STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675850	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Portland	221 Cedar Dr Portland, TX 78374

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 interview and record review the facility failed to ensure the comprehensive care plan was developed and implemented for each resident consistent with resident rights to include measurable objectives and timeframes to meet residents medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 2 of 5 residents (Resident #1 and Resident #2) reviewed for care plans.The facility failed to develop the comprehensive care plans for Resident #1 and Resident #2.These failures could place residents at risk of receiving improper or inadequate care and services.The findings included:1. Record review of Resident #1's face sheet, dated 03/18/2026, revealed a [AGE] year-old female with an admission date of 02/24/2026 and a discharge date of 03/11/2026 at 6:55 PM. Pertinent diagnosis included Essential Primary Hypertension (high blood pressure).Record review of Resident #1's admission MDS, dated [DATE], revealed a BIMS score of 09, moderately impaired cognition. MDS also revealed assessment signed as completed on 03/04/2026.Record review of Resident #1's care plan tab, reviewed 03/18/2026, revealed Resident #1 had no comprehensive care plan.2. Record review of Resident #2's face sheet, dated 03/19/2026, revealed a [AGE] year-old male with an original admission date of 02/17/2026, a current re-admission date of 03/06/2026. Pertinent diagnosis included Encounter for Surgical Aftercare Following Surgery on the Circulatory System.Record review of Resident #2's care plan tab, reviewed 03/19/2026, revealed Resident #2 had no comprehensive care plan.Record review of Resident #2's BIMS evaluation, dated 02/17/2026, revealed a BIMS score of 15, cognition intact. In an interview on 03/19/2026 at 9:20 AM, the MDS nurse stated if there was not a care plan under the care plan tab, then one was never opened or created. She stated at one point she did mention in the morning meeting a care plan for Resident #1 and Resident #2 needed to be opened because she was not able to create or open a care plan. The MDS nurse stated there was only one RN who other than the DON who could open or create a care plan. The MDS nurse stated once the care plan had been opened, she went in and updated the clinical aspect of the care plan. She stated she typically went by a three-day rule after admission to have comprehensive care plans opened in the chart. In an interview on 03/19/2026 at 12:55 PM, the DON stated care plans were utilized to determine the care and needs of a resident, and any of the IDT could have initiated, opened or created the care plan, but it was closed by the DON, or another RN. The DON stated he could find the baseline care plans for Resident #1 and Resident #2, which he showed to nurse surveyor, but he was unable to find the comprehensive care plans. He was unsure why the comprehensive care plans were not completed, but stated the responsibility ultimately fell back on him to verify care plans had been completed. Record review of the facility's Comprehensive Care Plans policy, revised March 2022, revealed Policy Statement: 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. Policy Interpretation and Implementation: 1. The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is (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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(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	developed within seven days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status).

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1's blood pressures were assessed prior to administering Metoprolol (a medication used to treat high blood pressure) per the prescribed order and blood pressure parameters in February and March of 2026. This failure could have placed residents at risk for complications and jeopardized their health and safety.The findings Included: Record review of Resident #1's face sheet, dated 03/18/2026, revealed a [AGE] year-old female with an admission date of 02/24/2026 and a discharge date of 03/11/2026 at 6:55 PM. Pertinent diagnosis included Essential Primary Hypertension (high blood pressure).Record review of Resident #1's physician orders, started 02/24/2026, revealed an order for Metoprolol 12.5 MG, give one tablet by mouth four times a day for Hypertension. Hold for systolic (the top number which measures the force of the blood against the arterial walls as the heart beats) blood pressure less than 110 or diastolic (the bottom number which measures the force of the blood against the arterial walls while the heart was at rest) blood pressure less than 60.Record review of Resident #1's care plan tab, reviewed 03/18/2026, revealed she had no comprehensive care plan. Record review of Resident #1's March 2026 MAR revealed Metoprolol 12.5 MG, give one tablet by mouth four times a day for Hypertension. Hold for systolic blood pressure less than 110 or diastolic blood pressure less than 60. There were no blood pressures listed in the MAR to coincide (reflect or occur at the same time) with this medication. The times listed for medication administration were 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM.Record review of Resident #1's vital signs revealed no blood pressures were taken at times to coincide