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	05/21/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident and/or representative had the right to participate in the development and implementation of his or her person-centered care plan for 1 of 6 residents (Resident #1) reviewed for the right to participate in planning care. The facility failed to ensure Resident #1 and Resident #1's representatives were included in the development and implementation of Resident #1's baseline, comprehensive, and discharge care plans. This failure could place residents at risk of not receiving adequate and individualized care while a resident of the facility and after discharge from the facility. Findings included: A record review of Resident #1's face sheet dated 05/21/2026 indicated he was a [AGE] year-old male who admitted to the facility 04/01/2026. He had diagnoses which included sepsis with septic shock (body's extreme, life threatening response to an infection characterized by dangerously low blood pressure and potential organ failure - considered a medical emergency), diabetes, atrial fibrillation (an irregular heart rhythm where the heart's upper chambers beat rapidly and out of sync with the lower chambers), and bacterial pneumonia (a serious lung infection that causes the air sacs in one or both lungs to fill with fluid or pus). Further review of the face sheet indicated Resident #1's spouse was the responsible party and first contact. Resident #1's son was listed as the second contact and the Resident's 2 (two daughters) were also listed as contacts. Resident #1 discharged from the facility on 04/16/2026. A record review of an admission MDS dated [DATE] indicated Resident #1 had a BIMS score of 13 which indicated his cognition was intact. He was able to feed himself, mobile via wheelchair, and was frequently incontinent of urine. A record review of Resident #1's physician's orders dated 04/14/2026 reflected the following orders:1.Consult with wound care provider for skin and wound conditions/prevention dated 04/01/26.2.Pressure reducing mattress to bed dated 04/01/2026.3.Resident to have heels offloaded while in bed every shift for DTI bilateral heels dated 04/09/2026.4.Cleanse bilateral heels daily and as needed with wound cleanser, apply betadine to heels, leave open to air and monitor for signs/symptoms of breakdown dated and offload heels with boots dated 04/14/2026. A record review of Resident #1's baseline care plan dated 04/01/2026 indicated his preference for notification of updates to the care plan was during normal care plan meetings. The signature page which included sections for the signature of Resident #1, his representatives, and the person completing the care plan were blank. A record review of Resident #1's comprehensive care plan (initiated on 04/08/2026) indicated concerns which included a full code status, visual impairment, DTI of the bilateral heels (a form of pressure ulcer on both heels), risk for infection, risk for impaired skin integrity, physical mobility weakness, and diabetes. The care plan included interventions to address these concerns. The signature page was blank. There was no documentation to indicate the comprehensive care plan had been reviewed with Resident #1 or his representative. A record review of Resident #1's discharge plan dated 04/14/2026 indicated it had not been signed by Resident #1 nor the representatives. During an interview on 05/20/2026 at 12:18 PM with one of Resident #1's representatives, Representative A, she said she requested a care plan meeting and a discharge care plan meeting a few days before he was discharged but was never (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified of one. During an interview with the DON on 05/21/2026 at 10:01 AM, she said Resident #1 was discharged from the facility 2 days after she began working at the facility and was not aware there had been no care plan meetings with Resident #1 and his representatives. She said the SW handled the scheduling of care plan meetings. During an interview with the SW on 04/21/2026 at 10:12 AM, she said she scheduled the quarterly and comprehensive care plan meetings. She said Resident #1 discharged home before she could schedule a comprehensive care plan meeting with Resident #1 and his representatives. She said the nursing staff handled the baseline and discharge care plans. During an interview with the DON on 05/21/2026 at 10:28 AM, she said the nurses should complete and print the baseline and discharge care plans, review them with the Resident and/or representative, and have the Resident and/or representative sign them. She said after the care plans were signed, the nurse should give the resident and/or representative a copy and scan the original into the computer system. The DON said the care plans were important for ensuring the residents' needs were adequately and consistently met. She said the inclusion of the resident and/or representatives helped to ensure the care plans were individualized and communicated to promote the highest level of well-being possible. Record review of the facility's policy entitled Resident Rights and dated October 2022 indicated the following: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:p.be informed of, and participate in, his or her care planning and treatment.