STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675522	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Monahans	1200 W 15th St Monahans, TX 79756

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 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 interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 12 residents (Resident #1 and Resident #2) reviewed for care plans.The facility failed to ensure the staff developed the comprehensive care plan goals and interventions from the comprehensive assessment for Resident #1. The facility failed to ensure the comprehensive care plans for Resident #1 and Resident #2 described the resident's goals for admission and desired outcomes.The facility failed to ensure the comprehensive care plan for Resident #2 described the resident's preference and potential for future discharge. The facility failed to ensure the comprehensive care plan for Resident #2 documented a desire to return to the community was assessed. This failure could place the residents at risk of inadequate care and services. Findings included:Record review of Resident #1's Face Sheet reviewed on 5/10/2026 reflected a [AGE] year-old female, with an admission date of 5/8/2025. Resident #1 had diagnoses which included: schizoaffective disorder (both schizophrenia and mood disorders that affect the perception of reality with hallucinations, delusions, disorganized thoughts or speech), Osteoporosis (loss of bone), Osteoarthritis (degenerative joint disease causing cartilage cap at the end of bones to wear away), lack of coordination, depression (persistent feelings of sadness), hereditary motor and sensory neuropathy (A group of genetic disorders affecting the peripheral nervous system characterized by progressive degeneration of motor and sensory nerves), unsteadiness on feet. Record review of Resident #1's MDS dated [DATE] reflected occasional urinary incontinence. Record review of Resident #1's CAA dated 3/23/2026 reflected urinary incontinence, dehydration/fluid maintenance, and falls was triggered and indicated a new care plan, revision, or continuation of care plan is necessary to address the identified area. It further reflected the care planning decision must be completed within 7 days.Record review of Resident #1's CAA dated 3/23/2026 reflected that she utilized a walker for mobility. Record review of Resident #1's Care plan undated lacked documentation/goals for urinary incontinence, dehydration/fluid maintenance, or falls. In an interview on 5/10/26 at 11:48 P.M., Resident #1 stated her medical needs are met by the facility. She stated she had not fallen and she had therapy. Record review of Resident #2's Face Sheet reviewed on 5/10/2026 reflected a [AGE] year-old female, with an admission date of 01/21/2026. Resident #2 had diagnoses which included: acute respiratory failure (not enough oxygen or too much carbon dioxide in your body), major depressive disorder (consistent sadness), history of leukemia (cancer of the body's blood forming tissues), and lack of coordination. Record review of Resident #2's care plan undated lacked documentation on her preference and potential for future discharge. In an interview on 5/10/2026 at 4:13 P.M., LVN D stated Resident #1 had a urinary incontinence decline, and poor fluid intake but the facility staff were addressing those needs. LVN D stated she had access to the care plans but did not use that for information but used reports from other staff. In an interview on 5/11/2026 at 2:11 P.M., CR C stated DON B and herself were responsible for care plans and she was (continued on next page)

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

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Avir at Monahans	1200 W 15th St Monahans, TX 79756

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not aware that urinary incontinence, dehydration/fluid maintenance, and falls were not documented in the care plan. CR C did not comment about what adverse effects could occur with this not being in the care plan. In an interview on 5/11/2026 at 2:18 P.M., DON B stated the facility did not have an MDS nurse until recently and she had done care plans, but CR C helped. She stated she was not aware Resident #1's care plan did not address urinary incontinence, dehydration/fluid maintenance, or falls. DON B stated Resident #1 had declined in urinary incontinence but had not had any falls and staff address hydration needs. DON B stated there have been no negative effects from not being in the care plan and she would do a complete audit to get it back on track. In an interview on 5/11/2026 at 2:58 P.M., ADM A stated DON B was responsible for care plans because the MDS nurse was new. ADM A stated bad things like not having their needs met or not receiving services they need if the services were not in the care plan could occur. She stated Resident #1 had a decline in urinary incontinence, but her needs were being addressed, but it should be in the care plan. ADM A stated Resident #2 had no plans to discharge from the facility and that information should be in the care plan. Record review of Care Plans, Comprehensive Person-Centered dated 2001 reflected, 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.