

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Avir at Converse		STREET ADDRESS, CITY, STATE, ZIP CODE 7700 Mesquite Pass Converse, TX 78109	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 5 residents (Resident #1, Resident #2 and Resident #3) reviewed for infection control: 1.The facility failed to ensure Resident #1's pure wick tubing was not on the floor. 2.The facility failed to ensure Resident #2 had enhanced barrier precaution signage and supplies by Resident #2's door. 3.The facility failed to ensure Resident #3 had enhanced barrier precaution signage and supplies by Resident #3's door. These failures could place residents at-risk for infection due to improper care practices.The findings included: 1. Record review of Resident #1's face sheet dated 2/3/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), diabetes (a chronic medical condition in which the body has trouble regulating blood sugar), chronic kidney disease, cognitive communication deficit and muscle weakness. Record review of Resident #1's most recent reentry MDS assessment dated [DATE] reflected the resident was severely impaired, did not have an external catheter, and was always incontinent of bowel and bladder. Record review of Resident #1's Order Summary Report dated 2/3/2026 reflected the following: - Change pure wick device (device used to manage urinary incontinence) q12 hours and pm: two times a day for urinary output supplies provided in room by family with an order date 1/4/2026 and no end date. Record review of Resident #1's comprehensive care plan with initiation date 1/4/2026 reflected the resident had a PURE WICK urinary system and at risk for UTI with interventions that included providing urinary catheter care, assessing for abnormal urine and emptying and recording output every shift and PRN. During an observation on 2/3/2026 at 12:40 p.m. Resident #1's bedroom entry revealed a sign which indicated the resident was on Enhanced Barrier Precautions. Resident #1 was observed in bed, and the pure wick catheter was sitting to the right of the bed, on a pad. Resident #1's pure wick catheter tubing was touching the floor. During an observation and interview on 2/3/2026 at 12:53 p.m., CNA A stated she was assigned to care for Resident #1 as part of her assignment in the hall she was working in. CNA A stated Resident #1 had a pure wick catheter and observed the resident's pure wick catheter tubing touching the floor. CNA A stated the pure wick catheter tubing should not be touching the floor as it was an infection control issue. CNA A stated she would let the nurse know the pure wick catheter tubing was on the floor. 2. Record review of Resident #2's face sheet dated 2/3/2026 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, retention of urine, and dysphagia (difficulty swallowing). Record review of Resident #2's admission MDS assessment dated [DATE] reflected the resident had moderate cognitive impairment and had an unhealed pressure injury/ulcer. Record review of Resident #2's Order Summary Report dated 2/3/2026 reflected the following: - heels protector when in bed due to multiple unstageable wounds, every shift with order date</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675452	Facility ID: 675452 If continuation sheet Page 1 of 3

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1/22/2026 and no end date. - unstageable wound to left heel: cleanse with ns or wound cleanser, pat dry. Apply moisturizer gauze to base of the wound. Secure with ABD, kerlix and ace bandage, every day shift every Mon, Wed, Fri with order date 1/22/2026 with no end date. -unstageable wound to right heel: cleanse with ns or wound cleanser, pat dry. Apply moisturizer gauze to base of the wound. Secure with ABD, kerlix and ace bandage every day shift every Mon, Wed, Fri with order date 1/22/2026 with no end date. - left thigh, upper anterior hematoma (collection of blood outside a blood vessel), cleanse with ns or wound cleanser, pat dry with betadine moistened gauze to wound base, cover with bordered gauze every day shift Mon, Wed, Fri order date 1/30/2026 and start date of 2/2/2026 with no end date. Record review of Resident #2's comprehensive care plan with revision date 1/22/2026 reflected the resident admitted with pressure ulcers (r/t Hx of ulcers, immobility) unstable right heel and unstageable left heel with interventions that include administering treatments as ordered and monitor for effectiveness. 