| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675619 | A. Building<br>B. Wing | 04/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Burnet | 507 W Jackson St<br>Burnet, TX 78611 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>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 for 1 of 1 kitchen reviewed for sanitation. The facility failed to properly label food containers stored in refrigerator with contents and use by date. This failure could place residents at risk of foodborne illness.Findings include: During initial kitchen observation and interview on 04/27/2026 at 6:10 AM revealed the following:*five small single serve condiment containers holding diced green onions that were not labeled or dated in the walk in refrigerator.*two bags of shredded lettuce that had expired on 04/22/2026.DM removed and disposed of these items and stated the containers were for garnish the previous evening, but they should have been labeled. She stated that the lettuce should have been removed. In an interview on 4/29/2026 at 9:30 AM with DM she stated that she frequently in-services her staff on food storage and handling. She stated that all containers should be labeled with the contents and use by date. She stated that expired food items should be removed from the kitchen as they could be used to prepare meals and cause the residents to become sick. In interview on 4/29/2026 at 9:37 AM with FA she stated that she was frequently in-serviced on food storage and handling. She stated that food items should be labeled with what they are as well as use by date. She stated if food items are used after they are expired it could make the residents sick. In an interview on 4/29/2026 at 9:40 AM with CK she stated that she was frequently in-serviced on food storage and labeling. She stated that food items should be labeled with what they are as well as use by date. She stated if food items are not labeled with a use by date they would not know when the food expired and if expired items were used to prepare food the residents could become sick. In an interview on 4/29/2026 at 12:49 PM with RVP, she stated that food items should be labeled with what they contain and the use by date. She stated that if items are used past their use by date and it could cause food borne illness. In interview on 4/29/2026 at 1:05 PM with the DON, he stated to his knowledge food storage containers are to be labeled with their contents and the use by date. He stated if items are used after the use by date residents could end up with food borne illness. Record review of facility policy, Food Receiving and Storage, revised November 2022 states that, food shall be received and stored in a manner that complies with safe food handling practices. In section labeled Refrigerated/Frozen storage it states, 1. All foods in the refrigerator or freezer are covered, labeled and dated ( use by date). 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 3 of 7 residents (Resident #36, Resident #49, and Resident #54) reviewed for infection control. CNA B did not change contaminated gloves prior to Resident #49's repositioning; contact with clean supplies; and she did not wash her hands after removing gloves post perineal care. ADON did not sanitize her hands between changing gloves and before exiting a room while performing wound care on Resident #54. LVN A did not sanitize hands after removing gloves and touching medication cart and documenting on the computer after completing blood sugar check on Resident #36. These failures could place the residents at risk of infection transmission, sepsis, and hospitalization.Findings included: A. Record review of Resident #49's face sheet, dated 04/27/2026, reflected [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: malignant neoplasm of unspecified part on bronchus or lung (a primary, cancerous tumor originating in the airway or lung tissue where the specific lobe or laterality is not documented), anxiety disorder, and Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out daily tasks). Record review of Resident #49's annual MDS assessment, dated 03/12/2026, reflected BIMS level of 5, severe cognitive impairment, with care areas triggered: urinary incontinence. Record review of Resident #49's comprehensive care plan, dated 11/05/2021, reflected a focus ADL self-care performance deficit with interventions included Toilet use: resident need extensive assistance with toilet use. Provide physical assistance with transfer, peri-care, adjusting clothing and hygiene as needed. Provide incontinence care as needed. Observation of Resident #49's perineal care on 04/27/2026 at 12:24 p.m. revealed CNA B did not change gloves between cleaning the front and back perineal (area between the anus and the genital organs) areas of Resident #49 and touched Resident #49's clothes, body, bedding and clean incontinence brief while repositioning her with contaminated gloves. CNA B removed contaminated gloves after completing Resident #49's perineal care and did not wash hands before lowering resident's bed, positioning call light at Resident #49 reach and opening resident's door. During an