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all services, as outlined by the comprehensive care plan, being provided meet professional standards for 1 of 12 residents (Resident #1) reviewed for care plans.The facility failed to ensure Resident #1 was diagnosed by a practitioner using evidence-based criteria that meet professional standards of quality and lacked supporting documentation (comprehensive assessment) in the resident's medical record for a schizoaffective disorder diagnosis. This failure could place the residents at risk of not meeting their mental health needs. Findings included:Record review of Resident #1's Face Sheet reviewed on 5/10/2026 reflected a [AGE] year-old female, with an admission date of 5/8/2025. Resident #1 had diagnoses which included: schizoaffective disorder (both schizophrenia and mood disorders that affect the perception of reality with hallucinations, delusions, disorganized thoughts or speech), Osteoporosis (loss of bone), Osteoarthritis (degenerative joint disease causing cartilage cap at the end of bones to wear away), lack of coordination, depression (persistent feelings of sadness), hereditary motor and sensory neuropathy (A group of genetic disorders affecting the peripheral nervous system characterized by progressive degeneration of motor and sensory nerves), unsteadiness on feet. Record review of Resident #1's Medical Diagnosis reviewed on 5/10/2026, reflected schizoaffective disorder dated 5/16/25. Record review of Resident #1's Care Plan undated reflected interventions provided for hallucinations, delusions and behaviors related to diagnosis of schizophrenia/psychosis/mental illness. Record review of Resident #1's electronic health records for the period of 05/08/25 to 05/11/26 lacked documentation of a comprehensive assessment diagnosing Resident #1 with schizoaffective disorder.In an interview on 5/11/2026 at 2:11 P.M., CR C stated the psychiatry physician had been told three times prior that the facility needed a comprehensive evaluation to diagnose a resident with schizoaffective disorder. She stated she spoke with the diagnosing physician on the phone a moment ago, and he told her to discontinue and delete the diagnosis because he did not have a comprehensive evaluation. CR C stated that Resident #1 was not receiving any psychotropic medications for the disorder. In an interview on 5/11/2026 at 2:18 P.M., DON B stated she could not locate a comprehensive evaluation for schizoaffective disorder for Resident #1. She stated she spoke to the psychiatric physician, and he stated not to discontinue the diagnosis because Resident #1 did have a history of the diagnosis and he would see the resident on the next visit. DON B stated the psychiatric physician told her he did not have a comprehensive evaluation to provide. In an interview on 5/11/2026 at 2:58 P.M., ADM A stated she was not aware Resident #1 did not have a comprehensive evaluation in her file supporting her diagnosis. ADM A stated the facility's clinical was to do a complete an audit of files after the last violation for the same thing. Interview attempted with psychiatric physician but was unable to speak to him as of 05/11/26 at 6:00 PM . Interview attempted with Medical Director but was unable to speak to him as of 05/11/26 at 6:00 PM . Record review of the facility's Care Plans, Comprehensive Person-Centered policy dated 2001, reflected The comprehensive, person-centered care plan: .e. reflects currently reorganized standards of practice from problem areas and conditions.