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	09/09/2025

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 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 two (Resident #16 and Resident #34) of six residents reviewed for medication errors in that: 1)Resident #16's blood pressure was not taken to assess if Resident #16 required her blood pressure/pulse altering medications (Midodrine HCl Oral Tablet) for 29 days in the month of August 2025 and 0 days in September 2025 per physician orders. 2) Resident #34's blood pressure was not taken to assess if Resident #34 required her blood pressure/pulse altering medications (Lisinopril 10 mg Oral Tablet) for 6 days in the month of September 2025 and 18 days in the month of August 2025 per physician orders. These failures could place residents who receive blood pressure/pulse altering medications at an increased risk for complications such as decreased blood pressure, decreased pulse, exacerbation of symptoms and disease process, and potential hospitalization. The findings include: 1) Record review of Resident #16's face sheet dated 09/08/25 reflected a [AGE] year-old-female with an original admission date 01/25/25. Diagnoses included epilepsy (brain condition that causes recurring seizures), COPD (lung condition caused by damage to the airways that limit airflow), and type two diabetes (insufficient production of insulin in the body). Record review of Resident #16's physician orders dated 7/26/2025 reflected: Midodrine HCl Oral Tablet 5 MG. Give 1 tablet by mouth every 12 hours as needed for hypotension (low blood pressure). Give if SBP is < 100. Record review of Resident #16's blood pressure log on 09/08/25 from August and September of 2025 revealed blood pressures were recorded only on the following days: 8/15/2025- 134/79 mmHg 08/11/2025- 128/80 mmHg Further review revealed Midodrine HCl Oral Tablet 5 mg was not administered in August and September of 2025. In an interview on 09/08/2025 3:57 PM, LVN E stated Resident #16's blood pressure should have been taken twice a day to assess if she required administration of prn blood pressure medication, Midodrine. LVN E stated she had no reason to why Resident #16's blood pressure was not being taken twice a day. LVN E stated it was important to check Resident #16's blood pressure to assess if resident required the medication per physician orders. LVN E stated by not taking Resident #16's blood pressure, she could have been at risk of experiencing signs and symptoms of low blood pressure such as dizziness or fainting An attempt interview with LVN F via telephone on 09/08/2025 at 4:10 PM was unsuccessful. In an interview on 09/08/2025 at 4:42 PM, the DON stated Resident #16's blood pressure should have been taken twice a day to assess if Midodrine was needed. The DON stated by staff not assessing Resident #16's blood pressure, her condition could have worsened. The DON stated the nurse manager who was assigned to the pharmacy task would have been the one in charge of auditing resident medications. The DON stated that position has not been filled for a few months and ultimately, he was responsible to ensure vitals were being taken and medication was being given. The DON stated there was no answer as to why Resident #16's blood pressure and Midodrine medication was not given as prescribed. In an interview on 09/09/2025 at 9:42 AM, Resident #16 stated once in a while staff checked her blood pressure but not twice a day. In a telephone interview on 09/09/25 at 10:31AM, LVN C stated she did not know why she was not documenting Resident #16's blood pressures. LVN C stated if Resident #16's blood pressure was normal she did not document it. LVN C stated, I don't (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know how Resident #16's blood pressure would be tracked and trended. LVN C stated there was no reason as to why Resident #16's blood pressure was not getting assessed twice a day. LVN C stated Resident #16 could have passed out and possibly hit the floor if her blood pressure became too low. 2) Record review of Resident #34's face sheet dated 09/08/25 revealed a [AGE] year-old female with an admission date of 04/17/25. Pertinent diagnosis included peripheral vascular disease (a condition that affects the blood vessels outside of the heart, typically in the legs.^It occurs when the arteries become narrowed or blocked, reducing blood flow to the lower extremities). Record review of Resident #34's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 (moderate impairment). Record review of Resident #34's comprehensive care plan dated 09/08/25 revealed the focus I have Heart Disease. I am at risk for associated cardiac complications such as chest pain, [shortness of breath], fatigue, dizziness, poor endurance/activity intolerance and edema . initiated on 04/21/25 and revised on 07/07/25. Interventions listed for the focus included: Administer my medications as ordered by my physician initiated on 04/21/25. Monitor vital signs as indicated and report abnormal findings to [Medical Director] as indicated initiated on 07/07/25. Record review of Resident #34's order summary revealed an active order for Lisinopril Oral Tablet 10 MG: Give 1 tablet by mouth every 24 hours as needed for [Hypertension] (high blood pressure) Give one tablet [by mouth] [every] day if [blood pressure] is above 140/90 initiated on 04/17/25 and revised on 04/19/25. Record review of Resident #34's blood pressure log on 09/08/25 from August and September of 2025 revealed blood pressures were not recorded on the following days: - 09/07/25, 09/05/25, 09/04/25, 09/03/25, 09/02/25, 09/01/25, 08/31/25, 08/30/25, 08/29/25, 08/27/25, 08/25/25, 08/24/25, 08/23/25, 08/22/25, 08/21/25, 08/19/25, 08/18/25, 08/17/25, 