STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675877	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Arlington	301 W Randol Mill Rd Arlington, TX 76011

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a Registered Nurse was on duty in the facility for a minimum of eight consecutive hours a day, seven days a week, for 1 of 5 quarters (Quarter 2 of 2025) reviewed for RN coverage. 1.The facility failed to have 8 consecutive hours of RN coverage for 15 of 31 days in January 2025.2.The facility failed to have 8 consecutive hours of RN coverage for 25 of 28 days in February 2025.3.The facility failed to have 8 consecutive hours of RN coverage for 5 of 31 days in March 2025. This failure could affect the residents by placing them at risk for not having their nursing and medical needs met and receiving improper care.Findings included:Record review of the CMS PBJ Staffing Data Report revealed no RN hours for the following dates:01/01/25, 01/05/25, 01/11/25, 01/12/25, 01/18/25, 01/19/25, 01/25/25, 01/26/25, 01/29/25, 01/31/25, 02/02/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25, 02/08/25, 02/09/25, 02/11/25, 02/12/25, 02/13/25, 02/14/25, 02/15/25, 02/16/25, 02/17/25, 02/18/25, 02/19/25, 02/20/25, 02/21/25, 02/22/25, 02/23/25, 02/24/25, 02/25/25, 03/18/25, 03/19/25, 03/20/25, and 03/21/25. Record review of an excel file, undated, for RN time stamp hours from 01/01/25 through 03/31/25 revealed no RN coverage on the following dates:01/01/25, 01/05/25, 01/11/25, 01/12/25, 01/18/25, 01/19/25, 01/25/25, 01/26/25, 01/29/25, 01/31/25, 02/02/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25, 02/08/25, 02/09/25, 02/11/25, 02/12/25, 02/13/25, 02/14/25, 02/15/25, 02/16/25, 02/17/25, 02/18/25, 02/19/25, 02/20/25, 02/21/25, 02/22/25, 02/23/25, 02/24/25, and 02/25/25. Further review of the excel file revealed there was less than 8 hours of RN coverage on the following dates:- 6.83 hours on 01/04/25- 7.43 hours on 01/08/25- 2.50 hours on 01/22/25- 7.67 hours on 01/27/25- 3.57 hours on 01/30/25- 2.35 hours on 02/01/25- 7.74 hours on 02/03/25- 4.00 hours on 02/10/25- 7.37 hours on 03/24/25Interview on 02/26/26 12:31 PM, the HR Director stated the staffing coordinator was responsible for scheduling. She stated she verified the 8 hour RN requirement was met during payroll. She stated she submits payroll to a company the facility outsources with and if there were questions the company would send it back so she could verify the PBJ data. Interview on 02/26/26 at 12:37 PM, the Staffing Coordinator stated she was responsible for the schedule and was aware of the 8 consecutive hour RN requirement. She stated they had a nurse consultant who was an RN, but she was not always on site. She said they had a lot of change of DONs and did not know why there was not an RN scheduled during that time. She said the Administrator that was working at the time worked closely with her to meet the RN hours but the Administrator was not available due to being on leave. The Staffing Coordinator stated there was no risk to residents not having an RN scheduled because they had other licensed nurses. Interview on 02/26/26 at 12:52 PM, the DON stated she had worked at the facility since January of 2026. She said the staffer was responsible for scheduling RN coverage. She said if there were any gaps like requested time off or call-ins, she would fill in that space herself or reach out to a prn RN on staff. She said the 8 hours was calculated through HR and the contracted company reviews the RN hours and makes sure they were submitted appropriate to CMS. She stated she did not know why there was no RN coverage during those times. She said the risk of not having an RN would be no oversight. Interview on 02/26/26 at 5:07 PM, the Interim Administrator stated there should be an RN scheduled (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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for 8 consecutive hours. He stated the staffing coordinator was responsible for scheduling and HR reviewed the hours. He said the risk to residents would be no oversight from an RN in the facility. Record review of the facility policy titled, Staffing, Sufficient and Competent Nursing revised August 2022, revealed .3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 3 of 3 residents (Resident #26, Resident #62, and Resident #63) reviewed for Medicare/Medicaid coverage. 1. The facility failed to ensure Resident #26, Resident #62 and Resident #63 were given a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) form when discharged from skilled services at the facility. 