

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Bradburn		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 16 residents (Residents #6, #27 and #29) reviewed for accuracy of assessments. The facility did not accurately code section J1300 of Resident # 6's annual MDS for smoking. The facility coded Section A1500 of Resident #27's admission assessment with information that was not available at the time of the completion of the MDS. The facility failed to ensure Residents #29's MDS assessment was accurately coded for Preadmission Screening and Resident Review (PASRR). These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: 1. Record review of Resident #6's face sheet dated 07/15/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (also known as COPD and refers to a progressive, incurable lung disease that causes restricted air flow and severe breathing difficulties). Record review of an annual MDS assessment dated [DATE] reflected Resident #6 had a BIMS score of 15 indicating his cognition was intact. The same MDS also indicated Resident #6 did not use tobacco. Record review of a list provided by the facility of residents who smoked identified Resident #6 as one of the residents who smoked. Record review of a Baseline Care Plan: Section H: Safety Risks dated 06/30/2025 indicated Resident #6 smoked with supervision. During observations of residents smoking on 07/14/2026 and 07/15/2026 at 01:00 PM, Resident #6 was observed to not be present. During an interview on 07/15/2026 at 01:15 PM, Resident #6 said he smoked sometimes but not very often. He said if he wanted to smoke, he would go outside with the other residents who smoked. During an interview on 07/15/2026 at 01:30 PM, LVN-A said Resident #6 smoked occasionally. 2. Record review of Resident #27's face sheet dated 07/15/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included bipolar disorder(a mental (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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health condition characterized by mood swings from extreme to another) and schizophrenia(a chronic, severe brain disorder characterized by an inability to distinguish between reality and imagination). Record review of Section A1500: Preadmission Screening and Resident Review (PASRR) of the admission MDS assessment dated [DATE] indicated Resident #27 was considered by the state level II PASRR process to not have serious mental illness and/or intellectual disability or a related condition. Record review of a PASRR Level I Screening was noted to have not been completed until 01/14/2026. The PASRR Level II Screening was noted to have not been completed until 02/18/2026. The dates of these PASRR Screenings indicated the information on the admission MDS assessment regarding PASRR Screenings was incorrectly documented since the information on the MDS was not available until after the MDS was completed. During an interview on 07/14/2026 at 01:45 PM with the DON, she said the MDS nurse was responsible for completing accurate MDS assessments and the PASRR process. She said the facility did not have an in-house MDS nurse and MDS nurses from sister facilities had been helping with the completion of MDS assessments and PASRR process. She said Resident #6 should have been coded for tobacco use. She said Resident #27's coding of PASRR Screenings was inaccurate since no PASRR Screenings had been done. The DON said she was ultimately responsible for the accuracy of the MDS assessments. The DON said she could not say why Resident #6's and Resident #27's MDS assessments were inaccurately coded because she was not employed at the facility at the time of those MDS assessments. The DON said accurate MDS assessments were important for care planning and reimbursement. During an interview on 07/14/2026 at 03:10 PM, the Regional Nurse Consultant said the MDS coding on Resident #6 and Resident #7's MDS assessments were an oversight that was most likely due to several people assisting with MDS assessments and the PASRR process. 3. Record review of Resident #29's face sheet for July 2026 indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #29 had diagnoses which included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety (intense, excessive, and persistent worry and fear about everyday situations), mood disorder (a mental health condition that primarily affects your persistent emotional state), and cerebral palsy (motor disability occurring in childhood with a group of lifelong neurological disorders). Record review of Resident #29's PASRR Level 1 screening completed 12/03/2025 indicated she did not have a primary diagnosis of dementia and was positive for mental illness and intellectual disabilities. Record review of Resident #29's PASRR Evaluation completed 01/06/2026 indicated she was positive for intellectual and developmental disabilities. Record review of Resident #29's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for 8 consecutive hours 7 days a week for 2 of 4 quarters of 2026 (Fiscal Year Quarter 2 January 1-March 1) (Fiscal Year Quarter 3 April 1 - June 1) reviewed for RN coverage. The facility did not have RN coverage for 8 consecutive hours on 