08/16/25, 08/15/25, 08/13/25, 08/12/25, 08/11/25, and 08/09/25 In an interview with LVN H at 7:56 AM on 09/08/25, LVN H stated Resident #34's blood pressure should have been checked at least once daily to determine if Resident #34 needed lisinopril 10 mg. LVN H stated Resident #34 should be given her lisinopril 10 mg oral tablet if her blood pressure was over 140/90 mm/Hg that day. LVN H stated if Resident #34's blood pressure was not checked on a given day, her blood pressure could be elevated, and the staff would not know that she needed her lisinopril 10 mg to lower it. LVN H stated untreated high blood pressure could lead to a stroke in residents. In an interview with the DON on 4:42 PM on 09/08/25, the DON stated according to the order, Resident #34's blood pressure should have been taken at least once per day to assess if lisinopril was needed. The DON stated by staff not assessing Resident #34's blood pressure, her condition could have worsened. The DON stated the nurse manager who was assigned to the pharmacy task would have been the one in charge of auditing resident medications. The DON stated that position has not been filled for a few months and ultimately, he was responsible to ensure vitals were being taken and medication was being given. The DON stated there was no answer as to why Resident #34's blood pressure and lisinopril medication was not given as prescribed. In an interview with Resident #34 at 10:18 AM on 09/09/25, Resident #34 stated she always received her medications on time. Resident #34 stated they measured her blood pressure most days. Resident #34 stated she had not experienced any symptoms of high blood pressure such as chest pain or dizziness, but she did get headaches. Resident #34 stated she has had headaches all her life so she did not think it was related to high blood pressure. Record review of facility's policy Medication Administration dated March 2019 and revised in January 2024 reflected: Compliance Guidelines: Resident medications are administered in accurate, safe, timely, and sanitary manner. RESPONSIBLE DISCIPLINES 5. If applicable and/or prescribed, take vital signs or tests prior to administration of the dose (e.g., pulse with digitalis). 6. Administer medications as ordered by the physician. Routine medications shall be according to the established medication administration schedule for the community. Non-Time Sensitive Medications/Treatments Liberalized time ranges are tasks related assignments. The licensed nurse should assign non-time sensitive medications/treatments to the appropriate liberalized time range and appropriate medication or treatment administration record in order to coordinate and facilitate administration.

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in one of one kitchen reviewed for dietary services. 1. The facility failed to ensure the ice machine was clean. 2. The facility failed to ensure food/ drink items in the reach-in refrigerators and freezers, dry storage area, and kitchen area were properly stored, labeled, and dated. 3. The facility failed to ensure cleaned dishes did not have food or beverage residue in or on them. 4. The facility failed to ensure the floor, dish washing machine, and dirty and clean dish washing tables did not have food residue and other trash on them. 5. The facility failed to ensure the dish machine temperature and sanitizing log was filled out 3 times a day. These failures could place residents who received meals and/or snacks from the kitchen at risk for food contamination and food borne illness. Initial tour and observation of the kitchen on 09/07/25 beginning at 11:01 AM revealed the following: The ice machine had a black colored substance on the inside left side wall near the hinge attachment of the lid. The ice machine lid had a rusty screw/washer on the inside left side hinge attachment of the lid. The ice machine had a rust-colored substance on the inside left side wall near the hinge attachment of the lid. The ice machine had a rust-colored substance on the left hinge attachment of the lid. The ice machine had a black colored substance on the inside of the lid along the back edge. The ice machine had a black colored substance on the inside right-side wall near the hinge attachment of the lid. The ice machine had a stripe of a black colored substance on the left side where the lid closed against the machine. The ice machine had a stripe of a black colored substance on the right side where the lid closed against the machine. A clear empty pitcher on the top of the metal table between the ice machine and microwave had a white colored film covering much of the inside of the pitcher. A tray on top of the metal table in front of the microwave had a spot of a reddish colored substance on it. The tray also had 12 sets of clean silverware individually wrapped in napkins on it. A box on the floor with a watermelon in it on the left side of the reach-in refrigerator. A box on the floor with flour tortillas in it on the right side of the DM's office. Observation of the facility's reach-in refrigerator on 09/07/25 beginning at 11:15 AM revealed the following: A box with Aug. 31st, 2025 written on it with an opened, unsealed plastic overwrap with approximately 4/5 of a block of cream cheese in it. The box was sitting on top of its lid. A partially opened one gallon zipper seal type plastic bag dated 09/06/25 that with Smoked-Sliced turkey breast lunch meat in its original opened plastic wrap which was dated 8/2?????5 (Date was unreadable). An opened unlabeled/undated 5-pound container of sour cream. An opened unlabeled/undated two-gallon zipper seal type plastic bag with another unsealed/unlabeled/undated bag in it that contained shredded cheese. There was also shredded cheese