

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from physical abuse for 2 of 10 residents reviewed for abuse. (Residents #2 and #3)The facility failed to ensure Resident #3 was free from physical abuse when Resident #2 punched Resident #3 in the left eye, resulting in bruising and a black eye.This failure could place residents at risk for physical abuse, mental abuse, emotional abuse, and harm.Findings included: 1. Record review of an admission record dated 7/25/26 indicated Resident #2 was an [AGE] year-old male who initially admitted to the facility on to the secured unit on 3/11/26 and readmitted on [DATE] with diagnoses including Dementia without behavioral disturbance (a decline in memory and thinking skills without accompanying agitation, aggression, psychosis, or mood changes), depression (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and low energy that interferes with daily life), mood disorder (mental health conditions that affect your everyday emotional state, primarily involving persistent sadness, extreme highs, or intense mood shift to anger), and anxiety disorder (group of mental health conditions involving persistent, excessive fear or worry that interferes with daily life). Record review of quarterly MDS assessment dated [DATE] indicated Resident #2 admitted on [DATE] from an inpatient rehabilitation facility and had clear speech, was able to make him self-understood by expressing ideas and wants; had clear comprehension. He had a BIMS score of 4 out of 15 indicating he had severe cognitive impairment, meaning the person had serious trouble with memory, attention, and knowing the date or year. Section E - Behaviors was marked indicating he had hallucinations and delusions but no physical, no verbal and no other behavioral symptoms directed towards others; He required supervision or touching assist with most ADLs and no DME required. Resident #2 was frequently incontinent of bladder and continent of bowel. The MDS assessment indicated Resident #2 had no fractures and/or other multiple traumas, and no skin condition, no skin injury/wound or treatment, and no recent falls since admission. Record review of Resident #2's undated Care plan initiated on 4/22/26 indicated Resident #2 had the potential to be physically aggressive towards others r/t Dementia, Poor impulse control. Goal: will not harm self or others through the review date. Interventions: The resident's triggers for physical aggression: others using or touching his personal belongings. The resident's behaviors is de-escalated by keeping other residents away from his belongings; Assess and anticipate [Resident #2's] needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.; If physical aggression towards others place on one on one; Monitor/document/report PRN any s/sx of resident posing danger to self and others; When [Resident #2] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #2's progress notes indicated the following:-On 7/7/26 at (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:23am; completed by LVN G: CNA informed this writer [LVN G] that [Resident #2 was observed telling roommate [Resident #3] that he is going to beat him up, roommate [Resident #3] was removed from room and assisted to another room.-On 7/10/26 at 6:11am; completed by LVN H: 5:50am went to secured unit after hearing yelling and noted [Resident #2] standing in doorway with staff. Staff stated [Resident #2] pushed and hit his roommate [Resident #3] in the left eye. Both residents [Resident #2 and #3] separated at [that] time. [Resident #2] place on one on one. Administrator notified.-On 7/10/26 at 6:28am; completed by LVN H:[Resident #2] pushed and shoved roommate [Resident #3].-On 7/10/26 at 8:01am; completed by DON: Labs ordered CBC, CMP, A1C, and UA. placed in lab portal.-On 7/10/26 at 10:03am; completed by DON: LATE ENTRY - [Resident #2] continues to be one to one in private room. Referrals sent to behavioral for behavioral admission.-On 7/10/26 at 3:04pm; completed by DON:LATE ENTRY - EDW taken before judge and judge denied, did not say why.[Behavioral Hospital #1 and Behavioral Hospital #2] both stated they need emergency detention unit to admit.-On 7/10/26 at 4:42pm; completed by DON: Staff with [Behavioral Hospital #1] called for update. [Behavioral Hospital #1 Staff] stated that he will help us get EDW come Monday morning as we have to wait for judge to be back in. [Resident #2] remain one-to-one in private room and will remain throughout the weekend until EDW can be obtained. No aggression noted towards staff since separation of him roommate [Resident #3].-On 7/10/26 at 9:13pm; completed by LVN G: [Resident #2] continued on 1:1 monitoring due to aggression towards roommate [Resident #3], has rested well thus far this shift. No aggression noted.-On 7/11/26 at 6:64am; completed by LVN H: [Resident #2] continued one on one care due to aggressive behavior. None reported at that time.-On 7/11/26 at 11:03pm; completed by LVN G: Resident #2 continued to have 1:1 care due to aggressive behavior, no aggression observed.