STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675320	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bradburn	520 Bradburn Rd Grand Saline, TX 75140

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 2 of 7 (Resident #1 and Resident #2) residents reviewed for quality of care. The facility failed to ensure Resident #1's wound care orders were implemented on 9/4/25 Wound Care NP's orders. The facility failed to ensure Resident #1 and Resident #2 received proper wound care to prevent deterioration and infection to their surgical wounds. The facility failed to ensure Resident #2's wound care orders were implemented on 9/11/25 and changed on 9/18/25 per the Wound Care NP's orders. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 2:20 p.m. on 9/24/25. While the IJ was removed on 9/25/25, the facility remained out of compliance with a scope identified as patterned and a severity level of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could result in residents with surgical wounds of not having their treatments performed as ordered, wounds becoming infected wounds, and decreased wound healing.Findings Included: 1. Record review of the face sheet dated 9/23/25 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including orthopedic aftercare following surgical amputation (surgical procedure where a body part, such as a limb, finger, or toe is removed), right below the knee amputation, diabetes, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 15 and was cognitively intact. The MDS indicated Resident #1 had a surgical wound. Record review of the care plan initiated on 9/16/25 indicated Resident #1 had a recent right below the knee amputation and was at risk for phantom pain (a painful perception an individual experiences relating to a limb or organ that is not physically part of their body), increase in disturbed self-image, increase in depression, and increase in need for assistance with ADLs. The care plan indicated Resident #1 had interventions in place including wound care/dressing changed to be performed to the stump/amputation area per physician orders. Record review of the physician orders which include active, completed, and discontinued order dated 9/23/25 indicated Resident #1 had an order to cleanse the wound on the amputated right knee with wound cleanser, cover with xeroform (a petroleum-based gauze), and cover with dry dressing starting 9/22/25. The physician orders did not indicate Resident #1 had any other wound care orders prior to 9/22/25. The physician orders indicated Resident #1 had an order for Cleocin ((Clindamycin) an antibiotic to treat infection) 150mg 2 capsules 3 times a day related to acquired absence of right leg below the knee. Record review of the TAR dated 9/2025 indicated Resident #1 had not received any wound care in the month of September 2025. The TAR indicated on 9/22/25 Resident #1 did not receive wound care due to being hospitalized . Record review of the Wound Care NP's progress note dated 9/4/25 indicated Resident #1's right leg amputation site had a 100% epithelial ((a wound in final stages of healing) with serosanguineous (a thin, watery discharge that is a mixture of pale yellow, clear liquid and blood) drainage. The progress not indicated Resident #1 had an order to cleanse the surgical site with wound cleanser, apply xeroform, and cover with dry dressing 3 times a week and as needed. Record review of a picture dated 9/4/25 indicated Resident #1's surgical amputation site was well approximated with minor bruising. Record review of the Wound Care NP's progress note dated 9/11/25 indicated Resident #1's right leg amputation site had a 100% epithelial ((a wound in final stages of healing) with serosanguineous (a thin, watery discharge that is a mixture of pale yellow, clear liquid and blood) drainage. The progress not indicated Resident #1 had an order to cleanse the surgical site with wound cleanser, apply xeroform, and cover with dry dressing every other day and as needed. Record review of a picture dated 9/11/25 indicated Resident #1's surgical wound site was well approximated with redness up the leg from the site to the knee. Record review of the Wound Care NP's progress note dated 9/18/25 indicated Resident #1's right leg amputation site had a 100% epithelial ((a wound in final stages of healing) with serosanguineous (a thin, watery discharge that is a mixture of pale yellow, clear liquid and blood) drainage. The progress not indicated Resident #1 had an order to cleanse the surgical site with wound cleanser, apply xeroform, and cover with dry dressing every other day and as needed. Record review of a picture dated 9/18/25 indicated Resident #1's surgical wound site was well approximated with eschar (thick, black, adherent crust of dead tissue) in several different areas near the surgical incision. Record review of the