loose in the two-gallon bag. 2 unlabeled/undated two-gallon zipper seal type bags containing sandwiches. Observation of the facility's dry storage area on 09/07/25 beginning at 11:21 AM revealed the following: An opened/unsealed plastic bag dated 08/25/25 with cereal in it. An open two-gallon zipper seal type plastic bag dated 8/12 with an opened/unsealed bag of graham cracker crumbs in it. An approximately 10-gallon white plastic round container with an unsecured and partially opened snap on lid with sugar in it. The sugar had an approximately 4 inch long by 1/4-inch-thick chunk of a beige colored substance in it. An approximately 10-gallon white plastic round container with an unsecured and partially opened snap on lid with flour in it. Observation of the facility's reach-in freezer on 09/07/25 beginning at 11:27 AM revealed the following: An open cardboard box dated 08/29/25 with an open/unsealed bag with frozen peanut butter cookies in it. An opened, unsealed bag of onion rings in the original bag dated 09/05/25. An opened, unsealed/unlabeled/undated bag with an unknown breaded meat product in it. Observation of the facility's dishwashing area on 09/07/25 beginning at 11:41 AM revealed the following: On a rack above the dishwashing sink area, a silver #26 frying pan with the adhesive layer from a sticker still on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the cooking surface was hanging on a hook. There was also an intact sticker on the bottom of the frying pan. On a rack above the dishwashing sink area, a fine mesh strainer with brown/black colored mesh and a ring of a thick, black substance around the top rim was hanging on a hook. Observation of a 4-shelf rack of clean dishes on 09/07/25 beginning at 11:46 AM revealed the following: 1 large dark blue bowl with flecks and chunks of a white substance on the inside and outside of it. 20 of 51 maroon bowls with a cream of wheat like substance on the inside and/or outside of them. 51 of 51 maroon bowls with flecks, spots, and/or chunks of a white substance on the inside and/or outside of them. 1 of 8 green bowls which appeared unwashed with a large amount of a thick yellowish substance in streaks on the bottom and sides of it. 1 of 8 green bowls with a reddish filmy substance on the outside of it. 8 of 8 green bowls with flecks, spots, and/or chunks of a white substance on the inside and/or outside of them. 1 of 1 beige bowl with a brownish filmy substance on the inside of it. 18 of 18 small blue bowls with flecks, spots, and/or chunks of a white substance on the inside and/or outside of them. 3 of 18 small blue bowls with a cream of wheat like substance on the inside and/or outside of them. 1 of 18 small blue bowls with a yellowish substance on the inside and outside of it. 23 of 23 maroon cups with flecks, spots, and/or chunks of a white substance on the inside and/or outside of them. 2 of 23 maroon cups with a cream of wheat like substance on the inside and/or outside of them. 3 of 3 blue cups with flecks, spots, and/or chunks of a white substance on the inside and/or outside of them. 1 of 5 grey cups with a cream of wheat like substance on the inside and/or outside of it. 1 of 5 grey cups that was very discolored on the inside with a brownish colored stain. 1 of 1 clear cup with flecks, spots, and/or chunks of a white substance on the inside and/or outside of it. 7 of 7 large porcelain plates with multiple different colored flecks and/or spots on the front and back of them. 11 of 21 small porcelain plates with multiple different colored flecks and/or spots on the front and back of them. 1 of 21 small porcelain plates with 2 chips out of the front edge of it. Observation of the automatic dish washing machine on 09/07/25 beginning at 12:59 PM revealed the following: Limescale build up on top, bottom, right, and left outside and inside edges of both doors. Limescale build up on the front, back, left, and right bottom edge of the inside of the dish washing machine. Limescale build up on the bottom of the dish washing machine. Food chunks including what appeared to be corn, green beans, carrots, and various other food products and a pink sugar replacement package covering approximately 1/3 of the drain pan underneath the dish washing machine. Food particles and trash-including salt and pepper packets, on the floor and in the holes of the black non-slip rubber mats in the dish washing area. A cup on the floor under the dirty side table of the dish washing machine. Food chunks and a wet pepper packet on the surface of the clean side table of the dish washing machine. Food chunks on the bottom of the first of 2 dish washing machine dish trays on the clean side table of the dish washing machine. A wet salt packet on the top of the second of 2 dish washing machine dish trays on the clean side table of the dish washing machine. During an interview on 09/07/25 at 12:05 PM, DA A stated the dishes on the 4-shelf rack in the dish washing area were clean dishes that had been run through the dish washer. DA A walked away before any more questions were asked. During an interview on 09/07/25 at 12:10 PM, the [NAME] stated the dishes on the 4-shelf rack in the dish washing area were clean dishes. He stated he would not have put the rack where it was, but his boss's boss wanted it there. Record review of the Dish Machine Temperatures and Sanitizing Log on 09/07/25 at 1:00 PM reflected the following: On 09/05/25 and 09/06/25, the PM wash temp, final rinse temp, and sanitizer PPM were not documented. On 09/07/25 the AM wash temp, final rinse temp, and sanitizer PPM and the noon wash temp, final rinse temp, and sanitizer PPM were not documented. During interviews at 1:15 PM on 09/07/25 and 8:29 AM on 09/08/25, the DM stated she was off