STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at San Augustine	902 E Main St San Augustine, TX 75972

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. The facility had a medication error rate of 21.62%, based on 8 errors out of 37 opportunities, involving 3 of 5 (Resident #16, Resident #19 and Resident #39) residents and 1 of 2 nurses (LVN B) reviewed for medication errors. LVN B failed to administer scheduled medications on 5/12/2026 to Resident #16 and Resident #39 and failed administer the correct dosage of medications on 5/12/2026 to Resident #16 and Resident #19.These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications.Findings Include:Resident #16Record review of Resident #16's facility face sheet, dated 5/12/2026, indicated Resident #16 was an [AGE] year-old female, admitted [DATE], with diagnosis of cerebrovascular disease (impaired blood flow to the brain). Record review of Resident #16's quarterly MDS assessment, dated 3/29/2026, revealed a BIMS of 05 that indicated Resident #16 had severely impaired cognition. She required moderate assistance with ADL's. Record review of Resident #16's comprehensive care plan, revision date 12/24/2025, indicated Resident #16 had a potential for malnutrition with a goal of nutrients to meet metabolic needs. Record review of Resident #16's order summary report dated 5/12/2026 indicated Resident #16 had an order for Ascorbic Acid (Vitamin C) 500mg 1 tablet by mouth daily, Calcium Carbonate 500mg 1 tablet by mouth daily and Vitamin B12 500mcg 2 tablets by mouth daily.Resident #19Record review of Resident #19's facility face sheet, dated 5/13/2026, indicated Resident #19 was an [AGE] year-old male, admitted [DATE], with diagnosis of traumatic subdural hemorrhage (bleeding on the brain). Record review of Resident #19's annual MDS assessment, dated 4/06/2026, revealed a BIMS of 15 that indicated Resident #19 had intact cognition. He was independent with ADL's.Record review of Resident #19's acute care plan dated 5/12/2026, indicated Resident #19 had constipation and dry eyes and to administer medications as ordered. Record review of Resident #19's order summary report dated 5/13/2026 indicated Resident #19 had an order for docusate sodium 250mg 1 tablet by mouth two times a day and Systane ultra ophthalmic solution 0.4-0.3 % instill 2 drops in both eyes two times a day. Resident #39Record review of Resident 39's facility face sheet, dated 5/13/2026, indicated Resident #39 was a [AGE] year-old female, admitted [DATE], with diagnosis of severe protein calorie malnutrition (decrease in weight and muscle mass). Record review of Resident #39's quarterly MDS assessment, dated 3/30/2026, revealed a BIMS was not completed. Further review revealed a SAMS was completed and indicated moderately impaired cognitive skills for daily decision-making. She was dependent on staff for all ADL's. Record review of Resident #39's comprehensive care plan, revision date 4/01/2026, revealed Resident #39 had impaired skin integrity and to administer medications as ordered.Record review of Resident #39's order summary report dated 5/13/2026 indicated Resident #39 had orders for: *Acidophilus/Citrus Pectin (improves digestion) 1 capsule per gastrotomy tube two times a day, *Octreotide acetate injection solution (regulates hormones) inject 2 mg/ml intramuscularly daily on Tuesday, and *Multiple vitamins with minerals 1 tablet per gastrostomy tube in the morning. During medication administration on 5/12/2026 from 8:00 am to 10:00 am, LVN B administered medications to Residents #16, #19 and #39, the following was observed: *LVN B did not administer Resident #16's ordered vitamin C and calcium (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	carbonate and administered vitamin b12 500mcg and not the ordered 1000mcg. *LVN B did not administer Resident #39's ordered octreotide injection, multivitamins with mineral and acidophilus. *LVN B administered Resident #19's docusate sodium and gave 100mg and not the ordered 250mg. LVN B administered Resident #19's Systane eye drops and gave 1 drop in each eye and not the ordered 2 drops in each eye. During an interview on 5/12/2026 at 10:20 am LVN B said she had been trained on medication administration and was nervous. She said she forgot the octreotide was in the refrigerator and just did not read her orders accurately to ensure all medications were given and the dosages were correct. She said she would administer the missed medications now and notify the MD of the medication errors and why the medications were late. She said failing to ensure proper medication administration could cause a negative resident outcome such as poor disease management. During an interview on 5/12/2026 at 10:42 am the DON said that the nurses were responsible for administering all medications accurately and timely. She said that the nurse should review the electronic medication administration record (EMAR) prior to administering any medication to ensure the right medication dose was prepared and that all medications ordered were given. She said all the nurses had been trained in medication administration and she expected them all to follow the policy for administering medications to prevent a negative resident outcome. During an interview on 5/13/2026 at 10:12 am, the Administrator said the DON was responsible for oversight of the nurses and medication administration. She said that the nurses should be following the EMAR to ensure all medications were given as ordered and should always administer medications per the facility policy. She said she expected all medications administered were done accurately and correctly to prevent poor disease management or a decline in resident health. Record review of a facility policy titled Administering Medications dated April 2019 indicated, .medications are administered in a safe, timely manner, and as prescribed. 7. Medications are administered within 1 hour of their prescribed time, 10. The individual administering the medications checks the label 3 times to verify right medication, right dosage, right time and right method of administration before giving the medication.

