STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675169	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Fredericksburg	1117 S Adams St Fredericksburg, TX 78624

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that Resident #1 was free of significant medication errors for 1 of 3 residents (Resident #1) reviewed for medication errors. - LVN A administered Resident #2's medications to Resident #1. Resident #1 had a change of condition (slow respirations and low oxygen saturation levels) and was sent to the hospital via 911 EMS where she was diagnosed and treated for opioid overdose.- LVN A did not administer Resident #2's daily 4:00 PM prescriptions. A past non-compliance Immediate Jeopardy (IJ) was identified at 1:50 p.m. on 5/27/2026. The immediacy began on 5/24/2026 and ended on 5/25/2026. While the immediacy was removed on 5/25/2026, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not IJ due to the need to evaluate the effectiveness of the corrective systems. This failure was identified as past noncompliance IJ as the facility had instituted adequate corrective measure to prevent recurrence of the noncompliance. The facility corrected the noncompliance before the survey began. This failure could place residents at risk for medication errors.Findings included: A record review of Resident #1's admission record, dated 5/26/2026, revealed an admission date of 5/15/2026 and a discharge date of 5/24/2026 with diagnoses which included atherosclerotic heart disease (fatty deposits called plaque clog the arteries supplying blood to the heart), myocardial infarction (heart attack - blood flow to a section of the heart muscle is blocked, depriving it of oxygen), and aortocoronary bypass graft (the surgical repair of a blocked heart artery). A record review of Resident #1's admission MDS assessment, dated 5/25/2026, revealed Resident #1 was an [AGE] year-old female admitted for rehabilitation after a heart attack and heart bypass surgery. A record review of Resident #1's physicians orders, dated 5/26/2026, revealed Resident #1 was not prescribed to receive medications in the afternoon nor was Resident #1 prescribed to receive any opioids (a class of medications which dulls the senses, relieves pain, and induces sleep or profound lethargy) or benzodiazepines (central nervous system depressants). A record review of Resident #1's care plan, dated 5/26/2026, revealed Resident #1 was a full Code status and wished to receive cardiopulmonary resuscitation if she became unresponsive without breaths or heartbeats. A record review of Resident #1's nursing progress notes, dated ??, revealed on 5/24/2026 at 6:53 PM the ADON documented that Resident #1 was not responding and assessed with a blood oxygen saturation of 65% (dangerously low blood oxygen levels. This is a medical emergency and requires immediate medical attention), EMS 911 was called, and Resident #1 was transferred to the hospital. A record review of Resident #1's hospital emergency room admission records, dated 5/24/2026, revealed Resident #1 was brought in by EMS and was assessed by Dr. P with low blood oxygen levels, poor respirations and Resident #1 was not responding to treatments. Dr. P administered naloxone (a life-saving medication used to rapidly reverse an opioid overdose by blocking the effects of opioids on the brain and restoring normal breathing). Dr. P ordered a urine drug screen laboratory report which revealed Resident #1 had methadone, opioids, and benzodiazepines in her body; . Urinary drug screen tested positive for methadone, opioids, and benzodiazepines, none of which are on patients' medication list. Emergency department medical doctor at bedside. A record review of Resident #2's admission record, dated (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/26/2026, revealed an admission date of 9/29/2025 with diagnoses which included malignant neoplasm of intra-abdominal lymph nodes (the spread of growing cancer tumors in the abdomen of the lymph nodes [small, bean-shaped structures that act as the body's primary defense filters]). A record review of Resident #2's quarterly MDS assessment, dated 4/13/2026, revealed Resident #2 was a [AGE] year-old male admitted for LTC with supports for ADL under hospice services (hospice services provide comfort care for those with a life expectancy under 6 months). A record review of Resident #2's care plan, dated 5/26/2026, revealed Resident #2 was receiving pain medications with nursing interventions to monitor Resident #2 for respiratory depression, respiratory rates, depth of respirations, and respiratory efforts after administration of medications. A record review of Resident #2's physicians orders, dated 5/26/2026, revealed the physician prescribed for Resident #2 to receive daily, between 4:00 PM and 5:00 PM, the following drugs:- Methadone (a powerful, long-acting synthetic opioid medication) 10mg 2 tablets.- Morphine sulfate (a strong pain-relieving medication that completely activates the opioid receptors in the brain and central nervous system to produce the maximum possible pain relief) extended release 60mg 1 tablet.- Alprazolam (a potent, fast-acting prescription medication used to treat anxiety disorders, panic disorders, and severe anxiety associated with depression) 0.5mg 1 tablet. A record review of the facility's Medication Audit Report, dated 5/26/2026, revealed LVN A documented on 5/24/2026 at 5:15 PM she administered the following medications to Resident #2:- Methadone 10mg, 2 tablets.