STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675241	A. Building B. Wing	02/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Jefferson	1307 Martin Luther King Dr Jefferson, TX 75657

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the resident's representative and physician when there were changes in the resident's physical, mental, or psychosocial status for 1 of 9 residents (Resident #2) reviewed for notification of changes.The facility failed to notify MD E of Resident #2 refusing meals and eating poorly during the month of 2/2026.The facility failed to notify MD E of Resident #2 being combative and refusing medications on 2/15/26.The facility failed to notify Resident #2's RP of his poor oral intake and refusing to eat the month of 2/2026.The facility failed to notify Resident #2's RP of him being combative and refusing his medications on 2/15/26.These failures could place residents at risk of not receiving adequate and timely interventions and a decline in condition. Findings included:Record review of Resident #2's face sheet dated 2/20/26 indicated he was [AGE] years old and admitted to the facility on [DATE] initially and re-admitted on [DATE]. Resident #2 had diagnoses including cerebral infarction, dysphagia (difficulty swallowing), cerebrovascular disease, chronic kidney disease, blindness right eye, vascular dementia (progressive decline in thinking skills caused by reduced flood flow to the brain), malignant neoplasm of the brain (mass that invades the surrounding brain tissue), unspecified symptoms and signs involving cognitive functions following cerebral infarction, repeated falls, depression and hypertension.Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated he had been admitted from a short-term hospital. The MDS indicated he had a BIMS score of 7, which indicated he had severe cognitive impairment. The MDS indicated Resident #2 used a wheelchair for mobility. The MDS indicated Resident #2 was dependent on staff assistance for all ADLs, including eating. The MDS indicated Resident #2 was always incontinent of bowel and bladder.Record review of Resident #2's Care Plan with an admission date of 12/27/25 revealed the resident had a nutritional problem or potential for nutritional problem with intervention including to monitor/document/report to MD as needed for signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals.Record review of Resident #2's Order Summary Report dated 2/21/26 revealed an order for may have health shake if resident consumes less than 50 % of meal as needed. Encourage intake of health shake if less that 50 percent of any meal consumed and notify nurse with a start date of 5/08/24.Record review of Resident #2's Nursing Medication Administration Record dated 2/1/26-2/28/26 revealed an order for may have health shake if resident consumes less than 50 % of meal as needed. Encourage intake of health shake if less that 50 percent of any meal consumed and notify nurse. There was no documentation that the resident received a health shake during the time period.Record review of Resident #2's Nutrition-Amount Eaten documentation revealed he consumed on:2/2/26-0-25% for one mealRefused one meal2/3/26-0-25% for one meal26-50% for 2 meals2/4/26-0-25% for one meal26-50% for 2 meals2/6/26-0-25% for two meals2/7/26-0-25% for one mealRefused one meal2/8/26-0-25% for two mealsNo documentation for 3rd (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meal2/9/26-0-25% for one mealNo documentation for two meals2/10/26-0-25% for one meal26-50% for one mealRefused one meal2/11/26-26-50% for one meal2/12/26Refused two meals2/13/26-0-25% for one meal26-50% for one meal2/14/26-Refused two meals2/15/26-0-25% for two mealsRefused one meals2/16/26-0-25% for one meal26-50% for one mealRefused one mealRecord review of Resident #2's weights indicated he weighed 158.6 pounds on 12/29/25 after discharging from the hospital on [DATE] and weighed 160.6 pounds on his last documented weight on 2/09/26.Record review of Resident #2's Nutritional Risk assessment dated [DATE] indicated his most recent weight was 160.6, he had a BMI of 22 (normal was 19-24.9), no weight changes were noted, his intake varied, and to continue current nutrition plan.Record review of Resident #2's nurses' notes from 2/1/26 through 2/16/26 did not indicate staff had notified the physician or Resident #2's RP related to refusing meals or eating poorly. MA D's note dated 2/15/26 at 7:01 PM indicated Resident #2 was resistant when trying to give medications, started swinging/swatting and Resident #2 was not allowing her to take his blood pressure and was not swallowing anything. There was no documentation MA D notified the nurse of behavior.During an interview on 2/20/26 at 10:53 AM, Resident #2's RP #1 said if he was refusing to eat or take his medication, the staff should have notified his nurse, so the nurse could have notified his physician, and his family, so they could help or intervene prior to him getting to the level he was currently in with dehydration and malnutrition.During an observation on 2/21/26 beginning at 9:30 AM, Resident #2 was observed lying in bed in the hospital. He only nodded that he was doing okay but would not or could not talk with this surveyor. He was noted to have a feeding tube inserted through his nose.During an interview on 2/21/26 at 1:58 PM, Resident #2's RP #2 said no one from the facility had contacted her regarding Resident #2 refusing to take anything by mouth. Resident #2's RP #2 said Resident #2 was in the hospital