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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 observations, interviews, and record review, the facility failed to establish and 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 diseases and infections for 3 of 5 staff (LVN B, the Treatment Nurse, and CNA D) reviewed for infection control.The facility failed to ensure the LVN B sanitized or washed hands between glove changes when colostomy care was provided to Resident #8 on 5/11/2026.The facility failed to ensure the Treatment Nurse sanitized or washed hands between glove changes when wound care was provided to Resident #8 on 5/11/2026.The facility failed to ensure CNA D washed or sanitized hands while passing lunch trays on 5/11/2026 on Hall 200. The facility failed to ensure CNA D changed gloves, sanitized or washed her hands while providing incontinent care to Resident #39 on 5/12/2026.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included:1.Record review of an admission Record for Resident #8 dated 5/11/2026 indicated she re-admitted to the facility on [DATE] and was [AGE] years old with a diagnosis of neuromuscular dysfunction of bladder (nerve damage or injuries that causes loss of control of the bladder).Record review of an Annual MDS Assessment for Resident #8 dated 4/19/2026 indicated she had moderate impairment in thinking with a BIMS score of 10. She had an indwelling catheter (tube placed in the bladder to drain the bladder) and an ostomy (an opening in the abdomen that allows waste to exit the body). She had a surgical wound.Record review of a care plan for Resident #8 dated 4/22/2026 indicated she had the potential/actual impairment to skin integrity due to surgical wound to the abdomen and a colostomy with an intervention to monitor for signs and symptoms of infections. Record review of active physician orders for Resident #8 dated 5/11/2026 indicated an order for wound care to surgical abdominal wound and colostomy care weekly. During an observation on 5/11/2026 at 10:15 AM, the Treatment Nurse and LVN B were in the room of Resident #8 to provide wound care and colostomy care. The Treatment Nurse sanitized her hands and donned (put on) a gown and cleaned an overbed table and placed wax paper down. The Treatment Nurse placed the wound supplies on the overbed table and entered the room. LVN B washed her hands in the room and donned a gown and put on gloves. LVN B removed the dressing that was noted to Resident #8 abdomen and removed her colostomy bag and placed it in the trash with her gloves. LVN B and put on clean gloves without sanitizing or washing her hands. She then wiped bowel movement from the abdomen area, changing gloves 5 times without sanitizing or washing her hands. LVN B applied a new colostomy appliance and bag with sanitizing or handwashing before glove application. LVN B then removed her gloves and washed her hands before leaving the room.During an observation on 5/11/2026 at 11:00 am in Resident 8's room, the Treatment Nurse sanitized and applied clean gloves before she cleaned the abdominal surgical wound on Resident #8 three times with normal saline and 4x4 gauze and placed the gauze in the trash, each time she removed her gloves and applied clean gloves without sanitizing or washing her hands. The Treatment Nurse patted the surgical abdominal wound dry with 4x4 gauze, packed the surgical wound with wet gauze and removed her gloves and placed them in the trash. The Treatment Nurse did not sanitize or wash her hands before she put on clean gloves. The Treatment Nurse applied an island dressing to Resident #8's abdominal area. The Treatment Nurse removed her gloves and placed them in the trash and sanitized her hands before leaving the room. During an interview on 5/11/2026 at 11:30 am, the Treatment Nurse said during the wound care that was provided to Resident #8, she should have sanitized or washed her hands each time she removed and donned clean gloves. She said there was a risk of spreading infections if correct handwashing was not followed. During an interview on 5/12/2026 at 11:30 am, LVB B said during the colostomy care that was provided to Resident #8, she should have sanitized or washed her hands each time she removed and applied clean gloves. She said there was a risk of spreading (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infections and contamination if correct handwashing was not followed.2. Record review of a face sheet dated 5/12/2026 for Resident #39 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnosis of severe protein malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), schizoaffective