with the blood pressure medication administration record on the following dates: 02/25/2026 at 12:00 PM, 02/25/2026 at 5:00 PM; 02/26/2026 at 9:00 AM, 02/26/2026 at 5:00 PM; 02/27/2026 at 12:00 PM, 02/27/2026 at 5:00 PM, 02/27/2026 at 9:00 PM; 02/28/2026 at 9:00 AM, 02/28/2026 at 12:00 PM, 02/28/2026 at 5:00 PM, 02/28/2026 at 9:00 PM; 03/01/2026 at 9:00 AM, 03/01/2026 at 12:00 PM, 03/01/2026 at 5:00 PM, 03/01/2026 at 9:00 PM; 03/02/2026 at 12:00 PM, 03/02/2026 at 5:00 PM, 03/02/2026 at 9:00 PM; 03/03/2026 at 12:00 PM, 03/03/2026 at 5:00 PM; 03/04/2026 at 9:00 AM, 03/04/2026 at 12:00 PM, 03/04/2026 at 5:00 PM, 03/04/2026 at 9:00 PM; 03/05/2026 at 9:00 AM, 03/05/2026 at 12:00 PM, 03/05/2026 at 5:00 PM, 03/05/2026 at 9:00 PM; 03/06/2026 at 9:00 AM, 03/06/2026 at 12:00 PM, 03/06/2026 at 5:00 PM, 03/06/2026 at 9:00 PM; 03/07/2026 at 12:00 PM, 03/07/2026 at 5:00 PM, 03/07/2026 at 9:00 PM; 03/08/2026 at 12:00 PM, 03/08/2026 at 5:00 PM; 03/09/2026 at 9:00 AM, 03/09/2026 at 12:00 PM, 03/09/2026 at 5:00 PM, 03/09/2026 at 9:00 PM; 03/10/2026 at 12:00 PM, 03/10/2026 at 5:00 PM, 03/10/2026 at 9:00 PM; and 03/10/2026 at 12:00 PM, 03/10/2026 at 5:00 PM. There was no documentation Resident #1 had and signs or symptoms of negative effects on these days the blood pressure medications was given without first checking the resident's blood pressure. In an interview on 03/19/2026 at 2:55 PM, the NP stated blood pressures should be checked prior to administering blood pressure medications, otherwise, you would not be able to tell if the Resident actually needed the medication. If a blood pressure medication is given outside of parameters, it could affect the resident's health. In an interview on 03/19/2026 at 4:00 PM, the ADON stated nurses should have checked the blood pressures prior to administering the blood pressure medication because it was required, and if blood pressure was already low, the blood pressure medication could have caused the blood pressure to continue to drop, placing the resident's health at risk. She stated the nurses had previously been in-serviced over this topic. In an interview on 03/19/2026 at 6:55 PM, the RNC stated nurses should always check the blood pressure prior to administering the blood pressure medication because if a blood pressure was already low, and the blood pressure medication was administered, the blood pressure could have continued to drop, and the resident's blood pressure could have bottomed out, causing potential health risks for the resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	such as dizziness, blurred vision, fainting, or even possibly shock. She stated she could only find a few blood pressures recorded in Resident #1's MAR and vital signs to coincide with the blood pressure medication, and this was because they were being taken for another medication being administered.In an interview on 03/19/2026 at 6:55 PM, the DON stated blood pressures should be assessed prior to administering blood pressure medication or it could have caused the resident to have side effects from the medication, such as blood pressure dropping too low. He stated the RNC could only find the same few blood pressures the nurse surveyor had already pointed out in Resident #1's MAR and vital signs to coincide with the blood pressure medication. He stated the physician had been informed, but the resident was no longer here and there were no negative effects. Record review of the National Institute of Health: National Library of Medicine, dated January 2020, revealed Blood Pressure Assessment in Adults in Clinical Practice and Clinic Based Research: The accurate measurement of blood pressure is essential for the diagnosis and management of hypertension. Statistical Considerations: The diagnosis of hypertension and evaluation of response to treatment require accurate assessment of blood pressure to prevent under or over treatment. https://pmc.ncbi.nlm.nih.gov/articles/PMC6573014/Record Review of the facility's Administering Medications policy, revised April 2019, revealed Policy: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 11. The following information is checked/verified for each resident prior to administering medications: b. Vital signs, if necessary.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 1 (Resident #2) of 5 residents reviewed for infection control practices.The facility failed to ensure Resident #2 received wound care consistent with best practices and facility policies and procedures on 03/19/2026, when during wound care with Resident #2, the NP and the WCN incorrectly donned PPE (to don PPE means to put on personal protective equipment) prior to wound care, performed improper hand hygiene during wound care, incorrectly cleansed the wound during wound care, incorrectly performed wound care, incorrectly disposed of contaminated trash and supplies during wound care, and incorrectly cleaned supplies after wound care. These failures could place residents at risk for the wrong PPE being utilized, cross-contamination, and possible infection.The findings included:Record review of Resident #2's face sheet, dated 03/19/2026, revealed a [AGE] year-old male with an original admission date of 02/17/2026, a current admission date of 03/06/2026. Pertinent diagnosis included Encounter for Surgical Aftercare Following Surgery on the Circulatory System.Record review of Resident #2's physician orders, with a start date of 03/09/2026, revealed