2. The facility failed to ensure Resident #26, Resident #62 and Resident #63 were given a Notice of Medicare Non-Coverage (NOMNC) form with information on how to appeal the decision when residents were discharged form skilled services prior to covered days being exhausted.This failure could place residents at risk of not being informed of changes to provided services. Findings included:Record review of the document titled Beneficiary Notice - Residents discharged Within the Last Six Months, dated 09/2024 through 02/2025, completed by the facility, revealed who discharged from a Medicare Part A stay with benefit days remaining. Residents #26, #62 and #63 were listed.Resident #26Record review of Resident #26's admission record dated, 03/02/26, revealed an [AGE] year-old female who admitted to the facility on [DATE] with a principal diagnosis of cerebral infarction due to embolism of right middle cerebral artery (stroke caused by a blood clot traveling from elsewhere in the body and blocking the middle cerebral artery). The date of discharge was 02/13/26, length of stay 42 days, and discharge home with home health. Record review of email, dated 03/02/26, sent to Surveyor by the DON revealed she was not able to provide Resident #26's MDS assessment by email.Record review of Resident #26's physician orders, dated 01/02/26, revealed admit to [facility name] under the care of Dr. [name].Record review of the SNF Beneficiary Protection Notification Review, completed by the facility, revealed Resident #26's Medicare Part A skilled service episode start date was 01/02/26 and the last covered day of Part A service was 02/13/26. The SNF ABN and NOMNC were marked as not provided to the resident with no explanation why the form was not provided. Record review of Resident #26's progress note, dated 02/13/26, revealed Resident discharged from facility accompanied by [family member] to home residence. Resident in stable condition denies pain or discomfort at time of discharge. Resident's [family member] given discharge instructions, medications, and educated [family member] about medication administration. NP made aware.Resident #62Record review of Resident #62's admission record, dated 03/02/26, revealed an [AGE] year-old female with an original admission date of 11/05/25 and readmission date of 11/13/25 to the facility. Resident #62's principle diagnosis was metabolic encephalopathy. The date of discharge was 11/30/25, length of stay 17 days, and discharge home with no home health.Record review of email, dated 03/02/26, sent to Surveyor by the DON revealed she was not able to provide Resident #62's MDS assessment by email.Record review of Resident #62's physician orders, dated 01/21/26, revealed admit to [facility name] under the care of Dr. [name].Record review of the SNF Beneficiary Protection Notification Review, completed by the facility, revealed Resident #62's Medicare Part A skilled service episode start date was 11/05/25 and the last covered day of Part A service was 11/21/25. The SNF ABN and NOMNC were marked as not provided to the resident with no explanation why the form was not provided.Record review of Resident #62's progress note dated 11/30/25 revealed Resident alert and awake, ate breakfast with assistance of CNA, AM care given. Clean and dressed. Resident in stable condition. Resident discharged home with Hospice via stretcher and ambulance with 2 attendants. Hospice representative present at discharge. Resident discharged to [Address] the [family member's] home. Medications given to Hospice representative. IDT made aware. MD notified.Resident #63Record review of Resident #63's admission record, dated 03/02/26, revealed a [AGE] year-old female who admitted on [DATE] with diagnosis that included cerebral (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infarction (stroke). The date of discharge was 12/27/25, length of stay 25 days, and discharge home with home health.Record review of email, dated 03/02/26, sent to Surveyor by the DON revealed she was not able to provide Resident #63's MDS assessment by email.Record review of Resident #63's physician orders, dated 01/2/26, revealed I Certify that the resident Requires/Continues to require Long Term Nursing care at this facility for the next 180 days.Record review of the SNF Beneficiary Protection Notification Review, completed by the facility, revealed Resident #63's Medicare Part A skilled service episode start date was not included and the last covered day of Part A service was 12/22/25. The SNF ABN and NOMNC were marked as not provided to the resident with no explanation why the form was not provided.Interview on 02/26/26 at 4:22 PM, the Director of Social Services stated she was responsible for issuing SNF ABN and NOMNC forms to residents. She stated she issued ones for managed care and did not realize they were needed for traditional Medicare. She said that if a resident was on managed care the insurance would send her the NOMNC and she would give it to the resident or POA the same day so they would have at least 48 hours notice and a chance to appeal by 12 the next day. She said she had just been educated on the facility policy and when to issue the forms. She said if the forms were not given to residents it could cause the facility not to be paid, the resident would not be able to appeal on time and the resident would not be informed of changes. Interview on 02/26/26 at 5:07 PM, the Interim Administrator stated the Director of Social Services was responsible for issuing the forms. He stated residents could be at risk of not being informed of changes to services. Record review of the facility's policy titled Medicare Advance Beneficiary and Medicare Non-coverage Notices revised September 2022, revealed the following: .Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) 1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare.will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s).Notice of Medicare Non-Coverage (CMS form 10123)1. If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-coverage (CMS from 10123) is issued to the resident at least two calendar days before benefits end. 2. The Notice of Medicare Non-Coverage informs the resident of the pending terminate of coverage and of his/her right to an expedited review by a Quality Improvement Organization.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were developed in consultation with the resident's and representative for 2 of 8 residents (Resident #10 and Resident #11) reviewed for comprehensive care plans.The facility failed to invite Resident #10 and Resident #11's resident representative to participate in the residents' care plan meetings.The failure could place residents at risk of their care plans not including resident-specific needs.Findings include: Resident #10Record review of Resident #10's face-sheet revealed an [AGE] year-old male initially admitted to facility on 05/12/20 and readmitted on [DATE]. His diagnosis included: Type 2 Diabetes Mellitus with Ketoacidosis without Coma (a serious, acute metabolic complication where the body produces high levels of ketones acid due to insulin deficiency or resistance, without causing loss of consciousness); Parkinsonism, Unspecified (neurological disorder causing motor symptoms like tremors, stiffness, slow movement, bradykinesia, balance issues, without a specific, determined cause); Dementia in other Diseases Classified elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (dementia is a symptom or manifestation of an underlying physical condition). Record review of Resident #10's MDS dated [DATE] noted BIMS score to be 15 with memory intact. Resident #10. Resident #10 able to make decisions r/t care and requires set-up to supervision with ADL care. Record review of Resident #10's clinical record revealed no documentation of quarterly care plan meetings with the resident or resident representative in the clinical records noted since admission. Interview on 02/26/2026 at 11:25 AM, Resident #10 revealed he has not been involved in care plan meetings with the team members. Resident #10 stated he had not been given any information about his medications. Resident #10 stated his family member was his RP. 02/26/2026 4:00 PM attempted to contact Resident #10's family member. Left message for family member to return call. Interview on 02/27/2026 at 4:00 PM, Resident #10's family member stated she had not been involved in the resident's care plan meetings since the resident had been at the facility. Family Member revealed that a care plan meeting was held with SW on 02/26/2026 by phone. Family member did not reveal time meeting was held. Resident #11Record review of Resident #11's face-sheet revealed a [AGE] year-old female admitted to facility on 01/04/2026. Her diagnosis included: Unspecified Fracture of Right Femur, Subsequent Encounter for Closed fracture with Routine Healing (healing or recovery phase, receiving routine follow-up care); Essential (Primary) Hypertension (high blood pressure that is multi-factorial with no distinct cause); Trigeminal Neuralgia (a chronic, often debilitating nerve disorder causing sudden, severe electric shock-like facial pain, usually on one side). Record review of Resident #10's MDS revealed BIMS score to be 15 with memory intact. Resident #10 was able to make independent decisions r/t to his care and required set-up to supervision to supervision with ADL care. Record review of Resident #11's clinical record revealed no documentation of initial care plan meeting with resident or resident representative. Interview on 02/24/2026 at 11:33 AM with Resident #11 revealed that she has not met with the SW or team members to discuss her plan of care. Resident #11 stated she has spoken with the SW concerning her discharge home and has appealed her discharge because she must be able to safely walk at home. Interview on 02/26/2026 at 4:30 PM with SW revealed the process for care plan meetings are to set up meeting with resident and family members or RP. Initial base line care plan meeting at admission. Discharge planning discussed. Quarterly care plan conference. Team will hold meetings in resident's room or the