for severe dehydration, not being fed, and pneumonia. Resident #2's RP #2 said had she known he was refusing to take anything by mouth; she would have come to see him and tried to intervene.During an interview on 2/21/26 at 4:26 PM, LVN B said she had worked at the facility for twelve years. LVN B said Resident #2 was an elderly man, had a tumor in the brain and was progressively going down, and had to be fed. LVN B said no one had reported to her that he was being combative or not taking his medications. LVN B said it should have been reported to her as his nurse. LVN B said she would have reported it to Resident #2's physician and Resident #2's family because it was out of character for Resident #2. LVN B said Resident #2 could have had a urinary tract infection or anything causing the changes. LVN B said she had never known Resident #2 to be combative, and no one had reported it to her. LVN B said there was a possibility if Resident #2 had an infection it could have gotten worse from not notifying the physician. LVN B said Resident #2's family was highly involved in his care and should have definitely been contacted.During an interview on 2/21/26 at 5:46 PM, MA D said she had worked at the facility since 9/2024. MA D said she would try three times if a resident refused their medications, then would tell the nurse to let them try. MA D said Resident #2 would not let her take his blood pressure on 2/15/26 and was swinging at her and she told the nurse, but she did not remember who the nurse was. MA D said she tried to give him his medications on a spoon with some pudding, and she put it in his mouth. MA D said then Resident #2 would not swallow the medication and he would not drink any water with the medication. MA D said she had crushed it in pudding and she ended up spooning it back out of his mouth so he would not choke on it later. MA D said she asked him if he was okay and he kept shaking his head no. MA D said the aide told her that he would not eat or even open his mouth for her. MA D said Resident #2 went from holding his food in his mouth to not even opening his mouth at all. MA D said she went and let the nurse know he would not take his medication. MA D said she normally documented in the note that the nurse was notified, because she does let (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them know. MA D said Resident #2 had greatly declined after he came back from the hospital the end of December. MA D said it was not normal for him to swing and swat. MA D said she thought his decline in health was part of why he was behaving. MA D said she always tells the nurse if there was anything going on with the residents, but she must have forgotten to document it the day Resident #2 was swinging/swatting and refusing to take his medication.During an interview on 2/22/26 at 1:49 PM, MD E said he had been Resident #2's physician for over twenty years and was also seeing him in the hospital. MD E said he did not remember being told Resident #2 was not eating well. MD E said Resident #2 had a history of significant weight loss and he had put medications in place and added health shakes. MD E said Resident #2 had gained some weight back and then went back into the hospital with the flu and got septic (life threating body's response to infection) and lost weight. MD E said he would have expected to be notified if the resident was not eating well, so he could have put interventions in place. MD E said he was not notified of Resident #2 being combative or refusing his medications on 2/15/26. MD E said the nurse may have been waiting to see if it was a pattern and needed to investigate before notifying him. MD E said if there was an active problem with the resident and staff did not notify him timely, it could delay diagnosis and treatment to some extent. MD E said Resident #2 had a tumor in his brain and it had gotten bigger, along with his age and history of stroke, which were contributing factors of his cognitive decline and did not feel it was related to his care at the facility.During an interview on 2/22/26 at 2:41 PM, the DON said Resident #2 could not feed himself at all. The DON said staff should notify the physician and RP about anything abnormal, such as lab results, changes, adverse reactions, for sure should notify of meal refusals and document it. The DON said the CNA should have notified the nurse if a resident was refusing or not eating well. The DON said the physician should have been notified if the resident was refusing medications. The DON said MA D should have notified LVN B so she could have determined if the physician and the RP needed to be notified. The DON said the physician not being notified of changes, did not allow the physician to intervene and put things in place such as labs or anything. The DON said Resident #2's RP should have be notified to keep them in the loop for that family member of what is going on.During an interview on 2/22/26 at 3:08 PM, the ADM said she had been the ADM for about two and a half weeks. The ADM said the physician should be notified about not eating, not swallowing, or any kind of change of condition. The ADM said she would notify the physician immediately if she knew there was a change in the resident's normal behavior. The ADM said the physician absolutely should have been notified about Resident #2's poor appetite. The ADM said not notifying the physician could have caused the patient to lose weight. The DON said the physician may have wanted to give orders, but we will never know since he was not notified. The ADM said not notifying the physician of a change in condition could delay the resident's treatment. The ADM said she would expect the facility policies to be followed. The ADM said the family should have also been notified with any changes in condition with the resident. The ADM said family should always be notified of any changes with their loved ones so they could be a part of the decision-making process. The ADM said RP/family probably did not know Resident #2 had a change until they got the call he was sent out to the hospital.Record review of the facility's policy titled Change in a Resident's Condition or Status dated revised April 2025, indicated . Our facility promptly notifies the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status . 