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	11/24/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that residents were free of significant medication errors for 1 of 2 residents (Residents #1) reviewed for pharmacy. The facility failed to ensure oral antibiotic medication was administered to Resident #1 as ordered, resulting in a medication error. As a result of incorrect medication entry, Resident #1 did not receive 6- days of prescribed oral antibiotic, specifically, (Sulfamethoxazole-Trimethoprim oral table 400-80 MG Bactrim), as ordered following hospitalization for sepsis and ureteral stent placement. This failure does not ensure that residents receive necessary treatment to prevent potential decline or worsening of infection. Findings included: A review of Resident #1's face sheet dated 11/20/2024 revealed he was a [AGE] year-old male initially admitted on [DATE] diagnoses of cerebrovascular disease (conditions affecting the blood vessels in the brain), cystostomy (surgery of the bladder to remove bladder stones, clots, tumors, or other obstruction), cystitis with hematuria, mixed incontinence, urinary stents, calculus of kidney, retention of urine, vascular dementia, anxiety, muscle weakness and difficulty in walking. A review of Resident #1's, quarterly MDS section C dated 10/1/2025, revealed a BIMS score of 14 dated 10/02/2025, which indicated he was cognitively intact. A review of Resident #1's medical records revealed that the resident was admitted to the hospital on [DATE] and discharged back to the facility on [DATE] following treatment for sepsis and the placement of a urethral stent. A review of Resident #1's nurse's re-admission notes dated 09/25/2025 at 7:20 P.M., revealed a clarification of the medication order for Sulfamethoxazole-Trimethoprim oral tablet 400-80 MG, by mouth, twice daily for seven days. The HS (bedtime) dose was administered at the hospital prior to discharge. A Review of Resident #1's physician orders dated 09/25/2025, revealed that the physician order was incorrectly transcribed by LPN A, entering a start date of 10/09/2025 and an end date of 10/02/2025. A review of Resident #1's nurse's notes dated 09/26/2025 during the early morning hours revealed that the resident was sent back to the hospital for replacement of a urinary catheter by a Urologist. The review further indicated that the catheter had not been replaced during the initial emergency room visit. A review of Resident #1's nurse's readmission notes dated 09/26/2025 02:00AM revealed that under Special Care it was documented that the resident was currently on antibiotics, listed as Sulfamethoxazole-Trimethoprim oral tablet 400-80 MG, Bid X7 days. The notes further indicated that the urinary catheter was intact and that the urine appeared clear and yellow in color, with no urinary complaints reported. A further review of the provider's order dated 10/2/2025 revealed: Related diagnosis associated with the antibiotic order: sepsis unspecified organism, urinary retention, and urinary stent placement. A new order for Sulfamethoxazole-Trimethoprim oral tablet 400-80 MG, Bid X 7 days for treatment of sepsis, with a start date of 10/2/205 and an end date 10/9/2025. Documentation indicated that the oral antibiotic was not administered between 09/26/2025 and 10/01/2025. A review of Resident #1's Medication Administration Record (MAR) showed that the antibiotic was scheduled to begin at 9:00PM on 10/02/2025. The Director of Nursing (DON) verified that the staff nurse, LVN A entered an incorrect medication start date, which resulted in a delay in treatment. A review of the facility progress notes assessment dated from 09/26/2025 to 11/20/2025, revealed documentation of no fever, no pain discomfort related to foley, and urine color noted clear since readmission to facility on 09/26/2025. A review of the Hospice Nurse visit documentation on 09/29/25 indicated Indwelling Catheter Assessment: No problems noted or verbalized. Drainage system: Bedside drainage, date last changed 09/26/2025, urine characteristics clear /yellow, odor slight. Clinical Findings: Genitourinary No problems noted or verbalized. On 11/20/2025 at 9:30A.M., observed and interviewed Resident # 1 was in his room seated in a wheelchair watching, the resident is interview able, alert and oriented. Resident # 1 was fully dressed, clean and well groomed, bed in low position, water at bedside, call light was in reach. Resident #1 denied abuse or neglect and said he still had his foley but currently there were no issues with his foley. On 11/20/2025 at 2:00P.M., an interview with the DON revealed that the intent of the provider's order was for the resident to begin the next dose of Sulfamethoxazole-Trimethoprim Bactrim orally upon return to the facility on [DATE]. The DON confirmed that the resident should had started the antibiotic immediately after re-admission from the hospital. The DON further stated, she was unsure of how the medication error was discovered, she revealed she was not the DON at the time of discovery. The DON said she was contacted by the VA case manager for clarification as to why the doctor re-ordered the Bactrim to re-start on 10/2/2025. The DON stated the staff nurse entered the wrong date and the veteran (Resident did not start the antibiotic). The DON stated the