conference rooms. SW revealed she would make a call the RPs and invite them to the meeting. SW uses the MDS Schedule as a guide to schedule care plan meetings. PASARR coordinator is involved with care plan with residents on specialized service. No documentation noted r/t to care plan meeting calls or invitations in SW progress notes for Resident #10 or Resident #11. No documentation of care plan meetings in SW progress notes for Resident #10 (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or Resident #11. SW did not indicate how far in advance notification was provided to resident or RPs r/t care plan meetings. Interview on 02/26/2026 at 4:46 PM with DON revealed the policy for care plan meetings with residents and the RPs are to follow CMS policy related to initial and quarterly care plan meeting schedules. DON's expectations are to follow the guidelines and be in compliance going forward DON stated the benefits of the care plan meeting are understanding the expectations of resident's diagnosis, changes of conditions, and knowledge of the resident's care. Interview on 02/26/2026 at 5:06 PM with Administrator revealed the care plan meetings are to be completed as required. Review of facility's Care Plans, Comprehensive Person-Center, revised March 2022 revealed in part, A comprehensive, person-centered care that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The resident is informed of his or her right to participate in his or treatment and provided advance notice of care planning conferences. If the participation of the resident and his/her resident representative in developing the resident's care plan in determined to not be practicable, an explanation is documented in the resident's medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents had the right to a safe, clean, comfortable and homelike environment to include maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 3 of 17 residents (Resident #14, Resident #2 and Resident #60) reviewed for environmental conditions.1. The facility failed to ensure flooring was replaced in Resident #14's room. 2. The facility failed to ensure the faucet knob was replaced in Resident #2 and #60's bathroom.These failures could place residents at risk of living in an unsanitary, unsafe environment and a diminished quality of life.Findings included: Record review of Resident #14's Quarterly MDS, dated [DATE], revealed a [AGE] year-old male who admitted to the facility on [DATE], with diagnoses that included unspecified dementia (memory loss and cognitive decline without a specific cause) and cerebral infarction (stroke). Resident #14's BIMS score was 5 indicating sever cognitive impairment. Observation on 02/24/26 at 10:24 AM in Resident #14's room, revealed the flooring was missing underneath one of the legs of A bed and two legs of B bed. The flooring was peeled back and started to roll up on the edge of the entrance to the bathroom. It appeared like black nonskid tape had been used to cover the missing and peeled areas of flooring. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a [AGE] year-old male who admitted to the facility on [DATE], with a primary diagnosis of Cerebral Infarction (stroke). Resident #2' s BIMS score was 14, indicating intact cognition. Record review of Resident #60's Face Sheet, dated 02/26/26, revealed a [AGE] year-old male who admitted to the facility on [DATE], with a diagnosis of hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side. Observation and interview on 02/26/26 at 10:45 AM in Resident #2 and #60's bathroom revealed the right knob on the sink was missing. Resident #60 stated he had been at the facility since Friday (02/20/26) and the knob had been broken since he had been there. He said it bothered him that it was broken.Interview on 02/26/26 at 1:48 PM, LVN D stated she Resident #14's floor looked bad before and she had called Maintenance and remembered putting it in the book. She could not recall how long ago or how long the floor had been like that. She stated when they did patient care the beds kept messing up the floors. She said staff were supposed to put maintenance requests in the computer. She said if repairs were not done it would not be homelike for the patient, and it would possibly be a tripping hazard. She stated she was not aware of Resident #2 and #60's faucet knob missing. She said residents could not be able to wash their hands and could spread infection.Interview on 02/26/26 at 3:49 PM, the Maintenance Director stated his expectation was for staff to report repairs to the nurse or place them in the work order system. He stated he was aware of the flooring in Resident #14's room and said the black tape was a layer of flooring. He said the risk was the resident could trip and it was not homelike. He said he already replaced the knob on the sink in Resident #2 and #60's room. He stated he looked in the work order system and nothing was