interview on 4/27/2026 at 12:34 PM, CNA B stated that she had an in-service on hand hygiene and infection control sometimes in last 6 months and she was supposed to change gloves between front and back perineal area and wash hands with soap and water after taking gloves off and before leaving Resident #49's room. She stated that not washing hands and changing gloves according to the facility's policy could lead to cross contamination and infection control issues that could negatively affect residents' health. CAN B stated she forgot to change gloves between front and back perineal area and wash hands with soap after taking gloves off. B. Record review of Resident #54's admission record, dated 04/28/2026, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of pressure ulcer of right buttock, stage 4 (the most severe type of pressure ulcer (bedsore), featuring full-thickness skin loss with extensive destruction, exposing muscle, tendon, or bone), pressure ulcer of sacral region, stage 2 (partial-thickness skin loss), pressure ulcer of right hip, stage 2, pressure induced deep tissue damage of right heel, and Parkinson (a progressive neurodegenerative disorder affecting dopamine-producing neurons in the brain). Record review of Resident #54's baseline care plan, dated 04/28/2026, reflected a focus: wound care management with indicated interventions: Provide wound care per treatment order. Monitor ulcer for signs of infection. Record review of Resident #54's orders revealed an order, dated 04/23/2026, right ischium stage 4 pressure ulcer: cleanse with normal saline, pat dry with gauze, apply collagen, particles, calcium alginate, and secure with bordered foam daily. Record review of Resident #54's wound care notes, dated 04/23/2026, right ischium with exposed tissue.with exudate (fluid) amount: moderate. Exudate description: serosanguineous (a thin, watery wound discharge that is light red or pink, containing both blood and<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | serum). Observation of Resident #54's wound care on 04/28/2026 at 1:41 p.m., revealed ADON washed her hands before starting wound care, applied PPE and used a clean gauze for cleaning right ischium stage 4 pressure ulcer wound, applied the collagen powder to the wound bed, and secure with bordered foam dressing without dating it. ADON removed gloves, discarded used supplies, picked up treatment scissors from Resident #54's table and did not wash her hands before exiting the room. She used a hand sanitizer dispenser outside the room. She did not sanitize the treatment scissors before putting them into the treatment cart. During an interview on 04/28/2026 at 1:45 PM, ADON stated that she had received a specialty training on infection control last month when she became an infection preventionist. She stated that she was responsible for the infection prevention and control program. She stated that according to facility's policy hand hygiene should be performed before entering resident's room, between gloves change, and before exiting resident's room. ADON stated that she was not aware of the requirement to date a dressing as soon as it was documented in treatment notes. She stated that she had a wound care module at hire and quarterly. ADON stated that a corporate nurse observed her skills for following infection prevention techniques during wound care. She stated that if proper hand hygiene and infection control policy were not followed, it could negatively affect residents due to cross contamination. She stated that in-service on hand hygiene and infection control was provided to staff on continues basis and nursing management including infection preventionist were responsible for monitoring staff followed the proper protocol for hand hygiene and infection control. ADON stated that she was nervous and forgot to wash her hands before exiting Resident #54's room. C. Record review of Resident #36's admission record, dated 04/08/2026, reflected a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: type 2 diabetes mellitus with hyperglycemia (occurs when insulin resistance and inadequate insulin production cause high blood sugar levels), hypertensive heart disease with heart failure (chronic, uncontrolled high blood pressure causes the heart muscle to weaken, limiting its ability to pump blood effectively), and chronic obstructive pulmonary disease (a progressive, treatable lung disease that causes severe breathing difficulties by blocking airflow). Record review of Resident #36's quarterly MDS, dated [DATE], reflected a BIMS score of 11, moderate cognitive impairment. Record review of Resident #36's comprehensive care plan, dated 05/28/2025, reflected Resident has a diagnosis of diabetes is at risk for low and high blood sugar episodes and complications related to disease process and interventions: Monitor accu checks as ordered. Notify Md or results less than 70 or greater than 400 mg/dl. During an observation on 04/29/2026 at 11:27 a.m., LVN A performed blood glucose monitoring test on Resident #36, she lanced (using a small needle [lancet] and device to prick the side of a fingertip) Resident #36's finger