the day before and, apparently the dietary staff did not do what they were supposed to do when I am not there to tell them. The DM stated the sticky frying pan was new, she did not know why it was sticky, and it had not been used yet. The DM stated the fine mesh strainer with the buildup on it was an old strainer and should have been thrown away since they had a new one already. The DM stated the dishes were not checked when they were removed from the dish (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	washer and put on the clean dish rack like they were supposed to be. She stated if the dishes were dirty, they had to be put through the dish washer again. The DM stated she would run the dishes through again and make sure they were clean before putting them back on the clean dish rack. She further stated there was a cleaning log that was supposed to be followed by the dietary staff, but she was not able to locate it, and the ice machine was wiped down daily and deep cleaned once a month. The DM stated it was everyone's responsibility to label, date, and seal food items before they were put in the refrigerator, freezer, or dry storage and her responsibility to make sure it was done. The DM stated if residents were served food that was not stored properly or were served on dishes that were not cleaned and sanitized properly, it could cause them to get sick. In an interview on 09/08/25 at 8:18 AM, DA B stated she checked the dish washing machine and removed any food debris from the inside of it before she ran dishes through it, and she ran the dishes through it three times before she put them on the clean dish rack. DA B stated if residents were served food on dirty dishes, it could cause food borne illnesses. In an interview on 09/08/25 at 8:26 AM, the dietician stated if food was not labeled and dated, staff would not know how long it was open and when it expired. If food that was not properly stored was served to residents, it could cause them to get sick. The dietician also stated residents could get sick of they ate or drank from dishes that were not cleaned and sanitized correctly which could lead to hospitalization or even death. In an interview on 09/09/25 at 1:13 PM, the DON stated it was important for the kitchen to store food properly so that food did not spoil. He stated it was important for dishes to be thoroughly cleaned and sanitized to prevent food borne illness. Record review of the facility's Food Storage Policy dated 01/2024 and revised on 01/2025 reflected in part: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Procedure: 1. Dry storage rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. h. Store all items at least 6 above the floor with adequate clearance between goods and ceiling to protect from overhead pipes and other contamination. 2. Refrigerators Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. 3. Freezers e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated. Record review of the facility's undated General Kitchen Sanitation Policy reflected in part: Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Procedure: 1. Clean and sanitize all food preparation areas, food contact surfaces, dining facilities, and equipment. After each use, clean and sanitize all tableware, kitchenware, and food-contact surfaces of equipment, except cooking surfaces of equipment and pots and pans that are not used to hold or store food and are used solely for cooking purposes. 6. Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition. Record review of the facility's undated Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment Policy reflected in part: Policy: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for mechanical cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards. Procedure: 1. Use only an approved dish machine that is properly installed and maintained. Operate the dish machine as instructed in the manufacturer's directions. Schedule and complete regular maintenance inspections. 2. Make sure that the automatic detergent dispenser and/or liquid sanitizer injector is working properly. 3. Rinse or scrape equipment and utensils and, when necessary, soak to remove gross food particles and soil prior to being washed. 4. Place equipment and utensils on racks, trays, or baskets, or on conveyors, so that all food-contact surfaces are exposed to the detergent wash and clean rinse water and the equipment and utensils can freely drain. 5. Empty strainer after each meal. 6. Clear the dish machine at least once each day. 7. If a machine that uses chemicals for (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitizing is in use, follow these guidelines: f. A test kit or other device that accurately measures the parts per million concentration of the solution must be available and used. 8. If a machine that uses hot water for sanitizing is in use, follow these guidelines: c. Temperatures must be monitored and recorded during each wash/rinse cycle.