3. Record review of Resident #3's face sheet dated 2/3/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included pressure ulcer to part of back, stage 3, pressure ulcer to part of back, stage 4, pressure ulcer of right heel, pressure ulcer of left heel. Record review of Resident #3's admission MDS assessment dated [DATE] reflected the resident had moderate cognitive impairment and had an unhealed pressure injury/ulcer. Record review of Resident #3's Order Summary Report dated 2/3/2026 reflected the following: - Stage IV sacrum pressure ulcer/injury: cleanse with wound cleanser/normal saline. Apply gentell blue to base of wound. Secure with superabsorbent dressing, every day shift with order date 1/16/2026 with no end date. -unstageable wound to lower back: cleanse with ns or wound cleanser, pat dry. Apply betadine to base of wound, leave open to air, every day shift with order date 1/16/2026 with no end date. -heel up boots when in bed due to multiple unstageable wounds, every shift with order date 1/22/2026 and no end date. -stage III wound to caudal space (base of spine) to lower back: cleanse with ns or wound cleanser, pat dry, apply collagen, calcium alginate to base of the wound. Secure with silicone bordered superabsorbent dressing, every day shift with order date 1/22/2026 with no end date. -unstageable wound to right heel: cleanse with ns or wound cleanser, pat dry. Apply betadine moistened gauze to base of the wound. Secure with ABD, kerlix and secure with tape, every day shift every Mon, Wed, Fri with order date 1/22/2026 with no end date. -unstageable wound to left heel: cleanse with ns or wound cleanser, pat dry. Apply betadine moistened gauze to base of the wound. Secure with ABD, kerlix and secure with tape, every day shift every Mon, Wed, Fri with order date 1/22/2026 with no end date. -unstageable wound to left lateral ankle: cleanse with ns or wound cleanser, pat dry. Apply Hydrogel Gauze to the base of the wound and secure with bordered gauze dressing, every day shift every Mon, Wed, Fri with order date 1/22/2026 with no end date. -unstageable wound to right lateral ankle: cleanse with ns or wound cleanser, pat dry. Apply Collagen to base of the wound, then betadine moistened gauze over collagen and secure with ABD, Kerlix, and ace bandage, every day shift every Mon, Wed, Fri with an order date of 1/20/2026 with no end date. Record review of Resident #3's comprehensive care plan with revision date 1/22/2026 reflected the resident admitted with pressure ulcers (r/t Hx of ulcers, immobility) unstable right heel and unstageable left heel with interventions that include administering treatments as ordered and monitor for effectiveness. During an observation on 2/3/2026 at 1:10 p.m. revealed Resident #2 and Resident #3 resided in the same room. Resident #2 and Resident #3's bedroom entry revealed lack of signage of EBP and supplies. During an observation and interview on 2/3/2026 at 1:16 p.m., LVN C stated any residents with open wounds would need to be on EBP. LVN C stated staff would know if a resident was on EBP if they had a sign stating so and a cart with supplies alongside it. When asked if Resident #2 or/and Resident #3 would need to be on EBP, LVN</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C stated LVN C wasn't sure and would need to ask the DON. LVN C stated if staff do not know a resident is on EBP there could be a risk of cross contamination or/and spreading infectious diseases. During an interview on 2/3/26 at 1:26 p.m., LVN D stated any residents with wounds would need to be on EBP. LVN D stated staff would know if a resident was on EBP if there were a sign and cart by their room. LVN D stated Resident #2 and Resident #3 should have had EBP signage and supplies due to both Residents having wounds. LVN D stated the risk of not having EBP or signage/using would be infections in the wound. During an interview on 2/3/2026 at 1:54 p.m., LVN B stated she oversaw Resident #1's care as she oversaw the hall Resident #1 was in. LVN B stated Resident #1's pure wick catheter tubing should not be on the floor. LVN B stated the risk could be contamination. During an interview on 2/3/2026 2:52 p.m., the DON stated residents were placed on EBP if they have indwelling catheters or chronic wounds. The DON stated staff know if a resident was on EBP if they had signs outside their door saying so and a cart. The DON stated the purpose of EBP was to prevent transmission of bacteria. The DON stated catheter tubing should not be on the floor due to the risk of bacteria being on the outside of the tube. Record review of the facility document titled Enhanced Barrier Precautions Program with revision date March 2024, reflected:5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization a. Wounds generally include chronic wounds (i.e. pressure ulcers.) b. indwelling medical devices include central lines, urinary catheters.</p>		