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	07/29/2025

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 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, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 7 residents (Residents #5, #6, and #33) reviewed for care plans in that: The facility failed to ensure Resident #5 had a care plan for Activities of Daily Living, Incontinence, Insulin, Psychotropic Medication, or Hospitalization. The facility failed to ensure Resident #6 had a care plan for Activities of Daily Living, Psychotropic Medications, Opiate Medications, and Hospice Care. The facility failed to ensure Resident #33 had a care plan for Activities, Psychotropic Medications, and Diuretic Use. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs.The findings included the following: Resident #5 1. Review of Resident #5's admission Record, dated 7/29/25, revealed he was a [AGE] year-old male readmitted to the facility 7/1/25 from the hospital with diagnosis that included cardiomyopathy (heart does not pump blood effectively), diabetes, depression, and contractures (the muscles begin to stiffen causing reduced mobility). Review of Resident #5's admission MDS, dated [DATE], revealed:He had a Brief Interview for Mental Status score of 8 of 15 (indicating moderate cognitive impairment).He was dependent on staff for Activities of Daily Living.He used a wheelchair.He had range of motion impairment of both legs.He was incontinent of bowel.He received insulin injections for 7 of 7 days prior to the assessment.He was on an anticoagulant(medication to prevent blood from clotting). Review of Resident #5's Order Summary, dated 7/29/25, revealed orders:The diuretic Bumetanide 1mg every 24 hours for fluid overload, dated 7/1/25.The anticoagulant Apixaban 5mg twice a day related to heart disease.Insulin Lispro (short-acting insulin) per sliding scale dated 4/10/25.Insulin Glargine (long-acting insulin) 13 units in the morning dated 7/1/25. Melatonin 3 mg at bedtime for insomnia dated 4/10/25. Review of the electronic care plan, updated 6/19/25, revealed No care plan for Resident #5's activities of daily living status.No care plan for Resident #5's incontinence of bowel.No care plan for Resident #5's medication use including Bumetanide, Apixaban, insulin, or Melatonin. No care plan for Resident #5's hospitalization. 2. Review of Resident #6's admission Record, dated 7/29/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including contractures. Resident #6 was on hospice services. Review of Resident #6's quarterly MDS assessment, dated 7/9/25, revealed:His Brief Interview for Mental Status indicated he scored a 15 of 15 (indicating he was cognitively intact).He was totally dependent on staff for ADL assistance.He was on an opioid medication.He was on hospice care. Review of Resident #6's Order Summary, reviewed 7/29/25, revealed orders:Admit to hospice services dated 7/22/24.The antidepressant Duloxetine dated 4/1/25 and Trazadone dated 4/1/25.The opioid pain medication Hydrocodone-Acetaminophen 10-235mg dated 4/22/25. The opioid pain medication Morphine Sulfate 20 mg/ 5 ml by mouth at bedtime and three times a day, dated 4/1/25. Review of Resident #6's care plan revealed:No care plan for Resident #6's ADL's including eating, dressing, bathing, hygiene, and bed mobility.No care plan for the use of anti-depressants.No care plan for the use of opioid medication.No care plan for hospice services. 3. Review of Resident #33's admission Record, dated 7/29/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including aftercare for surgery. Review of Resident #33's Initial MDS Assessment, dated 4/23/25, revealedShe scored a 12 of 15 on her Brief Interview for Mental Status (indicating she was moderately cognitively impaired).She had constipation.She took an anti-depressant and a diuretic. Review of Resident #33's Order Summary, dated 7/29/25, revealed orders:Docusate Sodium 100 mg twice a day dated 4/17/25. Trazadone 50 mg for insomnia at bedtime dated 4/17/25. Review of Resident #33's care plan, dated 5/14/25 revealed:Focus: Resident #33 enjoys the following solitary activities: word search, coloring, talking. The identified goal was Resident #33 would be provided opportunities to enjoy solitary activities of choice. There were no interventions identified.There was no care plan for the Docusate Sodium 100 mg.There was no care plan for the Trazadone 50 mg or insomnia. Interview on 07/28/2025 at 3:32 PM the Business Office Manager said the Social Worker was responsible for care plans. Interview on 07/28/2025 3:32 PM the MDS Coordinator stated the transition from the previous electronic documentation program to the current documentation occurred in March 2025. The MDS Coordinator stated she did not do a care plan in the current documentation program because the RN or DON had to approve or open the care plan. The MDS Coordinator stated the Corporate RN went over care plans. The MDS Coordinator said there were a lot of