- Morphine sulfate extended release 60mg, 1 tablet.- Alprazolam 0.5mg, 1 tablet. A record review of the United States of America's National Library of Medicines' website: https://www.ncbi.nlm.nih.gov/books/NBK560654/accessed 6/1/2026 titled, Nursing Rights of Medication Administration, dated 9/4/2023, revealed, Introduction: Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration.[1] It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the ?five rights' or ?five R's' of medication administration. The five traditional rights in the traditional sequence include:?Right patient' - ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed. This is best practiced by nurses directly asking a patient to provide his or her full name aloud, checking medical wristbands if appropriate for matching name and ID number as on a chart. It is advisable not to address patients by first name or surname alone, in the event, there are two or more patients with identical or similar names in a unit. Depending on the unit that a patient may be in, some patients, such as psychiatric patients, may not wear wristbands or may have altered mentation to the point where they are unable to identify themselves correctly. In these instances, nurses are advised to confirm a patient's identity through alternative means with appropriate due diligence. During an interview on 5/25/2026 at 2:20 PM the Administrator and the DON stated LVN A had failed safe medication administration expectations during her 6:00 A.M. to 6:00 PM shift on the facility's 100 and 200-halls when around 5:00 PM she was passing medications and administered Resident #2's medications to Resident #1 and had not administered Resident #2's medications to Resident #2. The Administrator and the DON stated Resident #2's medications included opioids. The Administrator and the DON stated Resident #1 was not prescribed opioids. The Administrator and the DON stated Resident #1 had an adverse reaction to receiving Resident #2's medications and required emergency hospitalization where she received naloxone to reverse the adverse effects from receiving Resident #2's medications. The Administrator and the DON stated they reported the allegation of abuse to the State Agency and suspended LVN A pending the investigation and began assessing all the residents LVN A passed medications to on halls 100- and 200. The Administrator and the DON stated all residents who were served by LVN A, were assessed without injuries, which included Resident #2. The Administrator and the DON stated Resident #2 received pain medications 4 times a day and had not reported any signs and or symptoms of pain during the afternoon. The Administrator and the DON stated the incident was caused by LVN A when she was pre-pouring medications, for (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	several residents, into small plastic pill cups and writing residents' names on the cups. The Administrator and the DON stated LVN A mistakenly then administered Resident #2's medications to Resident #1. The Administrator and the DON stated they began an in-service for not pre-pouring medications and basic medication administration for the 10 facility nurses and the 1 facility medication aide, and no one could take a shift unless they received the in-service. The Administrator and the DON stated they had scheduled an ad hoc QAPI (quality improvement and performance improvement) meeting to address the failure (ad-hoc meeting which was spontaneously to tackle a specific, pressing issue). During an interview on 5/25/2026 at 7:00 PM, RN F stated she was a hospital emergency room nurse when Resident #1 was brought in by EMS 911. RN F stated Resident #1 was treated by Dr. P and diagnosed with respiratory distress, low blood oxygen saturation, needed oxygen, had low respirations, 6 per minute, and was unresponsive to Dr. P's treatments until Dr. P prescribed naloxone for Resident #1, twice. RN F stated that Dr. P ordered a urinary drug screen which revealed Resident #1 had opioids and benzodiazepines in her blood stream. RN F stated per Resident #1's records, Resident #1 was not prescribed to receive those drugs. During an interview on 5/25/2026 at 7:10 PM, Dr. P stated she re-enforced RN F's interview and supported RN F's account of events. Dr. P stated Resident #1 had ingested opioids and benzodiazepines which were not in line with her previous prescribed medications and caused her a life threating incident of lethargy and respiratory depression. During an observation and interview on 5/25/2026 at 7:20 PM, Resident #1 was in her hospital room in the hospital's intensive care unit. Resident #1 stated, the last thing I remember was taking my pills from the nurse, but the pills looked different. During an interview on 5/26/26 at 9:02 A.M., LVN A stated on 5/24/2026 she was assigned to care for residents on the 100-200 hall and was administering the 4:00 PM to 5:00 PM medications when she felt there was a potential to run late with the medication administration and began to Pre-pour medications, I dispensed the medications for Resident #2 and placed his name on the small plastic pill cup. LVN A stated on the morning of 5/25/2026 she learned from the Administrator and the DON that Resident #1 had been sent to the emergency room due to lethargy. LVN A stated she reported to the Administrator and the DON that she may have been responsible because she pre-poured medications for Resident #2 during the afternoon medication pass and may have erroneously given