01/03/2025, 01/04/2026, 01/24/2026, 01/25/2026, 02/07/2026, 02/08/2026, 02/14/2026, 02/15/2026, 03/07/2026, 03/08/2026, 03/15/2026, 03/21/2026, 03/22/2026, 04/04/2026, 04/05/2026, 04/25/2026, 05/02/2026, 05/03/2026, 05/17/2026, 05/31/2026, 06/13/2026, 06/14/2026, 06/21/2026, 06/27/2026, and 06/28/2026. This failure could place residents at risk of lack of nursing oversight and a higher level of care. Findings included: Record review of the CMS PBJ reports indicated Quarter 2 2026 (January 1-March 1) there were no consecutive 8 hours of RN coverage on 01/01/2026 (Thursday); 01/03/2026 (Saturday); 01/04/2026 (Sunday); 01/24/2026 (Saturday); 01/25/2026 (Sunday); 02/07/2026 (Saturday); 02/08/2026 (Sunday); 02/15/2026 (Sunday); 03/07/2026 (Saturday); 03/08/2026 (Sunday); 03/21/2026 (Saturday). Record review of the RN time sheets indicated Quarter 2 2026 (January 1 -March 1) there were no consecutive 8 hours of RN coverage on 01/03/2025 (Saturday), 01/04/2026 (Sunday), 01/24/2026 (Saturday), 01/25/2026 (Sunday), 02/07/2026 (Saturday), 02/08/2026 (Sunday), 02/14/2026 (Saturday), 02/15/2026 (Sunday), 03/07/2026 (Saturday), 03/08/2026 (Sunday), 03/15/2026 (Sunday), 03/21/2026 (Saturday), and 03/22/2026 (Sunday). Record review of the RN time sheets indicated Quarter 3 2026 (April 1 -June 1) there were no consecutive 8 hours of RN coverage on 04/04/2026 (Saturday), 04/05/2026 (Sunday), 04/25/2026 (Saturday), 05/02/2026 (Saturday), 05/03/2026 (Sunday), 05/17/2026 (Sunday), 05/31/2026 (Sunday), 06/13/2026 (Saturday), 06/14/2026 (Sunday), 06/21/2026 (Sunday), 06/27/2026 (Saturday), and 06/28/2026 (Sunday). During an interview on 07/13/2026 at 3:20 PM the DON said she had been at the facility since 04/15/2026. She said she had 1 RN working as a day shift charge nurse that occasionally worked some weekends. She said usually every other weekend but not always. She said she was in the process of hiring an RN weekend supervisor but the prospective employee had not completed her onboarding yet. She said some weekends RN D worked the day shifts (6AM-6PM) on the weekends and she had 8 consecutive hours of coverage on those weekends. She said some weekends RN D worked the night shift (6PM-6AM) and although she would have over the hours required they would not be consecutive hours. She said some weekends she had no RN coverage and she told the facility staff to call her if they needed her but she was not normally onsite on those weekends. She said it had been difficult to find anyone to work. She said she had interviewed 2 RNs and they both had agreed to hire on at the facility. She said one called back and declined the position and the other had not completed the onboarding. The DON said she would provide time sheet documentation for RN coverage for the months of January, February, March, April, May, June and July 2026. During an interview on 07/15/2026 at 9:30 AM the Regional Nurse Consultant said she was aware they did not have adequate RN coverage that fulfilled the 8 consecutive hours 7 days a week requirement for RN coverage but knew the DON was actively seeking RN applicants. During an interview on 07/15/2026 at 9:35 AM the Administrator said she had been at the facility for one week and was not aware they did not have adequate RN staffing coverage.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the resident or resident representative in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 1 of 5 residents (Resident #18) reviewed for resident rights. The facility did not obtain written consent for Resident #18's prescription of Ativan (a benzodiazepine medication used to treat anxiety disorders and insomnia) and ensure the responsible party was notified of the medication change. This failure could affect residents who receive psychotropic medications by placing them at risk of receiving medications without informed consent. The findings included: A record review of Resident #18's face sheet dated 07/15/2026 indicated a [AGE] year-old female admitted to the facility 06/17/2022. Resident #18 had diagnoses which included schizophrenia, unspecified (a mental health condition that can result in symptoms including hallucinations, delusions, and disorganized thinking), insomnia, unspecified (a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and not being able to return to sleep), and major depressive disorder, single episode, severe with psychotic features (a form of depression characterized by low mood, loss of interest, and psychotic symptoms such as delusions or hallucinations). A record review of Resident #18's most recent Quarterly MDS assessment dated [DATE] indicated a BIMS score of 5, which indicated severe cognitive impairment. The MDS indicated Resident #18 was taking an antianxiety medication. A record review of Resident #18's comprehensive care plan indicated on 05/06/2026 Resident #18 used anti-anxiety medications. The care plan indicated Resident #18 would be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions included administer anti-anxiety medications as ordered by the physician, monitor/document/report any adverse reactions to anti-anxiety therapy, and monitor/record occurrence for target behavior symptoms (pacing, wandering, disrobing, inappropriate responses to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. A review of Resident #18's medication orders indicated an order dated 05/06/2026 for Ativan 0.5 milligrams 1 tablet by mouth three times a day for anxiety. An interview was attempted with Resident #18 on 07/13/2026 at 10:41 AM and Resident #18 did not respond to questions asked. A record review of Resident #18's electronic medical record on 07/14/2026 at 2:00 PM did not indicate a psychoactive medication consent present for the prescription of Ativan. During an interview on 07/15/2026 at 9:18 AM, Resident #18's representative and medical power of attorney stated she thought staff had called her to discuss a medication to treat anxiety and agitation. During an interview on 07/15/2026 at 9:25 AM, the DON stated she could not find the medication consent for Resident #18's prescription of Ativan, but she would look for it as some consents were still needing to be scanned into the electronic medical records. The DON stated the ADON had been responsible for ensuring psychoactive medication consents were completed, but she had quit about a month ago. The DON stated since the ADON quit she became responsible for ensuring psychoactive medication consents were completed. During an interview on 07/15/2026 at 9:50 AM, the DON stated she could not find a psychoactive medication consent for Resident #18's prescription of Ativan. The DON stated the risk to residents for not having a completed psychoactive medication consent included that it was their right to give their approval to take any medication and know what it was meant to treat. During a record review on 07/15/2026 at 10:11 AM, there were no progress notes evident in Resident #18's electronic medical record that indicated Resident #18's responsible party was notified of Ativan being (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed. A record review of a progress note dated 05/07/2026 at 5:42 PM written by LVN A indicated a status post 1/3 Ativan 0.5 milligrams three times a day routinely. The progress note indicated Resident #18 had slept off/on most of the shift and had no behaviors nor anxiety noted. The progress note did not indicate if Resident #18's responsible party was notified of the new prescription of Ativan. During an interview on 07/15/2026 at 10:45 AM, LVN A stated she could not find documentation that she notified Resident #18's responsible party of the new prescription of Ativan. LVN A stated she usually did obtain consent from the resident or their responsible party for a new medication and felt like she had done so for Resident #18's prescription of Ativan, but she forgot to document it. LVN A stated the risk to Resident #18 was low as she was being monitored for any side effects, but stated it is their right to be notified of the risks and benefits of any new medication. During an interview on 07/15/2026 at 1:50 PM, the ADM stated when the doctor sent in a new order nursing staff was responsible for obtaining consent and the DON was responsible for overseeing that it was completed appropriately. The ADM stated Resident #18's psychoactive medication consent might have been missed due to the DON being new and she was still implementing new policies and procedures. The ADM stated the previous DON's office had many papers that had not been scanned into the medical record and the consent might have been completed but was misplaced. The ADM stated the risk of not having informed consent when starting a new psychoactive medication included the resident or family not being educated on the side effects or being able to consent to the medication with knowledge of the side effects. A record review of a facility policy, dated July 2022, titled Psychotropic Medication Use indicated the following: Policy Interpretation and Implementation1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications:a. Anti-psychotics;b. Anti-depressants;c. Anti-anxiety medications; and d. Hypnotics.3. Residents, families, and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying, and responding to adverse consequences.Resident Evaluations .4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide evidence of State Level 1 prescreening to determine if a newly admitted resident had or may have had MI, ID, or related condition for 1 of 5 residents (Resident #27) reviewed for the pre-admission screening and resident review (PASRR) program and PASRR assessments and evaluations. The facility failed to ensure Resident #27's PASRR Level 1 screening was completed prior to admission to the facility. This failure could place residents with psychiatric diagnoses at risk of not being properly placed and/or evaluated for PASRR services and potentially not receiving services for care and treatment. Findings included: Record review of a face sheet dated 07/15/2026 indicated Resident #27 was a [AGE] year-old male who admitted to the facility 12/11/2025. He had diagnoses which included bipolar disorder (a mental health condition characterized by mood swings from extreme to another) and schizophrenia(a chronic, severe brain disorder characterized by an inability to distinguish between reality