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure adequate supervision and assistance devices was provided for 2 of 3 residents reviewed for transfers (Resident #26 and #52).The facility failed to ensure staff locked the breaks of the mechanical lift (device used to assist in lifting a resident) during transfer for Resident #26.The facility failed to ensure staff completed gait belt transfer correctly for Resident #52. This deficient practice has the potential to affect residents in the building who required extensive assistance with proper transfers. The findings included: Resident #26Review of Resident #26's Quarterly MDS assessment dated [DATE] revealed Resident #26 was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses including arthritis, osteoporosis (bone thinning due to loss of calcium) without fracture, and contractures.Resident #26's Brief Mental Status was scored at 13 of 15 (indicating she was cognitively intact).Resident #26 had range of motion impairment on both sides of her lower extremities. Resident #26 was totally dependent on staff for transfers.Observation at [DATE] at 10:13 AM revealed CNA A and CNA H entered the room and donned(put on) gloves. The aides put the sling(material used to hold resident) under Resident #26, then hooked the sling to the electrical mechanical lift. CNA A told CNA H to make sure the sling was positioned high enough on Resident #26's head. CNA A operated the lift while CNA H steadied the resident. CNA A did not lock the lift while raising or lowering Resident #26. While lowering the Resident #26, the lift was noted to rock back and forth not allowing Resident #26 to be positioned in her wheelchair correctly. Interview on [DATE] at 1:27 p.m. the DOR stated the mechanical lift should be locked when moving a resident up and down because the weight was unsteady and it could cause the lift to roll away. The DOR said if the lift moved away while the resident was still up in air they could not be controlled during the lowering of the resident. The DOR stated especially the electrical lifts needed to be locked. The DOR stated they had not done any checkoffs regarding resident Hoyer lift transfers for the nursing staff. Resident #52Review of Resident #52's admission Record, dated [DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including unspecified dementia. Resident #52's admission care plan, dated [DATE], did not have transfer status checked. Resident #52 did not have an admission MDS as she was still in her assessment period. Observation on [DATE] at 3:11 PM revealed CNA I and CNA A putting a gait belt on Resident #52 loosely. CNA A locked both sides of the wheelchair. Both aides were observed hooking their arms under Resident #52. CNA I grabbed the gait belt that slid up Resident #52's torso. CNA A grabbed the back of Resident #52's pants. Interview on [DATE] at 3:19 PM CNA A said Resident #52 could be spicy and she (CNA A) got bit by Resident #52 on [DATE]. CNA A said she grabbed the back of Resident #52's pants because she felt like the like the belt was slipping. Interview on [DATE] at 1:27 p.m. PTA J stated a two-person gait belt transfer should be completed by putting the gait belt on the resident and one staff stand on each side of the resident. PTA J stated at the count of three both aides should lift the resident by the front and back of the gait belt. PTA J said in her opinion it was not ok to hold a resident by the back of their pants. The Director of Rehab who was present stated it was not acceptable to hook their arms under a resident. The DOR stated grabbing the back of the pants was not comfortable for the resident and there was no point if the gait belt was present. PTA J stated the last time the therapy department in-serviced the facility on transfers was 1.5 years ago. Interview on [DATE] at 1:52 the Administrator and DON were informed of the transfers. The DON stated a two-person transfer was supposed to look like the aides putting on the gait belt at the waist or right above the hips tight enough to slide two fingers under the belt. The DON stated the aides were supposed to grab the gait belt on each side and help the resident stand up on the count of three. The DON stated hooking under the arms was not ok because the arms were more prone to fractures. The DON said if the resident had weight bearing issues the resident should be a mechanical lift. The Administrator stated picking up a resident by the waist of the pants would not be comfortable. The DON said she did not have a chance to do checkoffs for transfers because she had only been in the facility three months. The DON stated the expectation for the mechanical lift was for the aide controlling the lift to lock the lift when the resident was going up or down. The DON said if the lift was not locked the staff could lose control of the resident. The DON stated if the resident was being placed in the wheelchair, the lift unlocked could cause the resident to not be aligned properly. The Administrator and DON stated they understood the issue with transfers. Review of the Facility's policy and procedure for Safe Lifting and Movement of Residents, revised 7/2017, revealed: In order to protect the safety and well being of staff

