

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZIP CODE 700 N Herndon Kirbyville, TX 75956	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 15 residents (Resident #48) reviewed for respiratory care. The facility failed to change the oxygen reservoir weekly for Resident #48. This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Findings included: Record review of Resident #48's face sheet, dated 9/02/25 revealed a [AGE] year old female admitted on [DATE] with diagnoses that included Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, and other cognitive functions), Chronic Obtrusive Pulmonary Disease (a progressive lung condition that causes breathing difficulties due to narrowed airways and damaged air sacs, leading to symptoms like chronic cough, shortness of breath, and wheezing), and Hypertension (a condition where the force of blood against artery walls is consistently too high, which can lead to serious health problems like heart attack and stroke) Record review of Resident #48's admission MDS assessment, dated 09/08/25, revealed Resident #48 had a BIMS score of 11, which indicated she had moderate cognitive impairment. The MDS showed that Resident #48 requires maximal assistance with ADLs. Record review of a physician's order for Resident #48, dated 9/29/25, showed that staff were to, Change oxygen humidifier every evening shift every Sunday and as needed. Record review of a physician's order for Resident #48, dated 9/29/25, showed that staff were to, O2 @ 2L/Minute via nasal cannula PRN to maintain O2 stats > 92% Record review of Resident #48's care plan dated 12/1/2025 showed no care planning for oxygen administration. During an interview and observation on 12/1/2025 at 8:58 a.m. it was observed that Resident #48's oxygen humidifier, or water reservoir, was dated 11/9/2025. Resident #48 said she uses her oxygen but rarely. She said she did not know how often her tubing is changed. During an interview on 12/03/2025 at 10:12 a.m., LVN A said nurses were responsible for ensuring that resident's oxygen tubing, reservoirs, and machines were maintained. She said residents' oxygen reservoirs should be changed per their orders. She said Resident #48's oxygen reservoir should be changed weekly or as needed. She said nighttime nurses on Sundays should change their reservoirs and clean up. During an interview on 12/03/25 at 12:00 p.m. with the DON she said that it was the responsibility of facility nurses on the nighttime Sunday shift to ensure that residents' oxygen reservoir was changed per orders and labeled with the new date. She stated that residents could be placed at risk for respiratory infections if their oxygen reservoir was not changed properly. She said that there could be a bacteria buildup inside the reservoir if it wasn't changed out regularly. During an interview on 12/03/25 at 12:05 p.m. with the ADM she said that it was the responsibility of night nursing staff to change the oxygen reservoir for oxygen concentrators as it was ordered. She said it was Sunday night nurses that were supposed to ensure that all residents who receive oxygen have their reservoirs clean. She said that residents could be placed at risk for respiratory infections if they were not supplied with clean oxygen reservoirs. Record review of an undated facility policy titled Oxygen Administration revealed that, Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675220
		If continuation sheet Page 1 of 6

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cardiac diseases. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The nasal cannula delivers 22-40 % oxygen and is the most common, inexpensive, and easiest device to use. Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident's bed or concentrator. The resident will be free from infection.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 4 resident personal refrigerators reviewed for food safety (Resident #46). The facility failed to ensure the refrigerator for Resident #46 did not contain a greenish/black substance in the freezer section. This failure could place residents at risk for food borne illnesses. Findings included: Record review of Resident #46's face sheet, dated 12/03/25, reflected he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included Parkinson's disease (a progressive neurodegenerative disorder that primarily affects movement due to the loss of dopamine-producing brain cells, leading to symptoms like tremors, stiffness, and balance problems), and type 2 diabetes mellitus (a chronic condition where the body doesn't use insulin properly, leading to high blood sugar levels). Record review of Resident #46's quarterly MDS assessment, dated 09/04/25, reflected he had a BIMS score of 6, which indicated severe cognitive impairment. During an observation and interview on 12/01/25 at 08:45AM, Resident #46 was lying in bed in his room. He gave this surveyor permission to check his refrigerator and there was a greenish/black substance in the freezer section. The Administrator came into the room and said she would have someone clean the refrigerator. During an interview on 12/03/2025 at 9:49 AM, the ADON said her expectation for the fridges was