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure the resident's right to privacy for 1 (Resident #11) of 6 residents reviewed for dignity in that:The WCN did not provide privacy for Resident #11 while performing his wound care. This failure could cause residents to feel uncomfortable, disrespected, and possibly a loss of dignity due to a lack of privacy. Findings included: Record review of Resident #11's face sheet dated 09/08/25 reflected a [AGE] year-old-male with an original admission date of 08/31/24. Diagnoses included heart disease, type two diabetes (insufficient insulin production in the body), chronic kidney disease, and COPD (lung condition caused by damage to the airways that limit airflow). During an observation on 09/07/2025 at 4:19 PM, the WCN did not provide privacy by leaving Resident #11's room door open while performing his wound care. Other residents, staff, and visitors passing by Resident #11's room were able to see his wound care being performed. In an interview on 09/07/2025 at 4:34 PM, the WCN stated it was important to provide privacy during Resident #11's wound care to maintain his dignity and respect. The WCN stated by not providing privacy, Resident #11 could feel shameful, sad, depressed or less than, by making him feel like he was not important. The WCN stated she did not realize she did not close Resident #11's door. In an interview on 09/08/2025 at 12:15 PM, the DON stated the WCN should have provided privacy to Resident #11 during his wound care to ensure his dignity and respect. The DON stated wound care should be confidential and by not providing privacy, it could make Resident #11 feel violated. Record review of facility's Statement of Resident Rights dated February 2017 and date revised in 2025 reflected: Compliance Guidelines: The facility should educate, encourage, and honor the rights of those we serve. Further, the facility should assist a resident/patient to fully exercise their rights applicable. Residents/Patients do not give up their rights when entering a [NAME] Community. Resident/Patient Rights Include: 4. Be treated with courtesy, consideration and respect; 6. To privacy, including privacy during visits and telephone calls;

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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 observations, interviews, and record reviews the facility failed to ensure residents received appropriate treatment and services to prevent urinary tract infections to the extent possible for one (Resident #49) of three residents reviewed for urinary catheters. The facility failed to ensure LVN C changed Resident #49's urinary catheter drainage bag on 09/01/25 per the physician's order. This failure places residents with urinary catheters at risk for urinary tract infections. Record review of Resident #49's admission record reflected a [AGE] year-old male originally admitted to the facility on [DATE] with most recent admission on [DATE]. His pertinent diagnoses included malignant neoplasm (cancerous tumor) of the prostate, obstructive and reflux uropathy (urine flow is blocked and causes urine to back up into the kidneys causing kidney damage), urostomy with suprapubic urinary catheter (an opening in the abdomen that connects to the urinary tract to allow urine to drain into a catheter and urinary collection bag), and difficulty walking. Record review of Resident #49's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated he had no cognitive impairment. Record review of Resident #49's care plan dated 01/31/25 reflected the focus, I require a catheter for obstructive and reflux uropathy, other artificial openings of the urinary tract, malignant neoplasm of the prostate, placing me at risk for infection, created on 01/31/25. Interventions listed for the focus included: Catheter Care every shift and as indicated initiated 05/20/25. Change catheter per my physician's order initiated 05/20/25. Monitor for s/sx infection initiated on 05/20/25. Record review of Resident #49's order summary report reflected the following orders: Suprapubic catheter dx: prostate cancer, obstructive and reflex uropathy dated 05/20/25. Suprapubic catheter: change monthly on the 15th day of the month 10-6 shift, every night shift dated 05/25/25. Suprapubic catheter: change collection bag Q2WKS and PRN, every night shift every 2 weeks on Monday dated 05/25/25. Suprapubic catheter: change collection bag Q2WKS and PRN, as needed dated 05/25/25. During an observation on 09/07/2025 at 3:35 PM, Resident #49's urinary catheter bag had the date 08/16/25 written in black marker on the upper left side of the front of the bag. During an interview on 09/07/25 at 3:37 PM, Resident #49 stated he had the suprapubic catheter placed 25 years ago when he was diagnosed with prostate cancer. Resident #49 stated the night nurse changed the catheter and the collection tubing/bag at the same time in August and the collection tubing/bag was not changed in the previous week. Resident #49 denied any signs or symptoms of a urinary tract infection. During an observation on 09/08/25 at 8:32 AM and 4:15 PM, Resident #49's urinary collection bag was dated 08/16/25. During an interview on 09/08/25 at 5:10 PM, LVN G stated, all resident care was to be documented immediately after it was done because if it was not documented right away, you could forget to document it, or another nurse could perform the same care again. LVN G stated it was important to do the care that was charted because it was fraud and false documentation if the care was not done. LVN G stated she was not aware that night shift did not change the urinary catheter collection tubing and bag on 09/01/25. LVN G further stated it was important to change the urinary catheter, tubing, and collection bag when ordered by the physician, so the resident did not develop a UTI or sepsis. During a telephone interview on 09/09/25 at 10:33 AM, LVN C stated the urinary catheter collection bag change was not due until 09/15. When asked why she documented she changed the urinary collection bag on 09/01/25, LVN C stated because she changed it that day. When asked if she dated the urinary catheter bag when she changed it, she stated she did. When LVN C was told the date on the urinary catheter bag was 08/16/25, she stated she must have intended to change it but got busy and did not get it done and forgot to strike it out on the MAR. LVN C stated she documented she changed the collection tubing/bag on 08/18/25 because it showed it was due on the MAR and she knew that it had been changed on 08/16/25. During a telephone interview on 09/09/25 at 12:54 PM, LVN D stated she changed Resident #49's suprapubic catheter and the collection (continued on next page)