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for and 1 of 3 medication carts (Hall 100 and 200 nurse medication cart) and 1 out of 1 med room reviewed for medication storage. The facility failed to ensure the nurses cart #1 for 100 and 200 halls did not contain insulin, that were opened and not labeled with the open date. The medication room had an open vial of tuberculosis (a bacterial infection that affects the lungs and can spread to other organs) solution that was not labeled with an open date. Findings included:Observation on 07/28/25 at 4:30 PM revealed the nurse's medication cart #1 for 100 and 200 halls had the following opened medications with no open date labeled:1. Humalog insulin vials (Insulin is an essential hormone that helps the body turn food into energy and manage the blood sugar levels)2. Novolog insulin Kwik pensObservation on 7/29/2025 at 10:30 AM revealed the refrigerator in Medication room [ROOM NUMBER] had the following opened medications with no open date labeled:1. Aplisol Tuberculin solutionInterview on 07/28/25 at 4:31 PM with LVN D, she said once insulin, and tuberculosis solution were opened they needed to be dated with open dates. She said it was the responsibility for all nurses to check carts for labelling and dating every shift, but she did not check the whole cart that morning. She stated insulins and tuberculosis solutions were good for 28 days. She stated the risk of not having an open date was they would not be able to know when they expire, and they will not be effective. Interview on 07/29/25 at 12:36 PM the DON said insulin, and tuberculosis solution when opened should be dated. She stated it was the responsibility of nursing management to check and audit the carts after the nurses. The DON said the nurses were responsible for dating the medication when opened. She stated insulin and tuberculosis solution was good for 28 days and should be dated once the box or pen was opened. Interview on 07/29/25 at 3:02 PM the Administrator said the expectations were for nursing staff to date any medications with an open date after they were put into use. The Administrator said that was supposed to be done so that the staff would know when to discard the medication. Record review of the Recommended Medication Storage policy, dated 2/2023, reflected the following:Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation and food storage. The facility failed to ensure foods were properly stored, labeled and dated.The facility failed to dispose of spoiled food items properly.The facility failed to prevent possible cross contamination.The facility failed to ensure dietary staff used hair restraints properly. These failures could place residents at risk for food borne illnesses.Findings included:Observation on 7/27/2025 at approximately 9:42 AM revealed [NAME] E touching the lid of a trash can to place paper towels in it after washing hands. Observation on 7/27/2025 at approximately 9:45 AM revealed a box with 5 bags of corn tortillas received 8/13/2024 did not have a use by date (UBD). The tortillas at the bottom of each bag were hard. Observation on 7/27/2025 at approximately 9:45 AM revealed 2 bags of crispy rice cereal removed from the original packaging, without a UBD.Observation on 7/27/2025 at approximately 9:45 AM revealed breadcrumbs in a sealed bin received 12/17/24, without a UBD.Observation on 7/27/2025 at approximately 9:55 AM revealed a bin of apples and oranges. Three of the oranges had fuzzy, green and white growth on them. Observation on 7/28/2025 at approximately 11:56 AM revealed the spoiled oranges were no longer in the bin.Observation on 7/28/2025 at approximately 11:59 AM revealed [NAME] E and Dietary Aide (DA) F were not wearing hair restraints correctly. Their hair was not restrained above the ears, at the nape of neck, and forehead. Observation on 7/28/2025 at approximately 12:15 PM revealed [NAME] E touched the food surface area of 3 serving utensils when she reached up to retrieve the utensils from an open-air hanging rack. Observation on 7/28/2025 at approximately 12:17 PM revealed [NAME] E touched the corn bread with a bare finger when dishing it from the pan to the first 6 plates.Observation on 7/28/2025 at approximately 12:17 PM - 12:43 PM revealed [NAME] E touched the rim and the food surface of plates with her bare hands while dishing food items.Observation on 7/28/2025 at approximately 12:43 PM revealed [NAME] E picked up a divided plate, used her thumb nail to flick something off the food surface of the plate then placed food items on the plate. During an interview on 7/29/2025 at 3:40 PM [NAME] E said she would not have used the corn tortillas. She said she used the bread/buns unless molded. Said she is not sure who should remove old products from dry storage. [NAME] E said the bags of cereal did not have a UBD because they were removed from the original box. [NAME] E said the staff did not use the step-open trash can at the hand sink because they never knew if it would have a bag in it. [NAME] E said they use the big rolling one next to it and must touch the lid to open it. [NAME] E said she was aware that hair nets must cover all hair. Said only one size is available at the facility. [NAME] E said she knows she is not supposed to touch the food surface of utensils, plates, or food with bare hands. [NAME] E said the divided plate she