that family were to maintain and clean the fridges. She said she also expected the housekeeping staff to check the fridges with temperature checks. She said the risk was there could be contamination that could make a resident sick. During an interview on 12/03/25 at 12:06PM, the DON said the resident and responsible party were responsible for cleaning the refrigerator. She said in absence of the responsible party and resident then the housekeeper should clean it. She said the food can develop bacteria and potentially make a resident sick. During an interview on 12/03/25 at 12:08PM, the Administrator said the resident and responsible party were responsible for cleaning the refrigerator. She said if they needed help then they can ask staff for help. Record review of the facility's policy, Personal Refrigerators Policy, dated 2022, stated: .The care and maintenance of any refrigerator is the responsibility of the resident and/or responsible party. It is also the responsibility of the resident and/or resident representative to properly store non-facility supplied foods that require refrigerator in their personal refrigerator. If food is expired or appears spoiled or moldy, the facility reserves the right to discard it. Housekeeping can assist the resident and/or family member by inspecting the refrigerators at least weekly and assist with removal of outdated food items and cleanliness. Care and MaintenanceThe resident and/or resident representative should clean and maintain the refrigerators according to the manufacturer's user manual. If needed you can ask facility housekeeping or maintenance staff for assistance.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 14 residents (Resident #49) reviewed for infection control practices. The facility failed to ensure the proper disinfectant cleaner was used to clean Resident #49's isolation room with clostridium difficile (bacteria that causes infection in the large intestine). This failure could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: Record review of Resident #49's face sheet, dated 12/02/25, reflected she was a [AGE] year-old female, initially admitted to the facility on [DATE], and most recently re-admitted on [DATE]. Her diagnoses included dementia (a decline in mental ability that interferes with daily life, affecting memory, thinking, and behavior), and schizophrenia (a chronic mental health disorder characterized by a breakdown in the relationship between thought and reality). Record review of Resident #49's quarterly MDS assessment, dated 10/09/25, reflected that she had a BIMS score of 03, which indicated severe cognitive impairment. She was also frequently incontinent of bowel. Record review of Resident #49's physician's orders, reflected this order: *Resident Requires contact isolation for clostridium difficile. The start dated was 11/24/25. Record review of Resident #49's care plan reflected a focus of Resident #49 is on contact precautions related to clostridium difficile. The focus was initiated on 11/24/25. The goal was the resident's infection will not spread to other residents. Interventions included: *After resident care, remove gown and gloves in the residents room in the container for soiled PPE *Have PPE readily available outside of the residents room *Perform hand hygiene after removing gown and gloves *Wash hands or use hand sanitizer prior to entering the room. During an observation on 12/01/2025 at 1:43PM, there was a sign on Resident #49's door that stated contact isolation. There was an isolation cart outside the room that contained PPE. Resident #49 was lying in bed in her room. During an observation and interview on 12/01/2025 at 2:27PM, Housekeeper B was cleaning rooms on 100 hall. She said if she was cleaning a room that was on isolation for clostridium difficile she would use the K-Quat Plus Cleaner. She showed this surveyor the bottle of K-Quat plus on her housekeeping cart. She said she uses that product on clostridium difficile rooms and all bathrooms. During an interview on 12/01/2025 at 2:58 PM, Housekeeper C said she was just about to start cleaning the hall that Resident #49 was on. She said she uses the K-Quat Plus cleaner for Resident #49's room. She said she cleans Resident #49's room last, and she said she lets the cleaner sit for 10 minutes. During an interview and observation on 12/02/25 at 8:48AM, the Housekeeping Supervisor said she expected the housekeeping staff to use the K-Quat Select disinfectant on clostridium difficile rooms. She showed the bottle of K-Quat Select in the chemical closet. She said the house keepers use the K-Quat select bottle to fill the bottles they use on their carts. She said she was not aware the K-Quat cleaner did not kill clostridium difficile. She said the risk was that the staff could potentially spread the clostridium difficile bacteria to other residents and get them sick. She said she would call corporate and figure out what cleaner she should be using instead. During an interview on 12/02/2025 at 09:10 AM, the Housekeeping Supervisor said she spoke with corporate, and she was supposed to use a 1:10 bleach solution for the clostridium difficile room. She said she will in-service her