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the results of an investigation in accordance with State law, including to the State Survey agency, within 5 working days of the incident for 1 of 4 incidents reviewed for reporting. The facility failed to provide the State Survey Agency with a report of the results of an investigation of an allegation of abuse within 5 working days of the incident. The facility reported an allegation of abuse regarding Resident #2 on 05/06/2026. This failure could place residents at risk for abuse if alleged violations are verified and appropriate corrective actions are not taken. Findings included: A record review of a face sheet dated 05/21/2026 indicated Resident #2 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included lupus erythematosus (chronic, inflammatory disease where the body's immune system mistakenly attacks healthy cells and tissues), bipolar disorder, anxiety, factitious disorder imposed on another (a severe form of abuse in which a caregiver fabricates, exaggerates, or induces illness in a dependent), diabetes, chronic kidney disease, and pneumonia. A record review of an annual MDS dated [DATE] indicated Resident #2 had a BIMS score of 15 indicating her cognition to be intact. A record review of progress notes dated 05/06/2026 indicated Resident #2 was sent to the hospital ER where she was diagnosed with pneumonia and returned to the facility with orders for antibiotic therapy. A review of a facility reported incident dated 05/06/2026 indicated the DON received a call from the hospital case manager who said that that while at the hospital ER, Resident #2 said the facility's Administrator used racial slurs including the N word. Upon receiving the allegation of verbal abuse, the Administrator was suspended and sent home, and the Regional Nurse Consultant reported the incident to the appropriate state agency. A review of the facility's investigation dated 05/06/2026 indicated the allegation of verbal abuse was investigated by the DON and the Regional Nurse Consultant. The allegation of verbal abuse was unsubstantiated, and the Administrator was allowed to return to work. A record review, completed on 05/20/2026 at 11:15 AM, of the TULIP (Texas Unified Licensure Information Portal, an online system for submitting long-term licensure applications for all provider types regulated by long-term regulatory agencies) system revealed that no provider Investigation Report (Form 3613-A) had been filed in the system. The facility filed the facility reported incident and CII Self-Report Template on 05/06/2026. During an interview on 05/20/2026 at 11:20 AM, the Administrator said she did not submit a report for the findings of the allegation because she was the alleged perpetrator and was not a part of the investigation. An attempt to interview the Regional Nurse Consultant by phone was unsuccessful during the investigation. A record review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating and dated September 2022 indicated the following: Policy StatementAll reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Investigating Allegations: 7. All allegations are thoroughly investigated. The administrator initiates investigations. 8. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. Follow-Up Report1.Within five (5) business days of the incident, the administrator will provide a follow-up investigation report.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 2 medication carts (Nurses cart) reviewed for pharmacy services. The facility failed to ensure the nursing staff responsible for the safekeeping of narcotics performed and documented change of shift narcotic counts. This failure could place residents at risk for loss of medications and possible drug diversion. Findings included: A record review of a face sheet dated 05/21/2026 indicated Resident #3 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included spinal stenosis (the narrowing of the spaces within the spine which puts pressure on the spinal cord and nerves), chronic neck and back pain, lumbar radiculopathy (irritation or compression of a nerve root in the lower back causing pain, tingling, and weakness that radiates down the buttock and leg), cervical radiculopathy (compressed nerve root in the neck causing pain in the neck), left shoulder pain, chronic neck and back pain, and post spinal cord surgery. A record review of an admission MDS dated [DATE] noted Resident #3 had a BIMS score of 12 which indicated he had moderately impaired cognition. He was able to feed himself, ambulate short distances, used a wheelchair, and was continent of bowel and bladder. A review of Resident #3's physician's orders dated 05/21/2026 indicated he had an order dated 04/30/2026 for Hydrocodone-Acetaminophen 10-325 mg: 1 tablet every 6 hours as needed for chest pain related to spinal stenosis. A review of an undated Controlled Medication Administration Record indicated that on 05/06/2026 the facility received a bottle of 29 Hydrocodone 10-325mg tablets from Resident #3's home. Resident #3 was given 1 (one) Hydrocodone tablet on 05/07/2026 and 1 (one) tablet on 05/08/2026. A review of a pharmacy packing slip dated 05/03/2026 indicated a card of 25 Hydrocodone-Acetaminophen 10-325mg tablets was delivered to the facility and signed for by RN-A on 05/03/2026 at 07:28 PM. During an observation and interview on 05/20/2026 at 11:30 AM, LVN-D was noted standing at the Nurses Cart located in the medication room. LVN-D said the Nurses Cart contained narcotics for PRN use. LVN-D said the on-coming and off-going nurses were supposed to count the narcotics at every change of shift. She said it was important to count narcotics every time the keys to the cart were passed from one person to another to reduce the risk of missing, lost, or unaccounted for narcotics. A review of the Nurse Cart's Narcotic Release and Acceptance of Narcotic Inventory sheet dated May 2026 revealed there were 4 (four) missing signature entries on the following dates:1)May 10, 2026 - No signature of the 6 AM nurse to indicate she performed a narcotic count at the end of her shift with the nurse coming on duty at 6 PM.2) May 14, 2026 - No signature of the 6 AM nurse to indicate she performed a narcotic count at the beginning of her shift with the nurse going off duty at 6 AM.3) May 19, 2026 - No signature of the 6 AM nurse to indicate she performed a narcotic count at the beginning of her shift with the nurse