-On 7/12/26 at 7:34am; completed by LVN H: [Resident #2] continued one on one care due to aggressive behavior. None reported since incident.-On 7/13/26 at 11:44am; completed by DON: Multiple calls placed to [Behavioral Hospital #1]. Unable to reach [Behavioral Hospital #1 Staff] with admissions. [Resident #2] remained 1:1 in private room at this time.-On 7/15/26 at 4:19pm; completed by FNP: ASSESSMENT AND PLAN -Male with dementia and mood disorder evaluated after an altercation with another resident, currently calm without reported pain, discomfort,or hallucinations; anxiety and dementia management addressed and observation level reduced given no ongoing agitation or combativenessduring evaluation1. AGITATIONAgitation after altercation with another resident, currently calm without observed ongoing agitation or combativeness during this visit- Discontinue one-on-one observation starting tonight- Continue Depakote 250 mg twice daily2. ANXIETYAnxiety addressed due to concern for becoming easily agitated- Start sertraline25 mg daily. Record review of Resident #2's physical aggression initiated incident report dated 7/10/26 completed by LVN H, indicated the incident happened in [Resident #2's] room. Incident Description: Nursing Description - CNA reported that [Resident #2] pushed and hit roommate [Resident #3] in the face because he used his bathroom. Resident Description: Resident unable to give description. Immediate Action Taken: Resident separated from other resident and placed on one. Labs ordered. Placed in room by himself, referrals sent out to behavioral units for psych stay if indicated. Mental Status: Oriented to Person. Other Info: [Resident #2] possessive over his items. Agencies/People Notified: Administrator and physician. During an observation and attempted interview on 7/25/26 at 5:35 pm, Resident #2 in his room on the secured memory care unit, resting in bed he did not respond to questions asked. Resident #2 was clean, well-groomed with no unpleasant odor and there were no visible bruising, skin tears or marks. 2. Record review of an admission record dated 7/25/26 indicated Resident #3 was an [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on to the secured unit on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/24/26 and passed away in facility on 7/20/26 unrelated to incident with diagnoses including Schizoaffective disorder bipolar type (is a mental health condition that combines symptoms of schizophrenia (such as hallucinations or delusions) with extreme mood swings, including both high energy mania and low energy depression), Dementia without behavioral disturbance (a decline in memory and thinking skills without accompanying agitation, aggression, psychosis, or mood changes), delusional disorder (is a mental health condition defined by holding one or more false, fixed beliefs for at least one month, while otherwise maintaining normal daily behavior and functioning), anxiety disorder (group of mental health conditions involving persistent, excessive fear or worry that interferes with daily life) and cognitive communication deficit (trouble with talking and listening caused by problems with thinking skills like attention, memory, and problem-solving, rather than a basic physical speech problem). Record review of quarterly MDS assessment dated [DATE] indicated Resident #3 had clear speech, difficulty communicating some words or finishing thoughts but was able if prompted or given time and comprehended most conversations. He had BIMS score of 7 out of 15 indicating he had severe cognitive impairment, meaning the person had serious trouble with memory, attention, and knowing the date or year. Section E - Behaviors was marked indicating he had hallucinations and delusions but no physical, no verbal and no other behavioral symptoms directed towards others; He and required supervision or touching assist with most ADLs and no DME required. Resident #2 was frequently incontinent of bladder and continent of bowel. Record review of Resident #3's physical aggression received incident report dated 7/10/26 completed by LVN H indicated the incident happened in [Resident #3's] room. Incident Description: Nursing Description - [Resident #3] was pushed and hit in the left eye by roommate. Roommate [Resident #2] was being obsessive over shared bathroom. Resident Description- [Resident #3] stated , Roommate hit me in left eye. Immediate Action Taken: Description- [Resident #2 and #3] were separated. Head to toe assessment done. No redness or bruising noted at that tune, Neuros checked. [Resident #3] was offered x-rays by DON and declined stated I'm fine. Injuries Observed at Time of incident: No Injuries observed at time of incident. Level of pain - 0. Predisposing situation/physiological factors: Wanderer and confused. Other information: Roommates; [Resident #3] often pees on floor. Record review of Resident #3's progress note indicated the following:-On 7/7/26 at 4:24am; completed by LVN G: CNA informed this writer [LVN G] that resident's roommate [Resident #2] was observed telling resident [Resident #3] that he is going to beat him up, [Resident #3] was removed from room and assisted to another room.