and imagination).Record review of Resident #27's State Level I PASRR process indicated the screening was completed on 01/14/2026 which was 34 (thirty-four) days after being admitted to the facility. Record review of Resident #27's State Level II PASRR process indicated the evaluation was completed on 02/18/2026 which was 52 days after admission. During an interview on 07/14/2026 at 03:07 PM, the Regional Consultant said the PASRR Level I screening was not completed timely. She said there were multiple nurses assisting with the MDS assessments and PASRR process which may have led to the oversight. During an interview on 07/15/2026 at 01:45 PM, the DON said she was not an employee at the time of Resident #27's admission to the facility and could not say why he did not have a PASRR Level I screening prior to admission. The DON said whoever completed the admission MDS assessment should have noticed the PASRR Level I screening had not been done and addressed it. She said the Marketing Director was currently responsible for obtaining PASRR Level I screenings for potential admissions. The DON said she did not know who was responsible for the PASRR process or MDS completion when Resident #27 admitted to the facility. The DON said failure to ensure the PASRR Level I process was followed could result in a resident not being properly placed and potentially not receiving services for which he or she qualified for. Record review of the facility's policy dated 01/20/2026 and titled PASRR indicated the following: The aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID), or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, ir ID/DD.The facility Admissions Coordinator or designee will ensure the referring entity provides a copy of the PL1 (PASRR Level 1)upon admission.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 2 of 5 residents (Resident #6 and Resident #27) reviewed for baseline care plans. The facility failed to ensure Resident #6's baseline care plan was completed within 48 hours of admission. The facility failed to ensure Resident #27's baseline care plan was correctly coded for smoking and included instructions for supervision when smoking. These failures could place newly admitted residents at risk of receiving inadequate care and services. Findings included: 1. Record review of Resident #6's face sheet dated 07/15/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (also known as COPD and refers to a progressive, incurable lung disease that causes restricted air flow and severe breathing difficulties), congestive heart failure (a chronic condition where the heart does not pump blood as effectively as it should leading to fluid retention), dementia (a decline in cognitive abilities including loss of memory, language, and problem-solving abilities), diabetes (a chronic metabolic disease characterized by high blood sugar levels), and atrial fibrillation (irregular heartbeat which can lead to stroke or heart failure). Record review of Resident #6's baseline care plan dated 06/30/2026 indicated the baseline care plan was completed 6 days after admission and was noted to identify Resident #6 as a smoker. 2. Record review of Resident #27's face sheet dated 07/15/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included bipolar disorder(a mental health condition characterized by mood swings from extreme to another), schizophrenia(a chronic, severe brain disorder characterized by an inability to distinguish between reality and imagination), cerebral infarction (a stroke), diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Resident #27 also had a history of smoking. Record review of Resident #27's baseline care plan dated 12/11/2025 indicated Resident #27 was not a smoker. During an interview on 07/13/2026 at 02:40 PM, RN-D said baseline care plans were to be completed within 48 hours of admission and should include directions for providing care specific to each resident's needs such as monitoring a resident for high or low blood sugars or monitoring residents who smoke during smoke breaks. During an interview on 07/14/2026 at 10:15 AM, the DON said she was not employed at the facility when Resident #6 and Resident #27 were admitted to the facility. She said she did not know why Resident #6's baseline care plan was not completed in a timely manner or why Resident #27 had no interventions to address his smoking. She said the baseline care plan served as an initial guide for providing care to a newly admitted resident based on his or her individual needs. She said failure to implement a baseline care plan in a timely manner or failure to accurately identify resident needs could put a resident at risk for not receiving needed care or services. Record review of the facility's policy titled Care Plans-Baseline and dated 2001 and revised March 2022 indicated the following: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 5 residents (Resident #6) reviewed for care plans. The facility failed to ensure Resident #6's care plan addressed his use of tobacco and non-compliance with the physician's order for fluid restrictions. This failure could place residents who smoke or have orders for fluid restrictions at risk