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	675850	A. Building B. Wing	09/09/2025

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tubing/bag on 08/16/25 and changed the collection tubing/bag on 09/09/25. LVN D stated she documented the 08/16/25 suprapubic catheter change on the MAR for 08/15/25 because she changed it after midnight but forgot to document the collection tubing/bag change because it was not showing due yet and she did not think to document it in the as needed area. She stated she documented the collection tubing/bag change on 09/09/25 in the as needed section in the MAR. LVN D stated it was very important to document care immediately after it was done because, If it was not documented, it was not done. LVN D further stated, If care was documented but not done for whatever reason, there was an option in PCC to strike out and explain. She stated if urinary catheter care was documented but was not provided, it could lead to infection and hospitalization. During an interview on 09/09/25 at 1:22 PM, the DON stated nurses should follow the physician orders for when to change residents' urinary catheters and collection tubing/bags and if there was an issue with timing, they needed to contact the physician to modify the orders or tell the DON. The DON stated, It was important to document care provided right after it was done. If care was documented as done but it was not, it would not trigger for the care to be provided and it would stay dirty longer. If the catheter and/or bag were not changed when it was ordered, it could cause infection which could lead to hospitalization. He stated when he first started here approximately 8 months ago, he had a meeting with staff concerning what his expectations were for documentation. The DON stated in-services on urinary catheter care were done at least annually. A copy of the facility's policy/procedure for urinary catheters and or urinary catheter care was requested on 09/08/25 and 09/09/25, however the facility stated they did not have one. Record review of the facility's Professional Standard of Care Policy dated 02/2017 and updated 01/2024 reflected in part: Compliance Guidelines: The community provides services that meet professional standards of quality and are provided by appropriately qualified persons (e.g., licensed, certified). Compliance with Professional Standard of Care Nursing Practices: a) Licensed nurses should practice within the constraints of applicable state laws and regulations governing their practice and should follow the guidelines contained in the communities' written policies and procedures.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of 4 medication carts (Nursing cart 1) reviewed for storage. The facility failed to keep nursing cart 1 locked when not in use. The failure could place residents in the facility at risk of drug diversion or misuse of medications leading to harm.Findings included:During an observation at 2:56 PM on 09/08/25, this state surveyor saw the top drawer on nurse cart 1 was slightly open in front of the nurse's station on wing 1. This state surveyor was able to fully open the drawer and gain access to medications with no nurse present. After approximately 45 seconds after the initial observation, RN E approached the medication cart and stated nurse cart 1 was hers. During an interview with RN E at 4:16 PM on 09/08/25, RN E stated the medication cart should be locked when not in use. RN E stated it was important to keep the cart locked so other people did not gain access to medications, ingest them, and have an adverse reaction. RN E stated the DON came around almost daily to remind nurses to keep their medication carts locked. During an interview with the DON at 4:48 PM on 09/08/25, the DON stated nurses should ensure their medication carts were locked when not in use. The DON stated it was important to keep medication carts secure because there were medications in there that anyone could gain access to and take. Record review of the facility policy titled Medication Cart Use & Storage, dated January 2023, revealed the following: The medication cart and its storage bins should be kept closed, secured and/or in the line of sight when not in use.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to maintain medical records on each resident that were accurately documented for one (Resident #49) of four residents reviewed for medical records. The facility failed to ensure LVN C did not document care that was not provided on 09/01/25. This failure could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment. Record review of Resident #49's admission record reflected a [AGE] year-old male originally admitted to the facility on [DATE] with most recent admission on [DATE]. His pertinent diagnoses included malignant neoplasm (cancerous tumor) of the prostate, obstructive and reflux uropathy (urine flow is blocked and causes urine to back up into the kidneys causing kidney damage), urostomy with suprapubic urinary catheter (an opening in the abdomen that connects to the urinary tract to allow urine to drain into a catheter and urinary collection bag), and difficulty walking. Record review of Resident #49's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated he had no cognitive impairment. Record review of Resident #49's care plan dated 01/31/25 reflected the focus, I require a catheter for obstructive and reflux uropathy, other artificial openings of the urinary tract, malignant neoplasm of the prostate, placing me at risk for infection, created on 01/31/25. Interventions listed for the focus included: Catheter Care every shift and as indicated initiated 05/20/25. Change catheter per my physician's order initiated 05/20/25. Monitor for s/sx infection initiated on 05/20/25. Record review of Resident #49's order summary report reflected the following orders: Suprapubic catheter dx: prostate cancer, obstructive and reflex uropathy dated 05/20/25. Suprapubic catheter: change monthly on the 15th day of the month 10-6 shift, every night shift dated 05/25/25. Suprapubic catheter: change collection bag Q2WKS and PRN, every night shift every 2 weeks on Monday dated 05/25/25. Suprapubic catheter: change collection bag Q2WKS and PRN, as needed dated 05/25/25. Record review of Resident #49's August 2025 MAR reflected LVN C documented she changed Resident #49's suprapubic catheter collection bag on 08/18/25. Record review of Resident #49's September 2025 MAR reflected LVN C documented she changed Resident #49's suprapubic catheter collection bag on 09/01/25. During an observation on 09/07/2025 at 3:35 PM, Resident #49's urinary catheter bag had the date 08/16/25 written in black marker on the upper left side of the front of the bag. During an interview on 09/07/25 at 3:37 PM, Resident #49 stated he had the suprapubic catheter placed 25 years ago when he was diagnosed with prostate cancer. Resident #49 stated the night nurse changed the catheter and the collection tubing/bag at the same time in August and the collection tubing/bag was not changed in the previous week. Resident #49 denied any signs or symptoms of a urinary tract infection. During an observation on 09/08/25 at 8:32 AM and 4:15 PM, Resident #49's urinary collection bag was dated 08/16/25. During an interview on 09/08/25 at 5:10 PM, LVN G stated, all resident care was to be documented immediately after it was done because if it was not documented right away, you could forget to document it, or another nurse could perform the same care again. LVN G stated it was important to do the care that was charted because it was fraud and false documentation if the care was not done. LVN G stated she was not aware that night shift did not change the urinary catheter collection tubing and bag on 09/01/25. LVN G further stated it was important to change the urinary catheter, tubing, and collection bag when ordered by the physician, so the resident did not develop a UTI or sepsis. During a telephone interview on 09/09/25 at 10:33 AM, LVN C stated the urinary catheter collection bag change was not due until the 15th of the month. When asked why she documented she changed the urinary collection bag on 09/01/25, LVN C stated because she changed it that day. When asked if she dated the urinary catheter bag when she changed it, she stated she did. When LVN C was told the date on the urinary catheter bag was 08/16/25, she stated she must have intended to change it on 09/01/25, but got busy and did not get it done and forgot to strike it out on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the MAR. LVN C stated she documented she changed the collection tubing/bag on 08/18/25 because it showed it was due on the MAR and she knew that it had been changed on 08/16/25. During a telephone interview on 09/09/25 at 12:54 PM, LVN D stated she changed Resident #49's suprapubic catheter and the collection tubing/bag on 08/16/25 and changed the collection tubing/bag on 09/09/25. LVN D stated she documented the 08/16/25 suprapubic catheter change on the MAR for 08/15/25 because she changed it after midnight but forgot to document the collection tubing/bag change because it was not showing due yet and she did not think to document it in the as needed area. She stated she documented the collection tubing/bag change on 09/09/25 in the as needed section in the MAR. LVN D stated it was very important to document care immediately after it was done because, If it was not documented, it was not done. LVN D further stated, If care was documented but not done for whatever reason, there was an option in PCC to strike out and explain. She stated if urinary catheter care was documented but was not provided, it could lead to infection and hospitalization. During an interview on 09/09/25 at 1:22 PM, the DON stated nurses should follow the physician orders for when to change residents' urinary catheters and collection tubing/bags and if there was an issue with timing, they needed to contact the physician to modify the orders or tell the DON. The DON stated, It was important to document care provided right after it was done. If care was documented as done but it was not, it would not trigger for the care to be provided and it would stay dirty longer. If the catheter and/or bag were not changed when it was ordered, it could cause infection which could lead to hospitalization. He stated when he first started here approximately 8 months ago, he had a meeting with staff concerning what his expectations were for documentation. The DON stated in-services on urinary catheter care were done at least annually. A copy of the facility's policy on nursing documentation was requested 09/09/25, however the facility stated they did not have a specific policy for it. The below referenced policy was provided. Record review of the facility's Professional Standard of Care Policy dated 02/2017 and updated 01/2024 reflected in part: Compliance Guidelines: The community provides services that meet professional standards of quality and are provided by appropriately qualified persons (e.g., licensed, certified). Compliance with Professional Standard of Care Nursing Practices: a) Licensed nurses should practice within the constraints of applicable state laws and regulations governing their practice and should follow the guidelines contained in the communities' written policies and procedures.