found for the sink. He said the risks included Residents #2 and #60 could cut their hand and they do not have proper access to water. Interview on 02/26/26 at 4:45 PM the DON stated she expected staff to communicate any repairs needed in the app that Maintenance used. She said it would not be homelike if repairs were needed and not done. Interview on 02/26/26 at 5:07 PM the Interim Administrator stated Maintenance was responsible for repairs and his expectation for staff was to place work orders in the computer system or paper log. He stated the risk would be quality of life, tripping hazards and sanitization. Record review of facility's policy tilted Maintenance Service revised December 2009, revealed the following: .2. Functions of maintenance personnel include, but are not limited to: .b. maintaining the building in good repair and free from hazards.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident's environment remained free of accident hazards for 1 of 8 residents (Resident #11) reviewed for accident hazards.The facility failed to assess Resident #11 for the ability to self-administer a dietary supplement, Gelatide Dietary Supplement, which was kept in her room at her bedside.This failure could affect residents by placing residents at risk of consuming unsafe medications.Findings included: Record review of Resident #11's face-sheet revealed a [AGE] year-old female admitted to facility on 01/04/2026. Her diagnosis included: Unspecified Fracture of Right Femur, Subsequent Encounter for Closed fracture with Routine Healing (healing or recovery phase , receiving routine follow-up care); Essential (Primary) Hypertension (high blood pressure that is multi-factorial with no distinct cause); Trigeminal Neuralgia (a chronic, often debilitating nerve disorder causing sudden, severe electric shock-like facial pain, usually on one side). Record review of Resident #11's admission MDS dated [DATE] revealed BIMS score to be 15 with memory intact. Resident #11 able to make decisions r/t her care but needs max to substantial assistance with ADL care. Record review of Resident #11's care plan revealed that there was no documentation r/t self-administration of medication. Record review of Resident #11's physician orders revealed no orders for self-administration of medication. Observation on 02/24/26 at 10:30 AM revealed a bottle of Gelatide Dietary Supplement (a plant-based weight management supplement) Warning label revealed in part, Keep out of the reach of children. Bottle located on Resident #11's bedside table. Interview and observation on 02/24/26 at 10:35 AM revealed when LVN C was asked about the Gelatide Dietary Supplement found on Resident #11's bedside table, she immediately went to the room and removed the supplement. Resident #11 currently was not in the room at the time. Interview on 02/24/2026 at 2:00 PM with LVN C revealed that Resident #11 stated she bought the supplement over the weekend. Resident #11 stated to LVN C if it was a problem she would send it back home with her family member. LVN C stated the policy of the facility was there are to be no medications of any kind at a resident's bedside. If staff find medications in room, they are to notify the physician and get an order for resident to have the medication. No orders are ever written to self-medicate. LVN C stated the risk of having medication at the bedside was that a resident could overdose, poly pharmacy, which was a concurrent use of multiple medications for same diagnosis, and drug interactions with current medications. Interview on 02/24/2026 at 11:33 AM, Resident #11 revealed that she did not realize she could not have supplement with her. Resident stated she was not told by the facility. Resident #11 stated the nurse came in and explained that another resident with dementia could come in and take the medication not know what it was. Resident #11 did not indicate how he got the supplement. Interview on 02/24/2026 at 1:29 PM, the DON revealed that Resident #11 had the supplement on her bedside table. The DON stated the risk could be Resident #11 could have an adverse reaction to current medications and the facility would not be aware of the cause. The resident rooms are usually checked during daily rounds for medications and other items residents should not have. The DON reported that the physician wrote an order for resident to take the supplement every day. Resident #11 was upset that she had to give it to the nurse to place in the cart. Physician stated there would be no adverse effects to resident if she continues to take supplement. Interview on 02/26/2026 at 5:06 PM with Administrator revealed r/t medications at bedside. Residents should have an assessment to determine if they can self-administer meds at the bedside. Provide a lockbox if they pass the assessment for the self-administration. May cause an adverse effect. The risk was having an adverse effect. Administrator's his expectation was to make sure the med self-administration was correct and make sure they have a lockbox in their room to lock up the medication. Staff are to make sure no meds are brought in from the outside unless checked off. Review of facility's policy (continued on next page)