1. The nurse will notify the resident's attending physician or on-call physician when there has been . d. a significant change in the resident's physical/emotional/mental condition . f. refusal of treatment or medications three or more consecutive times . 2. A significant change of condition is a major decline or improvement in the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions . b. impacts more than one area of the resident's health status . c. requires interdisciplinary review and/or revision to the care plan . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when . b. there is a significant change in the resident's physical, mental, or psychosocial status . 5. Except in medical emergencies, notifications will be made within twenty-four hours of change occurring in the resident's medical/mental condition or status .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 care plan to meet the medical, nursing, mental and psychosocial needs for 2 of 9 residents (Resident #1 and Resident #2) reviewed for care plans.1. The facility failed to ensure a care plan was developed and implemented for Resident #1's allergies, discharge plans, code status, cognitive status, incontinence status, activities, pain management, diet, ADL assistance required, risk for falls, risk for pressure ulcers, risk for bleeding, preferences, disease processes: hypertension, hemiplegia and hemiparesis following cerebral infarction, nutritional deficiency, heart disease, or polyneuropathy, and medications: antianxiety, opioid, antiplatelet, anticonvulsant, diuretics and antidepressant.2. The facility failed to update Resident #2's ADL care plan to show he was dependent on staff for eating.3. The facility failed to implement Resident #2's order of: may have health shake if resident consumes less than 50 % of meal as needed. Encourage intake of health shake if less that 50 percent of any meal consumed and notify nurse.This failure could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed to address their needs. Findings included:1. Record review of Resident #1's face sheet dated 2/20/26 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including cerebrovascular disease (narrowing, blockage, or rupture of the blood vessels that supply the brain), hemiplegia (unable to move one side of body) and hemiparesis (weakness on one side of body) following cerebral infarction (stroke-death of brain tissue caused by lack of oxygen due blocked blood flow) affecting unspecified side, adult failure to thrive, polyneuropathy (nerve pain), hypertension (high blood pressure), atherosclerotic heart disease (plaque buildup in the blood vessels supplying the heart), and nutritional deficiency.Record review of Resident #1s admission MDS assessment dated [DATE] indicated he had been admitted to the facility on [DATE] from a short-term hospital. The MDS indicated he had a BIMS score of 12, which indicated he had moderate cognitive impairment. The MDS indicated Resident #1 had functional limitation in range of motion with impairment affecting upper and lower extremities on one side. He used a wheelchair for mobility. He required partial to substantial assistance performing most ADLs. The MDS indicated Resident #1 was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS indicated Resident #1 received scheduled pain medication for frequent pain. The MDS indicated he had a history of falls prior to admission. The MDS indicated he had a risk of pressure ulcers. The MDS indicated he received antidepressant (treats depression (persistent sadness), diuretic (reduces excessive fluid in the body), opioid (narcotic-used to manage severe pain), antiplatelet (used to treat heart disease with common risk of bleeding), and anticonvulsant (used to treat seizures, nerve pain, and mood disorders) medications. The MDS was signed as completed on 1/29/26.Record review of Resident #1's undated Care Plan with an admission date of 1/18/26 revealed he only had problem areas related to risk for impaired skin integrity wound and a problem area of the resident had an actual fall. Resident #1's care plan did not include problem areas and interventions related to allergies, discharge plans, code status, cognitive status, incontinence status, activities, pain management, diet, ADL assistance required, risk for falls, risk for pressure ulcers, risk for bleeding and preferences. The care plan did not include problem areas and interventions for disease processes of hypertension, hemiplegia and hemiparesis following cerebral infarction, nutritional deficiency, heart disease, or polyneuropathy. The care plan did not include problem areas and interventions for antianxiety, opioid, antiplatelet, anticonvulsant, diuretics and antidepressant (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications.During an observation and interview on 2/21/26 at 4:15 PM, Resident #1 was sitting up in his wheelchair. Resident #1 said he was not able to use his right arm or leg. Resident #1 said he had been a very independent and active man until his recent stroke. Resident #1 said he was continent of urine, but he did need assistance of someone to hold his urinal because he could not navigate getting his pants down far enough, pull his penis out, and hold the urinal all with one hand. He said he did not want to ask for assistance, but he did not want to piss on himself either. Resident #1 said he was mad about his current health situation and his whole life had changed, and he did not feel the facility realized that.2. Record review of Resident #2's face sheet dated 2/20/26 indicated he was [AGE] years old and admitted to the facility on [DATE] initially and re-admitted on [DATE]. Resident #2 had diagnoses including cerebral infarction, dysphagia (difficulty swallowing), cerebrovascular disease, chronic kidney disease, blindness right eye, vascular dementia (progressive decline in thinking skills caused by reduced flood flow to the brain), malignant neoplasm of the brain (mass that invades the surrounding brain tissue), unspecified symptoms and signs involving cognitive functions following cerebral infarction, repeated falls, depression and hypertension.Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated he had been admitted from a short-term hospital. The MDS indicated he had a BIMS score of 7, which indicated he had severe cognitive impairment. The MDS indicated Resident #2 used a wheelchair for mobility. The MDS indicated Resident #2 was dependent on staff assistance for all ADLs, including eating. The MDS indicated Resident #2 was always incontinent of bowel and bladder.Record review of Resident #2's undated Care Plan with an admission date of 12/27/25 revealed the resident had an ADL self-care performance deficit related to confusion and impaired balance. The ADL intervention related eating stated the resident was able to feed himself with meal and tray set-up with a revision date of 8/20/25. The ADL care plan was not updated to show the resident was dependent on staff for eating.Record review of Resident #2's Order Summary Report dated 2/21/26 revealed an order for may have health shake if resident consumes less than 50 % of meal as needed. Encourage intake of health shake if less that 50 percent of any meal consumed and notify nurse with a start date of 5/08/24.Record review of Resident #2's Nursing Medication Administration Record dated 2/1/26-2/28/26 revealed an order for may have health shake if resident consumes less than 50 % of meal as needed. Encourage intake of health shake if less that 50 percent of any meal consumed and notify nurse. There was no documentation the resident received a health shake during the time period.Record review of Resident #2's Nutrition-Amount Eaten documentation revealed he consumed on:2/2/26-0-25% for one mealRefused one meal2/3/26-0-25% for one meal26-50% for 2 meals2/4/26-0-25% for one meal26-50% for 2 meals2/6/26-0-25% for two meals2/7/26-0-25% for one mealRefused one meal2/8/26-0-25% for two mealsNo documentation for 3rd meal2/9/26-0-25% for one mealNo documentation for two meals2/10/26-0-25% for one meal26-50% for one mealRefused one meal2/11/26-26-50% for one meal2/12/26Refused two meals2/13/26-0-25% for one meal26-50% for one meal2/14/26-Refused two meals2/15/26-0-25% for two mealsRefused one meals2/16/26-0-25% for one meal26-50% for one mealRefused one mealRecord review of Resident #2's weights indicated he weighed 158.6 pounds on 12/29/25 after discharging from the hospital on [DATE] and weighed 160.6 pounds on his last documented weight on 2/09/26.Record review of Resident #2's Nutritional Risk assessment dated [DATE] indicated his most recent weight was 160.6, he had a BMI of 22 (normal was 19-24.9), no weight changes were noted, his intake varied, and to continue current nutrition plan.Record review of Resident #2's nurses' notes from 2/1/26 through 2/16/26 did not indicate he had been offered or refused health shakes.During an interview on 2/21/26 at 4:26 PM, LVN B said she had worked at the facility for twelve years and had provided care for Resident #2. LVN B said the purpose of the comprehensive care plan was to let them know (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	how to take care of the resident and what they needed. LVN B said if the care plan was not complete, the resident may not get the care or services they needed. She said if a resident had an order for a health shake if he consumed less than 50% of his meal, then they should have followed the physician's orders.During an interview on 2/21/26 at 5:22 PM, LVN C said she had worked at the facility for eleven years. LVN C said Resident #2 had a brain tumor and had a huge decline and even declined further after his last hospitalization in December 2025. LVN C said the comprehensive care plan purpose was to better take care of the resident. LVN C said it would have fall mats, if meds should be crushed, diet, anything that would be special for that person, disease processes, medications, ADL care, etc. LVN C said if the comprehensive care plan was not complete or inaccurate, then they may not know what care the resident needed and the resident could potentially not receive needed care/services. She said they should follow the physician's orders.During an interview on 2/21/26 at 6:15 PM, MDS Coordinator A