for not receiving care and services to meet medical, mental, psychosocial, and nursing needs. Findings included: Record review of Resident #6's face sheet dated 07/15/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (also known as COPD and refers to a progressive, incurable lung disease that causes restricted air flow and severe breathing difficulties), and congestive heart failure (a chronic condition where the heart does not pump blood as effectively as it should leading to fluid retention). Record review of an annual MDS assessment dated [DATE] reflected Resident #6 had a BIMS score of 15 indicating his cognition was intact. Record review of a baseline care plan dated 06/30/2025 indicated Resident #6 smoked and required supervision when smoking. The baseline care plan did not address fluid restrictions. Record review of physician orders dated 07/15/2026 indicated he had an order for fluid restrictions of 1500 cc per 24 hours dated 10/10/2025. Record review of Resident #6's comprehensive care plan with the last revision date of 04/27/2026 indicated there were no concerns or interventions to address smoking nor the physician's order for fluid restrictions. During an interview on 07/15/2026 at 01:30 PM, LVN-A said Resident #6 smoked occasionally, but not very often. She said residents who smoked were supervised by staff when smoking. She said Resident #6 was not compliant with fluid restrictions. She said staff encouraged Resident #6 to limit his fluids. She said Resident #6 had not exhibited any issues with fluid retention that she was aware of. During an interview on 07/15/2026 at 02:45 PM, the DON said Resident #6 was not compliant with fluid restriction orders and had not shown any evidence of fluid retention. She said no resident who smoked was allowed to smoke without staff supervision. The DON said smoking and fluid restrictions should have been addressed on Resident #6's care plan. She said care plans were a joint effort of the interdisciplinary team and she was ultimately responsible for ensuring the comprehensive care plan included interventions to address potential problem areas and conditions. The DON said failure to include interventions in the care plan that address problem areas or conditions could place a resident at risk for not receiving needed care or services. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered and dated as revised March 2022 indicated the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, .e. reflects currently recognized standards of practice for problem areas and conditions.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Bradburn		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 3 residents (Resident #6 and Resident #27) reviewed for accident hazards. The facility failed to assess Resident #6 and Resident #27 for safety when smoking. This failure could place residents at risk of accidents and injuries. Findings included: Record review of Resident #6's face sheet dated 07/15/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included dementia (a decline in cognitive abilities including loss of memory, language, and problem-solving abilities) and chronic obstructive pulmonary disease (also known as COPD and refers to a progressive, incurable lung disease that causes restricted air flow and severe breathing difficulties). Record review of an annual MDS assessment dated [DATE] reflected Resident #6 had a BIMS score of 15 indicating his cognition was intact. He was ambulatory and able to voice needs. A record review of physician orders dated 07/15/2026 indicated Resident #6 did not have any orders related to smoking. Record review of a list provided by the facility of residents who smoked identified Resident #6 as one of the residents who smoked cigarettes. Record review of Resident #6's undated comprehensive care plan indicated smoking was not addressed. The care plan did not include any information regarding Resident #6's smoking status nor did it include any safety needs to prevent injury. A record review of Resident #6's medical records did not reflect Resident #6 had been assessed for safe smoking. During observations of residents smoking on 07/14/2026 and 07/15/2026 at 01:00 PM, Resident #6 was not present. During an interview on 07/15/2026 at 01:15 PM, Resident #6 said he smoked sometimes. He said if he wanted to smoke, he would go outside with the other residents who smoked. 2. Record review of Resident #27's face sheet dated 07/15/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included bipolar disorder(a mental health condition characterized by mood swings from extreme to another), schizophrenia(a chronic, severe brain disorder characterized by an inability to distinguish between reality and imagination), and chronic obstructive pulmonary disease (also known as COPD and refers to a progressive, incurable lung disease that causes restricted air flow and severe breathing difficulties). Record review of a quarterly MDS assessment dated [DATE] indicated Resident had a BIMS score of 9 indicating his cognition was moderately impaired. The MDS also noted Resident #27 was a tobacco user. A record review of physician orders dated 07/15/2026 indicated Resident #27 did not have any orders related to smoking. Record review of a list provided by the facility of residents who smoked identified Resident #27 as one of the residents who smoked cigarettes. Record review of Resident #27's comprehensive care plan indicated Resident #6 smoked cigarettes with interventions to educate Resident on the facility's tobacco/smoking policy and orient Resident to smoking times and procedures. The care plan did not include any information regarding Resident #6's smoking status nor did it include any safety needs to prevent injury. A record review of Resident #27's medical records did not reflect Resident #27 had been assessed for safe smokingDuring observations of residents smoking on 07/14/2026 and 07/15/2026 at 01:00 PM, Resident #27 was sitting in a chair and smoking a cigarette. He was observed to hold the cigarette safely and use the ashtray appropriately. Facility staff were noted to be present in the area and controlled the dispensing of cigarettes and use of lighters. During an interview on 12/09/2024 at 11:20 AM, Resident #27 said he had smoked a long time and had never burned himself. He said he was going inside and could not talk anymore. During an interview on (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Bradburn		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/15/2026 at 01:30 PM, LVN-A said Resident #6 smoked occasionally, but not very often. LVN-A said Resident #27 smoked routinely per the smoking times schedule. She said residents were supervised by staff during the smoking times. She said residents were not allowed to smoke unsupervised. She said she did not know of any resident who smoked needing more than staff supervision when smoking. She said she did not know who performed the smoking assessments. During an interview on 07/14/2026 at 02:10 PM, the DON said she did not find a smoking assessment for Resident #6 nor Resident 27. She said the smoking assessment was not automatically triggered on admission to the facility. She said when a nurse finds that a resident smokes during the admission assessment, the nurse should complete a smoking assessment. She said she was not employed by the facility at the time Resident #6 and Resident #27 admitted to the facility and did not know why they had not been assessed for safe smoking. The DON said smoking assessments were important for identifying what safety needs were needed to reduce the risks of burns when a resident is smoking. Record review of the facility's policy titled Smoking Policy - Residents and dated October 2022 indicated the following: This facility shall establish and maintain safe resident smoking practices.7. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker or smokeless tobacco user, the evaluation will include: a) Current level of tobacco consumption . d) Ability to smoke safely with or without supervision (per a completed Smoking Assessment). 9. A resident's ability to smoke or chew tobacco safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff.		

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NAME OF PROVIDER OR SUPPLIER Avir at Bradburn		STREET ADDRESS, CITY, STATE, ZIP CODE 520 Bradburn Rd. Grand Saline, TX 75140	
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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident rooms measured at least 80 square feet per resident in multiple resident rooms and at least 100 square feet in single resident rooms for 2 of 10 resident rooms (Resident room [ROOM NUMBER] and 311) reviewed for square footage. The facility failed to provide 80 square feet per resident for a room certified for 4 residents and provide 100 square feet for a room certified as a private room. The failure could place residents at risk of not having adequate space to meet their needs. Findings included: During an observation on 07/14/2026 at 9:55 AM, it was observed that no residents were residing in room [ROOM NUMBER] and no residents were residing in room [ROOM NUMBER]. During an interview on 07/14/2026 at 10:00 AM, the Administrator said she was not aware the facility had any rooms with room waivers. She said she had been at the facility about a week. She was informed rooms [ROOM NUMBERS] had room waivers in previous years. She was told resident rooms [ROOM NUMBERS] still required room waivers and room [ROOM NUMBER] was certified for 4 residents and measured 74 square feet per resident and room [ROOM NUMBER] was certified as a private room and measured 81 feet instead of 100 square feet. She said room [ROOM NUMBER] was used as a staff break room. She said there were no residents currently residing in those rooms. During an interview on 07/15/2026 at 9:40 AM, the Administrator said she had not found any physical papers indicating a room waiver had been filed last year. She said she also had a waiver from life safety code and was told by life safety code all she had to do was on the plan of correction indicate she was requesting the waiver and indicate no end date so that it went on forever. Record review of the bed classification form dated 07/13/2026 indicated room [ROOM NUMBER] was certified for 4 residents and room [ROOM NUMBER] was certified for 1 resident.		