disorder (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), anxiety (fear characterized by behavioral disturbances), and seizures (a sudden change in behavior, movement, or consciousness caused by abnormal electrical activity in the brain). Record review of a significant change MDS assessment dated [DATE] for Resident #39 indicated she had severe impairment in thinking with a BIMS score of 99. She was always incontinent of bladder and always incontinent of bowel. She was dependent on staff for ADL's. Record review of a care plan revised 3/25/2026 for Resident #39 indicated an ADL self-care performance deficit. She required the total assist of direct care staff member for ADL completion for toilet use.During an observation on 5/12/2026 at 1:30 PM. CNA D went into Resident #39 room to provide incontinent care. CNA D donned appropriate PPE prior to approaching Resident #39's bed. CNA D opened the brief and pulled it down between Resident #39's thighs. CNA D removed a wipe from the plastic bag and wiped the resident's right inner thigh and folded it over and wiped the left inner thigh and placed the wipe in the trash. CNA D removed a wipe from the plastic bag and wiped down the middle of the vagina from front to back. CNA D removed wipes from the plastic bag and wiped Resident #39's perineal area from front (vagina) to back (buttocks) and placed wipe in the trash. CNA D rolled the soiled brief under Resident #39's buttocks and instructed Resident #39 to roll to her right side. CNA D removed soiled brief and placed it in the trash. CNA D placed clean brief under Resident #39 and rolled Resident #39 to her left side. CNA D positioned clean brief under Resident #39. Resident #39 was rolled onto her back and the brief was secured by CNA D and the resident was repositioned in the bed. CNA D removed her gloves and washed her hands in resident bathroom. CNA D did not change her gloves or perform any hand hygiene while providing incontinent care and repositioning Resident #39.During an interview on 5/12/2026 at 1:40 PM, CNA D said she has worked at the facility for 7 months. She said with the incontinent care provided to Resident #39 earlier, she believed she had followed all proper steps. She stated she had never been taught to change her gloves during incontinent care. She stated during CNA training that gloves were removed if exiting the room and then clean gloves put on when entering the room. She stated she did not recall any training about hand hygiene during incontinent care. She said residents could be at risk of infections if staff did not change gloves after touching body fluids or wash their hands between gloves changes. 3. During observation of meal service on 05/11/2026 at 12:45 PM to 1:05 PM revealed the following:*CNA D took meal tray into room [ROOM NUMBER], opened utensils, uncovered meal and moved bedside table in position with tray on top of table for Resident #15.*CNA D took meal tray into room [ROOM NUMBER], turned on light, opened utensils, and opened condiments after placing tray on bedside table for Resident #16.*CNA D took meal tray into room [ROOM NUMBER], uncovered meal, opened utensils, raised Resident #12 head of bed utilizing button control and positioned bedside table next to resident.*CNA D then took meal tray into room [ROOM NUMBER] and moved bedside table to Resident #19. CNA D did not sanitize hands prior to passing trays to any of the rooms on B hall during observation. During an interview on 05/11/2023 at 1:23 PM with CNA D stated the staff are to use hand sanitizer before getting the tray and after serving. She stated she had used hand sanitizer before she started passing the trays but did not perform any hand hygiene between entering and exiting resident rooms. CNA D stated that germs could be passed to other residents if hands were not sanitized during meal service. During an interview on 5/13/2026 at 9:00 am, the DON said she had been employed at the facility for a few months. She said she was obtaining her IP certification and currently the interim ADON was the IP. She said she already completed an Inservice with staff on infection control that included hand washing. She said she monitored the staff daily to ensure they were following infection control measures. She said the staff were trained on hire, annually and as (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed. She said hand hygiene should be done before and after care, and when hands were visibly soiled. She said she expected her staff to follow protocols for infection control including hand washing. She said she will be providing more