and when received an error message, she reached for the new supplies removing just one glove and touched her medication cart with contaminated glove. She did not sanitize her hands between gloves change. LVN A got a new test strip, inserted it in glucometer (a portable, medical device used to measure blood sugar level via a finger-prick blood sample) and after obtaining the blood sugar level she properly discarded the used lancet and removed the gloves, but did not sanitize her hands before documenting the test results on the computer. During an interview on 04/29/2026 at 11:26 p.m., LVN A stated she was trained on handwashing and infection control policy in last 6 months. She stated she recalled not sanitizing her hands between changing gloves during the blood sugar check on Resident #36. LVN A stated that not washing or sanitizing hands after removing gloves and touching medication cart with contaminated hands/gloves could introduce bacteria to the residents. During an interview on 04/28/2026 at 02:42 p.m., the DON stated he expected staff to follow infection control and hand hygiene policy when performing medical procedures or direct care to a resident. He stated that nursing management, including DON, ADON and infection preventionist, was responsible for monitoring staff following facility infection control policies and providing staff in-services on infection control to protect residents and prevent the cross contamination. He stated that hand washing should be completed before going to resident's room, after completing incontinent care, wound care or any<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | other invasive medical procedures, and before exiting the room. He stated that hand hygiene should be performed between gloves' changes. He stated that if not following proper infection control policy, it could negatively impact residents due to their vulnerable status. During an interview on 04/29/2026 at 3:50 p.m., RVP stated she expected staff to follow all infection control protocols when performing peri care, medication administration, and wound care. She stated that not following infection control during medical procedures and direct resident care could lead to cross contamination. Review of facility policy titled Handwashing/hand hygiene, dated October 2010, reflected: The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Indications for Hand Hygiene: c. after contact with blood, body fluids, or contaminated surfaces;d. after touching a resident;g. immediately after glove removal.5. The use of gloves does not replace hand washing/hand hygiene. Review of facility policy titled Wound care, dated 2001, reflected: 19. Disinfect overbed table. 21. Wipe reusable supplies with alcohol as indicated (i.e., outside of containers that were touched by unclean hands, scissor blades, et.). 23. Wash and dry your hands thoroughly. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR) Level I assessment accurately reflected the resident's status for 2 of 5 residents (Resident #3 and Resident #6) reviewed for PASARR Level I screenings.1. The facility failed to ensure the accuracy of the PASARR Level 1 screening for Resident #3 and Resident #6. The PASARR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis major depressive disorder and bipolar disorder was present upon admission.2. The facility did not complete a 1012 form to update Resident #3 and Resident #6's PASARR Level 1 with the diagnosis.These failures could place residents who had a mental illness at risk of not receiving a needed assessment (PASARR Evaluation), individualized care, or specialized services to meet their needs. Findings included:1.Record review of Resident #3's undated face sheet indicated an [AGE] year-old male who admitted to the facility on [DATE]. Resident #3 had diagnoses of unspecified dementia ( diagnosis used when symptoms of cognitive decline are present, but the underlying cause cannot be clearly identified), major depressive disorder (serious, common mental health condition characterized by persistent, severe low mood, loss of interest in activities, and low energy lasting at least two weeks), and hypertension (high blood pressure).Record review of Resident #3's MDS record dated 04/24/2026 indicated he had a diagnosis of depression which was labeled under psychiatric/mood disorders.Record review of Resident #3's care plan indicated a diagnosis of major depressive disorder. The care plan stated resident would not have any signs of anxiety or depression through the review date. Record review of Resident #3's level 1 PASARR dated 03/21/2026 indicated that Resident #3 did not have evidence of a mental illness.2.Record review of Resident #6's undated face sheet indicated a [AGE] year-old female who admitted to the facility on [DATE]. Resident #6 had diagnoses of bipolar II disorder (chronic mental health condition characterized by recurrent, severe depressive episodes alternating with milder, elevated mood periods called hypomania), depression (serious, common medical illness causing persistent sadness, loss of interest, and functional impairment), anxiety disorder (mental health