said she had worked at the facility since August of 2025. She said the Comprehensive Care Plan was the responsibility of herself and another MDS Coordinator. She said the Comprehensive Care Plan should include areas related to code status, diet, allergies, assistance needed, skin, bowel and bladder, medications, risk of falls, risk of pressure ulcers, and health conditions. She said the purpose of the care plan was to communicate to all staff the needs of the resident. She said they had twenty-one days from admission to complete the comprehensive care plan. She said Resident #1's comprehensive care plan was not completed within the twenty-one days if he admitted on [DATE]. She said over the past week, she had been working the floor and may have missed Resident #1's comprehensive care plan, but it should have been completed within twenty-one days of admission. She said the comprehensive care should be a reflection of the comprehensive assessment and if Resident #2's comprehensive assessment stated he was dependent on staff assistance with meals, the comprehensive care plan should have also indicated he was dependent on staff for meals. She said if the Comprehensive Care Plan was not completed or was inaccurate, everyone may not know what was going on with the resident.During an interview on 2/22/26 at 1:49 PM, MD E said he had been Resident #2's physician for over twenty years and was also seeing him in the hospital. MD E said he did not remember being told Resident #2 was not eating well. MD E said Resident #2 had a history of significant weight loss and he had put medications in place and added health shakes. MD E said he would have expected his orders to have been followed for Resident #2 to have a health shake for eating less than 50% of his meals to prevent weight loss.During an interview on 2/22/26 at 2:41 PM, the DON said the MDS Coordinators were responsible for the comprehensive care plan but the IDT as a whole helped with updating and making changes. The DON said the MDS coordinators would be the ones to update the care plan at the time they were talking about it. The DON said the Comprehensive Care Plan told you how to take care of the patient overall and let you know of any changes. The DON said the Comprehensive Care Plan should include mobility, diet, code status, ADLs, incontinent status, fall risk, medications, disease processes, basically everything about the resident. The DON said if the Comprehensive Care Plan was not completed or inaccurate, you could miss on how to take care of the resident, or the resident could potentially not receive care/services they needed. The DON said the Comprehensive Care Plan should be followed. The DON said Resident #1 definitely should have had more than two problem areas. The DON said Resident #2 could not feed himself at all. The DON said if the staff did not know he needed assistance it could have potentially affected Resident #2, but the staff knew he needed assistance with meals. The DON said physician orders should be followed because it was a physician order and they should follow physician orders. The DON said a health shake would be important for the resident's nutrition. The DON said good nutrition was important for skin integrity and overall health.During an (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 2/22/26 at 3:08 PM, the ADM said she had been the ADM for about two and a half weeks. The ADM said the Comprehensive Care Plan was how they cared for the resident. The ADM said the Comprehensive Care Plan should include diet, transfers, ADLs, behaviors, everything they needed to know to care for the resident the right way. The ADM said the Comprehensive Care Plan should be followed. The ADM said the risk to the resident if the Comprehensive Care Plan was not completed or was inaccurate could cause them to not meet the residents' needs and could throw off their care and it was important. The ADM said Resident #1 definitely should have had more than two problem areas. The ADM said Resident #2's Comprehensive Care Plan should have been updated to him being dependent on staff for meals. The ADM said she would expect the physician orders to be followed. The ADM said Resident #2 not receiving his health shakes when he consumed less than 50% of his meals, could have caused him to have unplanned weight loss and affected the healing process and skin integrity. The ADM said she would expect the facility policies to be followed.Record review of the facility's policy dated March 2022 and titled Care Plans, Comprehensive Person-Centered, indicated . A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . 2. The comprehensive, person-centered care plan was developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission . 3. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 4. Each resident's comprehensive person-centered care plan was consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: . g. receive the services and/or items included in the plan of care . 7. The comprehensive, person-centered care plan: a. included measurable objectives and timeframes; b. described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . e. reflected currently recognized standards of practice for problem areas and conditions . 11. Assessments of residents were ongoing, and care plans were revised as information about the residents and the resident's conditions change . 12. The interdisciplinary team reviews and updates the care plan . c. when the resident has been readmitted to the facility from a hospital stay .