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering and receipt of all drugs and biologicals, to meet the needs of 1 of 9 (Resident #1) residents reviewed for pharmacy services. The facility failed to ensure Resident #1's antibiotic (Cleocin) was started on 9/19/25 when ordered from the Vascular Surgery NP instead waiting 2 days until 9/21/25 to initiate the antibiotic. The facility failed to ensure the nurses had access to the Pyxis (a machine used to safely and efficiently dispense medications) to obtain available medication such as antibiotics while waiting for pharmacy to deliver medications. The facility failed to ensure Resident #1's antibiotic was initial dosed when delivered from the pharmacy on 9/20/25 instead initiating the antibiotic on 9/21/25 and Resident #1 required hospitalization due to infection on 9/22/25. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 2:20 p.m. on 9/24/25. While the IJ was removed on 9/25/25, the facility remained out of compliance with a scope identified as isolated and a severity level of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents with an order for an antibiotic at risk for spread of infection leading to hospitalization, need for intravenous antibiotics, or sepsis (a life-threatening complication of infection). Findings Include:1. Record review of the face sheet dated 9/23/25 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including orthopedic aftercare following surgical amputation (surgical procedure where a body part, such as a limb, finger, or toe is removed), right below the knee amputation, diabetes, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 15 and was cognitively intact. The MDS indicated Resident #1 had a surgical wound. Record review of the care plan initiated on 9/16/25 indicated Resident #1 had a recent right below the knee amputation and was at risk for phantom pain (a painful perception an individual experiences relating to a limb or organ that is not physically part of their body), increase in disturbed self-image, increase in depression, and increase in need for assistance with ADLs. The care plan indicated Resident #1 had interventions in place including wound care/dressing changed to be performed to the stump/amputation area per physician orders. Record review of the physician orders which include active, completed, and discontinued order dated 9/23/25 indicated Resident #1 had an order for Cleocin ((Clindamycin) an antibiotic to treat infection) 150mg 2 capsules 3 times a day related to acquired absence of right leg below the knee. Record review of the MAR dated September 2025 indicated Resident #1 did not receive his Cleocin 300mg on 9/20/25 at 8:00 a.m. or 12:00 p. m. due to medication not being available. The MAR indicated Resident #1 received his Cleocin 300mg on 9/20/25 at 4:00 p.m. The MAR indicated Resident #1 did not received his Cleocin 300mg on 9/21/25 at 8:00 a.m. or 12:00 p.m. due to medication not being available. The MAR indicated Resident #1 received his Cleocin 300mg on 9/21/25 at 4:00 p.m. Record review of the Pyxis Inventory Sheet dated 5/5/25 indicated the Pyxis had Clindamycin 150mg capsules with 20 capsules available for dispensing. Record review of the Pharmacy Packing slip dated 9/19/25 and signed by unknown facility staff on 9/20/25 indicated Resident #1's Clindamycin 150mg capsules had been delivered to the facility. Record review of the Nursing Progress Note dated 9/19/25 at 4:08 p.m. written by LVN A indicated, [Resident #1] returned from the doctor's office with new orders. Cleocin 300mg by mouth three times a day for 10 days. Record review of the Administration Progress Note dated 9/20/25 at 7:07 a.m. written by MA D indicated the facility was waiting on Resident #1's Cleocin 150mg to be delivered from the pharmacy. Record review of the Administration Progress Note dated 9/20/25 at 11:38 a.m. written by MA D indicated the facility was waiting on Resident #1's Cleocin 150mg to be delivered from the pharmacy. Record review of the Administration Progress Note dated 9/21/25 at 7:25 a. m. written by MA D indicated the facility was waiting on Resident #1's Cleocin 150mg to be delivered from the pharmacy. Record review of the Administration Progress Note dated 9/21/25 at 11:48 a.m. written by MA D indicated the facility was waiting on Resident #1's Cleocin 150mg to be delivered from the pharmacy. Record review of the Administration Progress Note dated 9/21/25 at 2:15 p.m. written by LVN indicated Resident #1's Cleocin was initial dosed per orders. During an interview on 9/23/25 at 12:35 p.m. the DON said she could not say why Resident #1's Clindamycin was not started for 2 days when it was available in the Pyxis. The DON said the importance of ensuring antibiotics and other medications were started timely