flicked something off was the last clean one. [NAME] E said she thinks it was something from the dishwasher. [NAME] E said she was not aware of touching the food surface of the plates while dishing food onto them. [NAME] E said all those things can cause residents to get sick. During an interview on 7/29/2025 at 4:10 PM the Administrator said the dietary staff knew all the rules/requirements. The Administrator said if the DM had been here, she feels like none of the findings would have been present. The Administrator said all dry storage items should have a received date and a UBD. The Administrator said the corn tortillas should not still be in the dry storage. Record review of the facility policy Food Receiving and Storage revised November 2022 revealed in part:- Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use.- Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in-first out system.Record review of the facility policy Food Preparation and Service revised November 2022 revealed in part:- Cross-contamination can occur when harmful substances. i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Cross-contamination can also occur when raw food touches or drips onto cooked or ready-to-eat foods.- Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.- Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays.- Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks.- Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.Record review of the Food Code, U.S. Public Health

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 help prevent the development and transmission of communicable diseases and infections for 1 of 5 staff (Medication Aide C) reviewed for infection control in that: -Medication Aide C did not sanitize or wash her hands before handling medication or in between administering medications to different residents. This failure could place residents at risk for infectious diseases. Findings Included: During an observation on 07/28/25 at 12:06 PM revealed Medication Aide C came out of a resident's room and proceeded to pour more medications without washing or sanitizing hands. Medication Aide C continued to not sanitize her hands in between the 12 residents she administered the med pass. During an interview on 07/28/25 at 12:07 PM, with Medication Aide C, she said she knew she was forgetting something. Medication Aide C said the facility policy and procedure was that all staff were required to conduct hand hygiene prior to handling and administering medication. During an observation on 07/28/25 at 12:15 PM revealed Medication Aide C administered medication to Resident #37, then prepared Resident #20's medications with no hand hygiene. Medication Aide C gave Resident #20's medications, left the room with no hand hygiene. Medication Aide C prepared Resident #46's medications with no hand hygiene, administered medications and left room with no hand hygiene. During an interview on 07/28/25 at 12:30 PM, the DON said based on the facility policy and procedure for infection control/hand hygiene, medication aides were required to conduct hand hygiene prior to handling medication, and she would expect medication aides to either wash their hands with soap and water before leaving a resident's room or use the hand sanitizer in the hallway. During an interview on 07/29/25 at 3:04 PM the Administrator said the expectations were for nursing staff to wash or sanitize their hands in between resident medication administration to prevent the spread of infections. Record review of the facility policy on Hand Hygiene revised October 2023, [NAME] Handwashing/Hand Hygiene reflected All Personnel shall follow the handwashing/Hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors .Before preparing or Handling Medications .Perform hand hygiene before applying non-sterile gloves.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for physical environment. The facility failed to ensure the refrigerator door adequately closed and sealed in the kitchen on 07/27/2025. This failure could place residents at risk of foodborne illnesses and potential for injury to residents and staff. Findings included:During an observation and interview on 07/27/2025 at 9:42 AM, 1 of 3 refrigerators observed in the kitchen revealed the door did not latch or seal. The refrigerator door stayed slightly open. [NAME] G said the door must be lifted and closed at the same time. [NAME] G demonstrated closing the door. [NAME] G said dietary staff were aware of the broken door and how to close it. During an interview with [NAME] E on 07/29/2025 at 3:40 PM, [NAME] E said the refrigerator door had been broken more than one year. [NAME] E said she thought the Dietary Manager (DM) reported it to the Administrator. [NAME] E said if the refrigerator was not sealed correctly the residents could get sick. During an interview on 07/29/2025 at 4:10 PM, the Administrator was made aware of the broken refrigerator door. The Administrator said the broken door was not reported to her by staff.Review of facility policy Sanitization, revised November 2022, revealed: All utensils, counters, shelves and equipment are kept cleaned, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair