social Worker/designee will schedule a PCSP Meeting and hold it within 14 days of admitting with the resident, LAR, RN, and LIDDA/LMHA in attendanceˆ The Social Worker or designee documents the PCSP Notes in Simple LTC Portal within 3 days of the meeting date. Notes are printed, reviewed by IDT, and filed in resident chart.LIDDA/LMHA will confirm their participation in the PSCP and Specialized Services agreed to within 5 business days of the meeting.ˆService Coordinator will conduct monthly visits and facilitate the initiation of LIDDA Specialized Services and the coordination of the resident's Specialized Services with the SPT. SPT (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	develops, revises, implements, and monitors a transition plan, as necessary.ˆ Facility initiates Specialized Services by submitting requests to DADS within 20 days of PCSP Meetingˆ IDT adds Specialized Service interventions to the Resident's Comprehensive Care Plan; a copy of the care plan is provided to the LIDDA/LMHA.ˆ Facility delivers Specialized Servicesˆ IDT communicates, via the Simple LTC Portal, changes in condition or need for changes to Specialized Services. Important things to remember: Community/self-referrals- must have Pre-admission Screening prior to being admitted .In the event the facility identifies a change in the resident status related to ID/MI the facility will submit a Form 1012 to have the LA/LMHA conduct a PE.