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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 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 #11) of 6 residents reviewed for infection control practices.1) The WCN did not perform hand hygiene after removing gloves before, during, and after performing Resident #11's wound care. This failure could place residents that require wound care at risk for healthcare associated cross-contamination and infections. Findings include: Record review of Resident #11's face sheet dated 09/08/25 reflected a [AGE] year-old-male with an original admission date of 08/31/24. Diagnoses included heart disease, type two diabetes (insufficient insulin production in the body), chronic kidney disease, and COPD (lung condition caused by damage to the airways that limit airflow). Record review of Resident #11's care plan revised on 08/08/25 reflected: Resident #11 was at risk for infection or recurrent/chronic infection r/t compromised medical condition. Resident #11 had actual MRSA to LBKA site. Interventions included: Resident #11 would be free from S/S of infections and any complications related to infection through the review date. Enhanced Barrier Precautions practices as clinically indicated. Educate Resident #11 about hand hygiene efforts and avoid coughing or sneezing directly into hands. Provide tissues and supplies as needed. Provide education to team members, resident and/or visitors regarding infection prevention practices as indicated. Record review of Resident #11's Significant Change MDS dated [DATE] reflected a BIM score of 7 (cognition moderately impaired) skin conditions of surgical wounds, surgical wound care, and nutrition or hydration intervention to manage skin problems. Record review of Resident #11's physician orders reflected the following: RBKA, cleanse with normal saline, dry with 4x4 gauze and pack with 1/4in Dakin's (antiseptic solution used to treat wounds) moistened plain packing, cover with dry dressing daily until resolved. Dated 7/18/2025. LBKA, surgical wound, cleanse with normal saline, pat dry with 4 by 4 gauze, apply Santyl (enzyme used to promote healing of skin ulcers, wounds, and burns) to wound bed, cover wound bed with hydrofera blue (antibacterial wound dressing), cover with dry dressing one time a day. Dated 7/4/2025. During an observation on 09/07/2025 at 4:09 PM, the WCN did not perform hand hygiene after removing gloves while preparing and setting up supplies for Resident #11's wound care. During an observation on 09/07/2025 at 4:11 PM, the WCN did not perform hand hygiene after removing gloves prior to beginning Resident #11's wound care. During an observation on 09/07/2025 at 4:24 PM, the WCN did not perform hand hygiene after removing gloves after cleansing Resident #11's wound. During an observation on 09/07/2025 at 4:25 PM, the WCN did not perform hand hygiene after removing gloves after pat drying Resident #11's wound. During an observation on 09/07/2025 at 4:27 PM, the WCN did not perform hand hygiene after removing gloves after completing Resident #11's wound care. In an interview on 09/07/2025 at 4:27 PM, the WCN stated hands need to be cleaned or washed after removing gloves to prevent cross contamination. The WCN stated Resident #11's wound could be introduced to bacteria that was not previously there causing the wound to deteriorate or worsen. The WCN stated she was thinking of all the other steps she had to perform during Resident #11's wound care and just did not realize she was not performing hand hygiene in between glove changes. In an interview on 09/08/2025 at 12:15 PM, the DON stated it was important staff performed hand hygiene after glove removal to avoid possible cross contamination. The DON stated Resident #11's wound could worsen if introduced to bacteria. Record review of the facility's Handwashing/Hand Hygiene policy dated January 2023 reflected: Guideline This facility considers hand hygiene the primary means to prevent the spread of infection. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for situations such as this (including but not limited to): Before handling clean or soiled dressings, gauze pads, etc.; Before moving from a contaminated/soiled to clean care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of procedures; After handling used dressings, contaminated equipment, etc.; Before glove changes/After removing gloves;