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Avir at Arlington	301 W Randol Mill Rd Arlington, TX 76011

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Labeling and Storage, revised February 2023 revealed in part, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy does not address medications found at the bedside or medications brought in by the resident and/or the resident representative found at the bedside. Record review of facility's policy General guidelines - Medication Administration Procedures revealed in part .Administration: 2. Medications are to be poured, administered, and charted by the same licensed person. 5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on one of two medication carts (station one) reviewed for pharmacy services.The facility failed to ensure the station one nurses' medication cart contained accurate narcotic logs for Resident #21 on 02/25/26.This failure could place residents at risk for medication error, and drug diversion. Findings included: Review of Resident# 21's Quarterly MDS Assessment, dated 01/29/26, reflected the resident was [AGE] year-old female admitted to the facility on [DATE] and readmission on [DATE], with diagnoses that included pain. The resident had moderately impaired cognition with a BIMS score of 11.Review of Resident #21's physician's orders dated 2/27/25 reflected an order for Resident #21 to receive one tablet of Acetaminophen-Codeine Tablet 300-30 milligrams (pain medication) by mouth as needed every six hours.Review of Resident #21's medication administration record for February 2026 on 02/25/26 reflected an order for Resident #21 to receive one tablet of Acetaminophen-Codeine Tablet 300-30 milligrams (pain medication) by mouth as needed every six hours and last administration was on 2/22/26 at 02:59.Observation and record review on 02/25/26 at 8:54 AM of station one nurses' medication cart and the Narcotic Administration Record, with LVN C, revealed the following:Resident #21's Narcotic Administration Record for Acetaminophen-Codeine Tablet 300-30 milligrams reflected a total of 4 pills remaining, while the blister pack count was 5 pills. It was last administered on 02/24/26 at 8:00 PM.Interview with LVN C on 02/25/26 at 12:47 PM revealed she did not realize the narcotic count and narcotic log was not matching. She stated she had counted with outgoing staff that morning and she did not know she was having more on count than what was documented on the narcotic log. She said nobody had noticed it during shift change. LVN C stated the Narcotic log should always match with the count. She stated signing off when no medication was administered it could lead to medication error. She stated she had done an in-service on medication administration, but she could not recall when. Interview on 02/26/26 at 12:05 PM with Resident #21 revealed she got pain pills as needed. She could not recall when she received one last. Interview on 02/26/26 at 01:35 PM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log to prevent discrepancies. She stated the oncoming should count with outgoing staff each shift and report any discrepancies. She stated the Narcotic administration record should match the count. She stated on 02/24/26 she had checked all the carts, and the Narcotic logs were balancing with count. The DON stated the nurses are responsible for checking on each other ensuring the counts are correct before shift change. She stated it was her responsibility to audit the carts monthly and because she has been to this facility for two weeks, she had managed to audit only one cart and one Medication administration record. She stated Failure to sign off could lead to risk based on resident assessment like pain not being controlled. She stated she had not done training on medication administration since she was newly hired.Interview on 02/26/26 at 05:20 PM, the Interim Administrator revealed he expected the nursing staff to be attentive when performing the narcotic shift change count. He also expected for the nursing staff to document on the narcotic log when a narcotic was administered. He stated the risks of not doing so was that a resident could miss a dose; it could create room for medication error; and drug diversion.Record review of the facility training reflected no previous in-services training was provided; the facility started training on narcotic count after the issue was noticed.Record review of the facility's current Administering Medication policy, dated April 2019, reflected the following: .g. The individual administering medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next dose.