education and in-services going forward to ensure staff were compliant. She said there was a risk for contamination of wounds and spreading infections. During an interview on 5/13/2026 at 9:40 am the ADON/Infection Preventionist said she was aware of staff not using proper infection control precautions. She said she has participated in training and will be training monitoring for compliance of hand hygiene and hand washing. She said there was a risk for spreading infections and causing sickness if proper infection prevention measures are not followed.During an interview on 5/13/2026 at 9:00 AM, the administrator said she expected staff to follow all infection control policies. She stated handwashing was the most important tool to prevent the spread of infection and that staff should either wash hands using soap and water or utilize hand sanitizer while providing care to the residents. She said that not following hand washing policy, can result in illness being spread to residents, visitors and other staff. She stated she expected staff to practice good hand hygiene while in the facility. She said hand hygiene in-services will be performed, return demonstrations will be performed and observation by management to ensure that proper hand hygiene and infection control and prevention policy is followed by staff. Record review of a facility policy titled Handwashing/Hand Hygiene revised October 2023 indicated, .This 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 contamination surfaces; f. before moving from work on a soiled body site to a clean body site on the same resident .Record review of a facility policy titled Perineal Care revised February 2018 indicated, .discard soiled gloves, sanitize hands, Re-glove prior to touching clean linens/ adult brief.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent infections and to restore continence to the extent possible for 1 of 3 (Resident #36) residents observed for urinary catheter (tube placed in the bladder that drains into a bag outside of the body) care.The facility failed to ensure the urinary drainage bag was kept off the floor for Resident #36 on 5/11/26.This failure could place residents at risk for bacterial infections from improper catheter care.Findings include:Record review of a facility face sheet dated 5/12/26 for Resident #36 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of traumatic brain injury (a brain injury that is caused by an outside force). Record review of a quarterly MDS assessment dated [DATE] for Resident #36 indicated he was in a persistent vegetative state and had an indwelling urinary catheter. Record review of a comprehensive care plan dated 2/24/26 for Resident #36 indicated he had an indwelling urinary catheter due to neuromuscular dysfunction of bladder (occurs when nerve damage disrupts communication between the brain, spinal cord, and bladder, leading to impaired bladder control) with an intervention to monitor for signs and symptoms of infection.Record review of physician's order summary report dated 5/12/26 for Resident #36 indicated he had an order for catheter care each shift and as needed dated 10/31/25.* During an observation on 05/11/2026 at 10:42 am Resident #36 was observed lying in bed. A urinary drainage bag was observed hanging on the side of the bed with the bag touching the floor. During an interview on 5/13/26 at 10:00 am CNA C said urinary drainage bags should always be kept off the floor. She said it was an infection control issue if the bag was allowed to touch the floor.During an interview on 5/13/26 at 10:06 am RN A said it was important that urinary drainage bags be kept off the floor. She said if the bag was on the floor, it could increase the risk of infections. During an interview on 5/13/26 at 11:00 am the DON said she expected her staff to keep urinary drainage bags off the floor. She said the bag could become contaminated with germs and increase the infection risk. She said going forward, she would be re-educating the staff and have department heads and nurse managers make more frequent rounds to monitor.During an interview on 5/13/26 at 11:15 am the Administrator said she expected staff to keep bags off the floor. She said it was an infection control issue as the bag could develop bacterial growth and create infections and possible cross contamination to other staff and residents. She said she would be providing further education and more frequent monitoring going forward. Record review of a facility policy titled Catheter Care, Urinary dated 2001 and revised July 2024 read .Be sure the catheter tubing and drainage bag are kept off the floor .