Resident #2's medications to Resident #1, they both have similar names and Resident #1 does not take medications at 4PM. During an interview on 5/27/2026 at 1:20 PM, the Administrator and the DON stated nursing staff were expected to administer medications, per professional standards, by administering medications to 1 resident at a time and to follow the rights of medication administration which included verifying the resident's identification and medications with the physicians' orders. The Administrator and the DON stated failure to follow these guidelines could place residents at risk for not receiving the intended effects of their medications. The Administrator and the DON stated LVN A had not reported to the Administrator and the DON that she was pre-pouring medications on her shift and denied the DON the opportunity to intervene for safe medication administration practices. A record review of the facility's Administering Medications policy, dated April 2019, revealed, Policy interpretation and implementation: . medications are administered in accordance with prescribers' orders, including any required time frame. The individual administering medications verifies the resident's identity before giving the resident his or her medications. Methods of identifying the resident included: checking identification bands; checking photographs attached to the medical record; and if necessary, verifying resident identification with other facility personnel. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and write method of administration before giving the medication. This failure was identified as past noncompliance IJ as the facility had instituted adequate corrective measure to prevent recurrence of the noncompliance. The immediacy existed from 5/24/2026 to 5/25/2026. The facility corrected the noncompliance before the survey began. This was determined to be a past non-compliance Immediate Jeopardy (IJ) on 5/27/2026 at 1:50 p.m. The Administrator and Interim DON were notified. The (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrator and the DON were provided with the IJ Template on 5/27/2026 at 1:50 p.m. A record review of the facility's Plan of Removal for Immediate Jeopardy, dated 5/25/2026, revealed, Summary of details which led to outcomes. Lab results confirm medication administration incident involving a resident who tested positive for benzodiazepines, opioids, and methadone despite no physician orders or history of administration within the facility. Plan:1. Immediate Actions Implemented:a. Nurse involved immediately suspended pending an investigation.b. Medication cart access / security review initiated to confirm only 1 nurse had access during the identified shift.c. Facility initiated nursing license verification for all licensed nursing staff.d. Medication carts, narcotic storage areas, and keys secured and audited immediately.e. Attending physicians, pharmacy, facility leadership, and HHSC notified as indicated.f. All Residents that nurse provided care to were assessed for physical / emotional adverse reactions.2. Audits:a. Facility conducted immediate narcotic reconciliation and audit for all controlled substances including methadone, opioids, and benzodiazepines.b. Facility verified current physician orders against medication administration records documentation and medication inventory.c. Any discrepancies identified were immediately escalated to the Administrator, the director of nursing, consultant pharmacist, and regional leadership.d. Facility initiated a review of all residents receiving controlled substances to identify any additional concerns, omissions, or adverse reactions.e. Facility implemented management oversight of all medication passes until investigation completion.3. Education:a. Facility wide nursing in-services initiated regarding documentation, following position orders, resident rights, abuse neglect and exploitation, add medication administration.b. All education includes signature verification and verbal competency validation to ensure understanding.c. Nursing staff educated regarding timely reporting expectations and immediate escalation of medication discrepancies or adverse events.4. Monitoring / compliance plan:a. Narcotic reconciliation audits to be completed by the director of nursing and or his designee daily for 14 days then every two weeks for two months then once a month for two months. Random audits will be conducted to ensure compliance.b. 100% medication pass observations to be conducted for all licensed nurses for a minimum of 14 days by the director of nursing and/or his designee.c. Findings to be reviewed during quality assurance performance improvement meetings to ensure ongoing compliance and sustained correction actions. Past non-compliance verification During an interview on 5/26/26 at 9:02 A.M., LVN A stated she was suspended and was not assigned any shifts at the facility pending the results of the investigation. A record review of the Texas Unified Licensure Information Portal's website, accessed 5/26/2026 revealed a facility reported allegation of neglect on behalf of Resident #1 on 5/25/2026 at 12:06 PM. Record reviews of the facility's census dated 5/24/2026 revealed LVA A served 25 residents on her 6:00 A.M. to 6:00 PM shift on 5/24/2026, as follows:1. Resident #12. Resident #23. Resident #34. Resident #45. Resident #56. Resident #67. Resident #78. Resident #89. Resident #910. Resident #1011. Resident #1112. Resident #1213. Resident #1314. Resident #1415. Resident #1516. Resident #1617. Resident #1718. Resident #1819. Resident #1920. Resident #2021. Resident #2122. Resident #2223. Resident #2324. Resident #2425. Resident #25 A record review of medical records for Residents #2 through Resident #25, dated ??, revealed all were assessed physically and emotionally without injuries or adverse effects. A record review of Resident #2's medical record, dated ??, revealed the ADON documented her assessment of Resident #2 on 5/24/2026, Resident alert with no signs or symptoms of distress. No signs or symptoms of adverse reactions to medications. A record review of Resident #2's medical record revealed the SW assessed Resident #2 and documented on 5/25/2026, Resident seen by Social Services for follow-up assessment related to medication error reported on previous date. Resident was alert and able to communicate needs and concerns appropriately during visit. Social Worker assessed resident's emotional status and coping response. Resident stated he is doing fine and denied any change in mood or emotional distress related to incident. Resident also denied pain, nausea, or other adverse symptoms at this time. No signs of acute emotional distress observed during visit. Support and opportunity for discussion provided. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident encouraged to notify staff of any concerns or changes in condition. No further social service interventions indicated at this time. A record review of the facility's, Medication Cart Monitoring/Order, MAR, inventory reconciliation check auditing worksheet tool, revealed the DON checked the medication carts and observed medication administration without incidents on the following dates and times:- 5/25/2026 PM- 5/26/2026 AM- 5/26/2026 PM- 5/27/2026 AM A record review of the facility's Quality Assessment and Performance Improvement Plan 2026 dated 5/25/2026 revealed the following leadership attended the QAPI meeting:- The Administrator- The DON- The Medical Director- The ADON A record review of the facility's ANE, following physicians' orders, medication administration (no pre-pouring), opioid overdose response in-service, dated 5/25/2026, revealed 12 nursing staff received the in-service from the DON and the ADON: which included:During an interview on 5/27/2026 at 10:13 A.M., RN O stated she was the charge nurse for 300-hall and some of 200-hall and stated she received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications 1 resident at a time. During an interview on 5/25/2026 at 6:10 PM, RN G stated she was the weekend RN supervisor who picked up the PRN holiday shift on 5/25/2026 and stated she received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications 1 resident at a time. During an interview on 5/25/2026 at 6:22 PM, the ADON stated she received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications for 1 resident at a time. During an interview on 5/25/2026 at 4:32 PM, LVN N stated she was the charge nurse for 300-hall and some of 200-hall and stated she received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications 1 resident at a time. During an interview on 5/25/2026 at 6:14 PM, LVN B stated she was the charge nurse for 300-hall and some of 200-hall and stated she received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications 1 resident at a time. During an interview on 5/25/2026 at 4:21 PM, LVN M stated she was the charge nurse for 300-hall and some of 200-hall and stated she received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications 1 resident at a time. LVN M stated she had not practiced pre-pouring medications and as a professional standard administered medications to 1 person at a time. During an interview on 5/26/2026 at 4:47 PM, MA K stated she was a Medication Aide for the facility and had worked evening shifts. MA K stated she received an in-service from the DON which included teaching on the rights of medication administration specific for not pre-pouring medications. MA K stated she had not practiced pre-pouring medications and as a professional standard administered medications to 1 person at a time. During an interview on 5/27/2026 at 9:05 A.M., RN L stated she was a nurse for the facility and had worked evening shifts. RN L stated she received an in-service from the DON which included teaching on the rights of medication administration specific for not pre-pouring medications. RN L stated she had not practiced pre-pouring medications and as a professional standard administered medications to 1 person at a time. During an interview on 5/26/2026 at 6:07 PM, LVN J stated she was a nurse for the facility and had worked evening shifts. LVN J stated she received an in-service from the DON which included teaching on the rights of medication administration specific for not pre-pouring medications. LVN J stated she had not practiced pre-pouring medications and as a professional standard administered medications to 1 person at a time. During an interview on 5/25/2026 at 6:18 PM, LVN C stated she was the charge nurse for 100-hall and some of 200-hall and stated she received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications 1 resident at a time. During an interview on 5/26/2026 at 9:00 A.M., RN D stated he received an in-service for medication administration and ANE prevention and reporting and did not practice pre-pouring medications and administered medications to 1 resident (continued on next page)

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