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 4 of 12 residents (Resident #2, Resident #4, Resident #5, Resident #10) reviewed for pharmacy services.The facility failed to ensure the hypertensive medication orders included adequate indications for its use to include parameters to administer or hold medications for Resident #2, Resident #4, Resident #5, and Resident #10. This failure could place the residents at risk of inadequate care and services. Findings included :Record review of Resident #2's Face Sheet reviewed on 5/10/2026 reflected a [AGE] year-old female, with an admission date of 01/21/2026. Resident #1 had diagnoses which included: acute respiratory failure (not enough oxygen or too much carbon dioxide in your body), major depressive disorder (consistent sadness), history of leukemia (cancer of the body's blood forming tissues), lack of coordination, and essential hypertension (high blood pressure). Record review of Resident #2's MAR dated 5/11/2026 reflected her Carvedilol Oral Tablet was to be given two times a day for hypertension. The MAR did not have parameters on when to hold or administer this antihypertensive medication. In an interview on 5/9/2026 at 11:05 A.M., Resident #2 said she received her medications timely and correctly with no concerns. Record review of Resident #4's Face sheet reviewed on 5/11/2026 reflected an [AGE] year-old female, with an admission date of 11/15/2024. Resident #4 had diagnoses which included: essential hypertension (high blood pressure), anxiety disorder (persistent worry or fear), lack of coordination, excoriation disorder (skin picking), pain disorder with related psychological factors, acute respiratory failure (not enough oxygen or too much carbon dioxide in your body).Record review of Resident #4's MAR dated 5/11/2026 reflected her Diovan Oral Tablet was given in the morning for hypertension. The MAR lacked parameters on when to hold or administer this antihypertensive medication. In an interview on 5/9/2026 at 10:02 A.M., Resident #4 said she received her medications timely and correctly with no issue. Record review of Resident #5's Face sheet reviewed on 5/11/2026 reflected a [AGE] year-old female, with an admission date of 01/21/2026. Resident #5 had diagnoses which included: essential hypertension (high blood pressure), atherosclerotic heart disease (hardening of the arteries), cardiomegaly (enlarged heart), osteoarthritis (degenerative joint disease-causing cartilage cap at the end of bones to wear away).Record review of Resident #5's MAR dated 5/11/2026 reflected her Losartan Potassium Oral Tablet was given two times a day for hypertension. The MAR lacked parameters on when to hold or administer this antihypertensive medication. In an interview on 5/9/2026 at 10:26 A.M., Resident #5 said she received her medications timely and correctly with no issue. Record review of Resident #10's Face sheet reviewed on 5/11/2026 reflected a [AGE] year-old male, with an admission date of 10/23/2025. Resident #10 had diagnoses which included: Alzheimer's Disease (appearance of buildup of proteins that affects the memory, thinking, and behavior), chronic kidney disease, stage 4 (moderately to severely damaged and not filtering waste from your blood), combined systolic (congestive) and diastolic (congestive) heart failure (heart muscle loses the ability to pump leading to significant blood backpressure), atherosclerosis heart disease of native coronary artery without angina pectoris (build up of plaque in the arteries without chest pain), heart failure. Record review of Resident #10's MAR dated 5/11/2026 reflected his Lotrel Oral Tablet was to be given by mouth one time a day for hypertension related to combined systolic (congestive) and diastolic (congestive) heart failure. The MAR lacked parameters on when to hold or administer this antihypertensive medication. In an interview on 5/9/2026 at 11:52 A.M., Resident #10 said he had no issues with any care concerns. In an interview on 5/9/2026 at 6:00 P.M., ADM A stated she was not aware of any medication concerns with any residents.In an interview on 5/10/2026 at 4:13 P.M., LVN D stated that she was not aware of any adverse effects to residents related to medications. In an interview on 5/10/2026 at 6:00 P.M., DON B stated that she was not aware of any issues with medications.In an interview on 5/11/2026 at 2:11 P.M., CR C stated the parameters of (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antihypertensive medications should be on the MAR. She stated she would get it fixed and educate staff to always ask that of the doctor. CR C stated the facility used their nursing judgement and monitored the residents for any medication effects. CR C stated she contacted the doctor and started fixing the orders to include the parameters. In a follow up interview on 5/11/2026 at 2:18 P.M., DON B did not comment on the need for parameters on antihypertensive medication orders. Record review of Administering Medications policy dated 2001 reflected, Medications are administered in a safe and timely manner, and as prescribed.2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.