

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Avir at Park Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 2122 Park Bend Dr Austin, TX 78758	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services which includes the accurate acquiring, receiving, dispensing and administering of medications to meet the needs for one resident (Resident #1) of 4 residents reviewed for pharmacy services, in that: MA failed to correctly administer a lidocaine patch medication to resident on 8/15/2025 at 11:03 AM. This failure placed residents at risk for medical errors, complications, decreased quality of life and hospitalization. Findings included: Review of Resident #1's face sheet dated 10/29/2025 reflected he was a [AGE] year-old-male admitted on [DATE] with diagnosis that included: Type 2 Diabetes Mellitus (characterized by high levels of sugar in the blood), Idiopathic Epilepsy (a brain disease which causes seizures.), Major Depressive Disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest), Anxiety Disorder (anxiety disorders, frequently have intense, excessive and persistent worry and fear about everyday situations). Review of Resident #1's admission MDS dated [DATE] reflected he had a BIMS of 05 indicates severe cognitive impairment. Review of Resident #1's MAR reflected an order start date of 11/12/2024: Lidocaine Pain Relief External Patch 4 % (Lidocaine). During an interview on 10/29/2025 at 3:44 pm, the DON stated on 10/9/25, at the care plan meeting she was made aware of a CNA was putting on the lidocaine patch on Resident #1. DON stated, the resident's sister told her that CNAs were applying patches. Asked who but sister couldn't identify. She started investigating but there was no date provided. She questioned all staff till someone cracked. Discovered it was Med aide CNA A. Both were educated on their scope of practice, 1/1 inservice and then all staff were in service. No disciplinary action. (They did 'verbal' warnings, and it was documented in their personnel files.) DON stated that facilities policy for medication administration is to be administer medication by licensed personnel only; Nurses and MA, not CNAs - she stated a CNA giving medications did not meet expectations. Potential outcomes of a CNA giving medication - severe reactions. Potentially death. They don't know what they are administering and if they're the right person because they don't have access to MAR. There could be allergic reactions, they could apply incorrectly or to the wrong area. Treatment isn't being achieved because med isn't administered properly. She stated this had not happened previously. During an interview with the ADM on 10/29/2025 at 3:52 PM he stated that he discovered that incident during the care plan meeting on 10/09/2025. The ADM stated, the family described the video recording which included CNA applying a lidocaine patch to Resident # 1. The ADM stated that facility policy only allows licensed professional to administer medication, even OTCDuring an interview on 10/29/2025 at 11:01 am CNA A stated she did put a lidocaine patch on Resident #1. She said she was told that she was not authorized to put a medication patch on a resident and was retrained. During an attempted interview on 10/29/2025 at 5:35 pm and 10/30/2025 at 10:03 am MA B was not at the facility and was not returning voicemails left on her personal phone. During an observation of a video dated 08/15/2025 at 11:03 AM, CNA A applied a lidocaine patch to Residents # 1 upper back. Record Review of undated policy 9.3. Medication Administration revealed, Facility staff should take all measures required by Facility Policy, Applicable Law, and the State Operations Manual when administering medications. Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.</p>		