staff on the bleach solution. During an interview on 12/03/2025 at 9:49 AM, the ADON said she expected the housekeeping staff to use the proper disinfectant to kill clostridium difficile. She said the risk was that the clostridium difficile could spread and cause an outbreak in the facility. During an interview on 12/03/25 at 12:06PM, the DON said she expected the housekeeping staff to use the proper disinfectant to kill clostridium difficile. She said the risk was that clostridium difficile could spread to other residents and staff and cause illness. During an interview on 12/03/25 at 12:08PM, the Administrator said she expected the staff to use the bleach (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solution to kill clostridium difficile. She said clostridium difficile was highly contagious and could spread to other residents. Record review of the following site was accessed on 12/01/25 at 03:30PM, and did not indicate the K-Quat Plus or K-Quat Select cleaner killed clostridium difficile bacteria.* List K: Antimicrobial Products Registered with EPA for Claims Against Clostridium difficile Spores US EPA https://www.epa.gov/pesticide-registration/epas-registered-antimicrobial-products-effective-against-clostridioid Record review of the following site was accessed on 12/01/25 at 03:35PM, and indicated the active ingredient in K-Quat Plus cleaner was registered under the name Maquat 64-PD.*Details for K-Quat Plus US EPA https://ordspub.epa.gov/ords/pesticides/f?p=PPLS:8:7342909364415::NO::P8_PUID,P8_RINUM:528655,10324-93 Record review of the following site was accessed on 12/01/25 at 03:40PM, and did not indicate the Maquat 64-PD cleaner killed clostridium difficile bacteria.*Details for Maquat 64-PD US EPA https://ordspub.epa.gov/ords/pesticides/f?p=113:8::NO::P8_PUID,P8_RINUM:35052,10324-93 Record review of the following site was accessed on 12/01/25 at 03:45PM, and indicated the active ingredient in K-Quat Select cleaner was registered under the name BTC 885 Neutral Disinfectant Cleaner-64.*Details for K-Quat Select US EPA https://ordspub.epa.gov/ords/pesticides/f?p=PPLS:8:7342909364415::NO::P8_PUID,P8_RINUM:479994,1839-169 Record review of the following site was accessed on 12/01/25 at 03:50PM, and did not indicate the BTC 885 Neutral Disinfectant Cleaner-64 cleaner killed clostridium difficile bacteria.*Details for BTC 885 Neutral Disinfectant Cleaner-64 US EPA https://ordspub.epa.gov/ords/pesticides/f?p=113:8::NO::P8_PUID,P8_RINUM:13680,1839-169 Record review of the facility's policy, Deep Cleaning Process - Resident Rooms with special precautions, dated 2022, stated: .6. Disinfect all contact surfaces using K-Quat Select. (or 10% bleach solution for [clostridium difficile]).		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 2 of 2 days reviewed (12/1/25 and 12/2/25) for nurse staffing posting. The facility failed to post the required current daily staffing information on 12/1/25 and 12/2/25. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included: During an observation on 12/1/25 at 8:20 AM, no nurse staffing data was posted in the facility. During an observation on 12/2/25 at 10:25 AM, no nurse staffing data was posted in the facility. During an interview on 12/2/25 at 11:00 AM, the DON said nurse staffing data was not posted. She said it used to be posted near the nurse's station, but it was no longer posted. She said she would run the staffing report and post it now. During an interview and observation on 12/2/25 at 11:25 AM, the DON said staffing was posted behind the nurse's station. This surveyor observed the daily nurse staffing posted behind the nurse's station. During an interview on 12/2/25 at 1:04 PM, the DON said she and the ADON were responsible for making sure staffing was posted. She said there was a miscommunication with her corporate. Corporate told her they did not need to post it. The DON said they use the staffing application for daily staffing and it could be printed out if needed. However, she understood it did not need to be posted. During an interview on 12/2/25 at 2:22 PM, the ADON said she used to post the daily staffing every day. She does not remember when she stopped. She understood from corporate that they did not have to post the daily staffing. She said corporate may have been misinformed or confused as well. She said she believed the last time she posted daily staffing was about 6 months ago. The ADON said the risk of not having daily staffing posted was residents/visitors would not know if there was enough staff to care for the residents. During an interview on 12/2/25 at 3:19 PM, the DON said the risk of not having staffing posting was that the residents would not know if there was an adequate number of staff to care for them for the day. During an interview on 12/2/25 at 3:52 PM the ADM said her Regional Area Director told her staffing had to be posted. She said it had not been posted in months, but she did not know how many. She said the risk of daily staffing not being posted was that personnel would not know what staffing was in the facility. During an interview on 12/2/25 at 12/03/2025 8:32 AM the ADM said they did not have a policy for posting daily staffing.		