conditions characterized by excessive, persistent fear or worry that interferes with daily life), and unspecified dementia (diagnosis used when symptoms of cognitive decline are present, but the underlying cause cannot be clearly identified). Record review of Resident #6's MDS record dated 02/04/2026 indicated she had a diagnosis of anxiety, depression and bipolar.Record review of Resident #6's care plan indicated a diagnosis of anxiety disorder, depression and bipolar disorder. The care plan stated resident would show decreased episodes of anxiety and depression through the review date.Record review of Resident #6's level 1 PASARR dated 07/21/2023 indicated that Resident #6 did not have evidence of a mental illness.An interview on 04/29/2026 at 11:03AM was conducted with MDS A who reported she had worked at the facility since 2021. MDS A stated she had received training on PASARR. MDS A stated that PASARR should be completed within 72 hours upon admission. MDS A stated that she was responsible for checking if the PASARRs are correct. MDS A stated that diagnoses such as bipolar, schizoaffective, cerebral palsy are all diagnoses that would indicate a positive level 1 PASARR. She stated the local authority would have been notified of a presumptive positive PASARR and they would come out and conduct a level 2, which was knows as a PE. MDS A stated that if a resident's PASARR was inaccurate then the resident could not receive services that they are eligible for. MDS A stated that Resident #3?s PASARR status was negative from the hospital. She stated she was working on a 1012 form for him, which would be a change to his PASARR status. MDS A stated that the resident's PASARR should have been positive since Resident #3 had a current diagnosis of major depressive disorder. She stated the level 1 PASARR would be deemed inaccurate. MDS A stated that Resident #6's PASARR status was negative and she would complete a form 1012 on her as well. She stated if they completed a<br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1012 on the resident, then had a diagnosis later, it would not change the PASARR status due to her having a primary diagnosis of dementia at that time. She stated she was not sure if the primary diagnosis was no longer dementia, if a new PASARR should have been completed.An interview on 04/29/2026 at 12:54PM was conducted with RVP who stated the policy for PASARR was to follow guidelines for CMS or HHSC. RVP did not elaborate what those guidelines were. RVP stated that depending on the admission, they would follow the protocol regarding PASARR and upon a change of a diagnosis. RVP stated that nurse management would have been responsible for ensuring that the PASARR was accurate. RVP stated that she was not sure which diagnosis would indicate a positive PASARR 1. RVP stated that if the level 1 was positive, they would then put a PE in place and notify the local authority. She stated an inaccurate level 1 PASARR could delay the evaluation from the local authority. RVP stated she did not know the status of Resident #3's PASARR status. She stated that to her knowledge a diagnosis of major depressive disorder would not indicate a positive PASARR. She stated if that were a diagnosis for PASARR then it would be inaccurate level 1. RVP stated she did not know the status of Resident #6's PASARR. Status. She stated that to her knowledge a diagnosis of bipolar disorder would indicate a positive PASARR. She stated that if Resident #6's diagnosis came after her level 1 PASARR was completed, then a new PASARR should have been generated. She stated that a delay in services could be the result of not having the PASARR regenerated.An interview on 04/29/2026 at 1:30PM was conducted with the DON who had been employed at the facility for 12 years. The DON stated that he did not know the policy on PASARR. The DON stated PASARR's should be completed upon admission. He stated that the MDS takes care of PASARR responsibilities. He stated he did not know which diagnoses would indicate a positive PASARR 1. The DON stated if a resident had an inaccurate PASARR the benefits residents may have been eligible for could be missed. The DON stated he did not know Resident #3's or Resident #6's PASARR status. The DON stated if a resident had a diagnosis of bipolar disorder, to his knowledge the PASARR should have been positive. The DON stated that if a resident's diagnosis changed after the level 1 PASARR was completed, a new PASARR should have been generated. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals for 1 of 3 residents (Resident #32) reviewed for pharmacy services. The facility failed to ensure CMA C administered a correct dose of Cholecalciferol Oral Tablet 10 MCG to Resident #32 for a week without obtaining a correct doze of medication according to the physician order. This failure could place residents at risk for overdosing, delayed healing, and other adverse consequences. Findings included: Record review of Resident # 32's face sheet, dated 04/28/2026, reflected [AGE] year-old male admitted on [DATE] with diagnoses that included: hypothyroidism (a condition where the thyroid gland fails to produce enough hormones, causing bodily functions to slow down), severe protein-calorie malnutrition (a critical condition resulting from extreme deficiencies in energy and protein intake, leading to severe metabolic imbalances, muscle wasting, and loss of subcutaneous fat), chronic obstructive pulmonary disease (a progressive lung disease that causes severe breathing difficulties), and chronic kidney disease (the long-term, progressive loss of kidney function, often causing waste to build up in the body). Record review of Resident #32's medication administration record for April 2026 revealed medication administration of Cholecalciferol Oral Tablet (vitamin D3 supplements) 10 MCG (400 Unit) Give 1 tablet by mouth one time a day for Supplement with start date 04/19/2026 and administered to Resident #32 every day from 04/19/26 - 04/27/26 for 9 days. Record review of Resident #32's Order Summary Report, dated 04/28/2026, revealed an order for Cholecalciferol Oral Tablet 10 MCG (400 Unit) Give 1 tablet by mouth one time a day for vitamin D supplement with start date 04/19/2026. During an observation of Resident #32's medication administration and interview on 04/28/2026 at 9:16 a.m., CMA C removed an over-the-counter container of Cholecalciferol Oral Tablet 50 MCG (2000 UT) and attempted to split a pill before putting in a medication cup with other medications for Resident #32. CMA C stated that it's the wrong doze, but they don't have the correct doze on the cart or medication storage, so she splits the tablet in quarters and administers to Resident #32 a quarter of the tablet. CMA C stated that the tabled was not scored and she approximated when she split a pill. CMA C stated that 50 MCG could not be split evenly to get a correct doze of 10MCG. She stated that she reported this discrepancy to a charge nurse whose name she could not remember for sure, but the charge nurse got busy and did not order the correct doze of medication (Cholecalciferol Oral Tablet 10 MCG). CMA C stated that usually DON ordered over-the-counter medications. She stated that she had training on mediation administration with verification of correct doze of each medication. She stated that not administering the correct dose could lead to a medication error and potentially resident's overdosing on medication. CMA C stated that she administered wrong doze of this medication for a week. She stated that she should document this discrepancy in resident's medication records and not administer the wrong doze of medication. During an observation and interview of Resident #32 on 04/28/2026 at 9:45 a.m., he stated that he did not know about wrong doze administered to him and did not feel any adverse effects of it. No adverse effects of D3 toxicity like upset stomach, vomiting, weakness, and frequent urination were observed at that time. During an interview on 04/28/2026 at 9:31 a.m., ADON stated that charge nurses and CMAs were responsible for following 5 rights of medication, including correct doze of medication, according to the physician order on MAR. She stated that if correct doze of medication was not available in the facility, charge nurses or CMAs were responsible to notify ADON or DON and they would contact physician to change the order. She stated that incorrect doze should not be administered or a pill split to get a correct doze which could lead to a medication error and adverse reaction to residents' health. She stated that if correct doze of medication was not available, it should not be administered while obtaining a correct doze or changing the order. ADON stated that<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medication errors should be reported to the physician and documented in Resident #32's progress notes. She stated that it was not done and she would immediately correct it. During an interview on 4/28/2026 at 9:45 a.m., DON stated that he was not informed of incorrect doze administered to Resident #32 before today. He stated that he was responsible for ordering over-the-counter medications in the facility. DON stated that charge nurses and CMA were responsible for administering correct medication dosages and holding medications if correct doze was not available in the building. He stated that per policy charge nurses and CMAs were responsible for documenting medication errors including wrong doze of medication administered to residents. He stated that medication errors should be communicated to him, ADON, physician and resident's representative. DON stated that the potential risk for administering wrong doze of medication would be overdosing and medication errors. Review of facility in service titled CMA C orientation/competency checklist, dated 1/20/26, reflected: 5 Rights when administering medication. Accurate measuring/dozing signed by CMA C. Review of facility policy titled Administering Medication, dated April 2019, reflected: Medications are administered in accordance with prescriber order,. 6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and/or the need for additional staff training. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: b. the dosage. |