an order to cleanse right foot surgical site with Dakins solution, rinse with normal saline, pat dry, apply adaptic (sterile, non-adherent wound dressing) to wound bed, apply alginate ag (highly absorbent wound dressing), lightly pack wound bed if needed, cover with ABD pad (highly absorbent wound dressing), wrap with Kerlix (a gauze used to wrap wounds), and secure with tape. Orders also revealed an order for EBP, started 03/09/2026: Practice EBP as indicated when in contact with wound and/or PICC line. Record review of Resident #2's care plan tab in PCC revealed Resident #2 did not have a comprehensive care plan. In an observation on 03/19/2026 at 1:45 PM, it was observed the WCN and the NP had set everything up prior to notifying the surveyor of the wound care. After performing hand hygiene, both the WCN and the NP only donned gloves. The did not don a disposable gown prior to wound care. There was no clean barrier placed between Resident #2's wounds to right foot and dirty sheet the resident was lying on. The NP was noted to lean over the wound, allowing her hair to fall around the wound. The WCN was observed to cleanse the wound inappropriately, cleansing from the outside to the inside (dirtiest to cleanest area of the wound). She then removed the dirty gloves and applied hand sanitizer, but did not rub all areas of her hands until thoroughly dry, and reapplied new, clean gloves. The WCN was noted to apply medicated gel to the wound bed, but when the gel ran down Resident #2's foot, the WCN wiped the unclean, bottom of the foot with gauze and clean gloves, then continued to perform wound care without performing hand hygiene and applying new, clean gloves. The WCN was noted to put some trash from wound care onto her clean barrier on the tray in which she had placed the clean wound care supplies. The WCN was noted to perform hand hygiene and put on clean gloves prior to grabbing the dirty tray and taking it to her treatment cart to clean with sanitizing wipes. The WCN did not have any sanitizing wipes on her cart, so she proceeded to carry the tray throughout the facility until she could find sanitizing wipes to clean the tray. In an interview on 03/19/2026 at 2:55 PM, the NP stated she and the WCN should have put on the appropriate PPE prior to entering Resident #2's room for wound care, to include gloves and a gown. She stated EBP was used to protect the patient and prevent cross-contamination. The NP stated she was leaning over the wound, but she did not think her hair touched the wound. She stated her hair would not stay back, but she should have raised the bed or gotten eye level with the wound instead of leaning her head over the wound. In an interview on 03/19/2026 at 3:05 PM, the WCN stated she should have put on the appropriate PPE, to include a gown, prior to entering Resident #2's room. She stated EBP was used to protect the patient and prevent cross-contamination. She stated she did not typically put a clean barrier between Resident #2's leg/foot and the sheets on the bed because she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not think it was necessary unless the wounds had a lot of drainage and could not be contained. The WCN stated she knew wounds were supposed to be cleaned from the inner to outer so as to not create cross-contamination and re-introduce germs or bacteria back into the wound. She also stated she should have performed hand hygiene and applied clean gloves after wiping the dirty area of the bottom of Resident #2's foot. The WCN also stated after applying alcohol-based hand sanitizer she should have rubbed her hands for at least 20 seconds and until dry prior to putting on new gloves. The WCN stated she usually kept sanitizing wipes on her cart to wipe her equipment down after wound care, but someone must have borrowed them.In an interview on 03/19/2026 at 4:00 PM, the ADON stated EBP was utilized for high contact activities such as wound care, dressing, bathing, transferring, and changing linens. She stated the order for EBP should specify high contact activities and not just wound care. She stated the required PPE to perform wound care for Resident #2 would consist of a gown and gloves if no splash back was expected. The ADON stated nurses should perform hand hygiene between glove changes when going from clean to dirty and back to clean. The ADON stated the wound should be cleansed from the inner to the outer of the wound, cleaning from cleanest area to dirtiest area; otherwise, they could possibly reintroduce bacteria back into the wound. Record review of the facility's Enhanced Barrier Precautions policy, revised February 2025, revealed Policy Statement: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Policy Interpretation and Implementation: 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high contact resident care activity requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use, wound care.Record review of the facility's Hand Hygiene policy, Revised October 2023, revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: Indications for Hand Hygiene: 1. Hand hygiene is indicated: c. after contact with blood, body fluids, or contaminated surfaces; f. before moving from work on a soiled body site to a clean body site on the same resident. Applying Alcohol-Based Hand Rubs: 2. Cover all surfaces of hands and fingers until hands are dry. 3. Rub hands together for a minimum of 15 seconds.