going off duty at 6 AM4) May 19, 2026 - No signature of the 6AM nurse to indicate she performed a narcotic count with the nurse coming on duty at 6PM LVN-D said a card of 25 (twenty-five) hydrocodone tablets came up missing while she was off from work earlier in the month May 2026. She said the May 2026 Narcotic Inventory sheets had several blank signature spots on it which made it look like change of shift counts had not been done. LVN-D said the nurses were in-serviced on performing narcotic counts at change of shift and signing the Nurse release and Acceptance of Narcotic Inventory. During an interview on 05/21/2026 at 09:20 AM, LVN-B said she relieved RN-A on the morning of 05/04/2026 and the 2 (two) of them counted the narcotics. She said she noted Resident #3's new card of 25 Hydrocodone and wrote Use Bottle First on the corresponding Narcotic Count sheet of the card. LVN-B said the card of Hydrocodone and the corresponding count sheet were in the cart when she counted narcotics with the night nurse the next morning (May 5, 2026) when she came to work and the card of Hydrocodone was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there when she counted with LVN-C that evening at the end of her shift. LVN-B said she was off and did not work on May 6 and May 7, 2026. LVN-B said she returned to work on the morning of May 8, 2026 and noted the card of Hydrocodone 10-325mg tablets and the corresponding count sheet were missing when she counted the narcotics with the night nurse, RN-A. She said she noted it was missing because she remembered writing Use Bottle First on the count sheet. She said she searched the Nurses' cart, the Medication Aides' cart and the medication room and when she did not locate the narcotic, she notified the DON. LVN-B said the 4 (four) missing signature entries after the date of the in-service on May 2026 Nurse Release and Acceptance of Narcotic Inventory sheet were hers. She said she performed the change of shift narcotic counts but forgot to sign the sheet. LVN-B said the task of performing change of shift narcotic counts was important for safeguarding the narcotics and reducing the risk for missing or unaccounted for narcotics. During an interview on 05/21/2026 at 10:20 AM, RN-A said she received a card of 25 Hydrocodone-Acetaminophen 10-325mg for Resident #3 on the evening of 05/03/2025. She said the card of Hydrocodone was there the next morning (May 4, 2026) when she counted with the morning nurse, LVN-B. RN-A said she was off 2 (two) nights and returned to work the evening of May 7, 2026. She said she relieved LVN-D. She said she and LVN-D did not perform a change of shift narcotic count. RN-A said she did not have a reason for not performing a change of shift count. She said she should have counted the narcotics with the off-going nurse. RN-A said that failing to perform the change of shift narcotic count with the LVN-D meant she could not prove what was or was not on the cart when she took possession of it. RN-A said she and LVN-B performed a change of shift narcotic count the next morning when LVN-B came into work. RN-A said LVN-B asked about the card of Hydrocodone tablets belonging to Resident #3. She said LVN-B said she remembered the card of Hydrocodone because she had written a note on the count sheet to remind everyone to use the bottle of tablets first. RN-A said she was upset with herself for not performing a narcotic count when she came to work the night before. RN-A said she and the other nurses had been in-serviced on performing change of shift narcotic counts and signing the Nurse Release and Acceptance of Narcotic Inventory sheet During an interview with Resident #3 on 06/20/2026 at 10:51AM, he said he was aware of the missing Hydrocodone tablets. He said he had not missed any doses of pain medication, and the nurses had promptly responded to his request for pain medication. Resident #3 said the facility replaced his missing tablets. During an interview on 05/21/2026 at 11:00 AM, the DON said she was made aware that a card of 25 Hydrocodone-Acetaminophen 10-325mg tablets and the corresponding Controlled Medication Administration Record were missing on 05/08/2026. She said a search for the drug was done but the drug was not found. She said she noted several missing signatures from 05/01/2026 through 05/07/2026 on the Nurse Release and Acceptance of Narcotic Inventory sheet. The DON said she made a copy of the sheet with the missing signatures but could not locate it. She said she audited all the carts and medication room and found no other discrepancies. When shown the May 2026 Nurse Release and Acceptance of Narcotic Inventory, the DON said the missing signatures from 05/01/2026 through 05/07/2026 had been filled in. The DON said she could not remember which signatures had been missing and were now filled in. She said she in-serviced the nurses on performing change of shift narcotic counts and signing the count sheet. The DON said she was responsible for ensuring the nurses performed and documented change of shift narcotic counts. When shown the 4 (four) missing signatures for the 05/10/2026 6PM off-going nurse, 05/15/2026 6AM on-coming nurse, and 05/19/2026 6PM on-coming and 6PM off-going nurses, the DON said the missing signatures implied the change of shift narcotic counts had not been done and the risk for loss of medications or drug diversion was still a concern. A review of an in-service training report dated 05/08/2026 indicated nursing staff were in-serviced on performing change of shift narcotic counts. A review of the facility's policy dated November 2022 and titled Controlled Substances indicated the following: Dispensing and Reconciling Controlled Substances1.Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	detection/follow-up.3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count.4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.