-On 7/10/26 at 5:50am; completed by LVN H: [Resident #3] pushed and hit in left eye by roommate [Resident #2].-On 7/10/26 at 6:07am; completed by LVN H: Heard yelling in secured unit, on entering staff standing in hallway with [Resident #3] and stated roommate [Resident #2] this resident in left eye. Separated at that time with assessment done. No redness or swelling at that time. [Resident #3] stated roommate [Resident #2] hit him in left eye.-On 7/10/26 at 7:03am; completed by LVN H: [Resident #3] noted with slight redness and faint bruising below left eye at that time.-On 7/10/26 at 9:17pm; completed by LVN G: Continues to have redness to left lower lid from previous altercation with another resident, denies blurry vision or pain.-On 7/11/26 at 6:32am; completed by LVN H: Continue to monitor for sign and symptoms being hit by roommate. Continue with redness to left eye; continue to deny pain/discomfort.-On 7/11/26 at 11:01pm; completed by LVN G: Continues to have redness to left lower eye lid from physical altercation, no complaints of pain or discomfort or blurred vision.-On 7/12/26 at 7:36am; completed by LVN H: Continue to monitor for sign and symptoms being hit by roommate. Continue with redness to left eye; continue to deny pain/discomfort. Record review of Resident #3's undated care plan indicated the following:-Revised on 3/14/26 indicated Resident #3 resides in the Secure/ Memory unit and am at risk for injury from (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wandering in an un- safe environment AEB impaired safety awareness. The resident is at risk for injury from others while residing in secure/memory unit D/T altered cognition, history of elopement. Goal: Dignity will be maintained, and [Resident #3] will wander about the unit without the occurrence of any injury through the next review date. Intervention: Anticipate behavior(s) and redirect when in close proximity to others that might invoke aggression; Ensure family/ MD aware of behaviors and/or any increase in behaviors noted; Explain all procedure using terms/ gestures I can understand- repeat as needed; Monitor and chart behaviors qshift and PRN and report to MD; Monitor for early warning signs of any behaviors- approach in calm manner, call by name, remove from unwanted stimuli; Redirect behaviors as [Resident #3] display them.-Revised on 6/9/26 indicated Resident #3 had a behavior problem of urinating on the floor no matter where he is. Goal: will have fewer episodes of urinating on the floor by review date. Interventions: Anticipate and meet [Resident #3's] needs; Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by; If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, people involved, and situations. Document behavior and potential causes. Record review of facility's typed post investigation submission report dated 7/9/26 Incident Type: Other- Resident to Resident Altercation. Agency Immediate Response to prevent recurrence/protect individuals: Agency contacted the local police department and self-reported the incident to HHS. Notified RP, the MD, Ombudsman and Administrator. [Resident #2 and Resident #3] were roommates, they were put in separate rooms;[Resident #2] was on increased monitoring until released by psychiatric services; Neuro checks and x-ray for [Resident #3]; The court denied an emergency detention warrant for [Resident #2]; seeking placement in a psychiatric facility for [Resident #2]. Description of the Allegation: [Resident #2] punched [Resident #3] in the eyes. Injury: Black eye; [Resident #3] reports no pain. Description of Assessment: Initially [Resident #3] left eye looked fine, then about 30 minutes later a bruise started to form underneath his eye. Investigation Summary: [Resident #2] pushed [Resident #3] in the bedroom doorway and had his fists ready to hit [Resident #3]. The CNA asked [Resident #2] what was his reason for all of this and [Resident #2] said he told [Resident #3] where the rest room was, and then he hit [Resident #3]. Both residents were separated and the nurse was notified. Increased supervision for [Resident #2] began immediately. Investigation Findings: Confirmed. Agency Actions Post Investigations: [Resident #2] given a room to himself and increased supervision. Labs were ordered and pain assessment was done. Inservices: abuse and neglect reporting requirements; deescalation tactics and increase supervision expectations and rationale. Record review of a 72-hour. neuro checks report dated effective 7/10/26 indicated Resident #3 had no change in neuro status. Resident #3's neuro remained at baseline, and he voiced no pain complaints. Record review of incident and accident log from 4/1/2026 to 7/25/2026 indicated Resident #2 was the physical aggressor for two previous incidents with other residents on 4/22/26 and on 5/10/26. On 4/22/26: Resident #2 hit a resident in the mouth. On 5/10/26 Resident #2 hit another seated near him and displayed physical aggression toward staff. Record review of handwritten witness statement dated 7/10/26 and completed by CNA J indicated the following: Saw [Resident #2] push [Resident #3] in their bedroom doorway and [Resident #2] had his fist ready to hit [Resident #3]. I [CNA J] asked [Resident #3] and [Resident #2] what was the reason for all of this. [Resident #3] said he just asked [Resident #2] where the restroom was and [Resident #2] went off on him. Both were separated and nurse was notified. During an interview on 7/26/26 at 5:30pm, DON stated that Resident #2 was discharged from Behavioral Hospital #1 on May 27, 2026, following inpatient psychiatric treatment. Upon his return, medication adjustments were (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented, including an increase in divalproex sodium to 250 mg and the addition of metformin. Behavior monitoring was documented on the nurse MAR, and direct-care staff were instructed to report behavioral concerns to the charge nurse. The DON stated that, following Resident #2's 4/22/26 incident with another resident on the secured unit, staff identified that he displayed possessive behavior regarding his belongings. Care-plan interventions were implemented to keep other residents away from his personal items and to redirect or de-escalate him when needed. The psychiatric provider subsequently ordered sertraline 50 mg daily and Depakote sprinkles 125 mg twice daily for mood regulation. Additional medication changes were made after the 5/10/26 and 5/11/26 incidents and during his later inpatient psychiatric treatment. The DON said Resident #3 was selected as a potential roommate after Resident #2 returned from the psychiatric hospital because Resident #3 was considered private and was not known to enter other residents' personal spaces or disturb their belongings. Resident #2 also had an order for one-to-one supervision until cleared by psychiatric services. The DON stated that one-to-one monitoring was initiated after incidents, communicated verbally during shift-to-shift reports, and discontinued after in-house psychiatric evaluation on 7/15/26. She said after Resident #2 threatened to beat up Resident #3 on 7/7/26, Resident #3 was moved to another room. However, he reportedly continued attempting to return to Resident #2's room despite staff redirection. The DON stated that the facility did not intentionally place the residents back together and that the 7/10/26 altercation occurred when Resident #3 entered Resident #2's room to use the restroom. She said following the 7/10/26 incident, the facility reviewed Resident #2's behaviors, laboratory results, and staff interviews. Staff determined that he appeared especially irritable during the morning. Laboratory testing, including an A1C, was ordered to determine whether blood-glucose concerns contributed to the irritability; however, no new medical orders resulted from the findings. Resident #2 was placed in a private room without a roommate. The facility attempted to transfer him to a psychiatric facility, but the emergency detention order was declined. He was later evaluated by the psychiatric provider, who continued Depakote 250 mg twice daily, started sertraline 25 mg daily for anxiety, and prescribed donepezil 10 mg at bedtime for dementia. The DON further stated that Resident #3 received neurological checks and an incident assessment following the injury; however, no photographs were taken. Facility policies regarding abuse prevention, resident-to-resident altercations, behavioral emergencies, and supervision were provided. The facility did not have a specific room-change policy and instead discussed room-placement decisions with department heads during morning meetings. During an interview on 7/26/26 at 6:15pm, Administrator stated he was not informed of the verbal threat that occurred on 7/7/26 until after the resident-to-resident altercation on 7/9/26 had already occurred. The Administrator stated he expected LVN G to have notified him of the verbal threat. The Administrator stated he was aware that Resident #2 had a history of conflicts with previous roommates and other residents. However, because Resident #3 generally did not interfere with other residents, he believed the two residents would be compatible as roommates. The Administrator stated he did not recognize until after the altercation that Resident #2 became agitated when others entered or remained within his personal space, which was identified as a behavioral trigger. He further stated that, based on this information, he believed another resident should not be assigned to Resident #2's room. The Administrator stated Resident #2's previous Resident -to- Resident incidents on 4/22/26 and on 5/10/26 listed on the incident and accident log was called in to the State and had already been investigated. During an interview on 7/26/26 at 6:32pm, LVN G stated she had worked at the facility since November 2025 as a charge nurse on the 6:00 p.m. to 6:00 a.m. shift. LVN G stated she had been assigned to the secured unit approximately two to three weeks earlier and was not yet familiar with all residents residing on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the unit. LVN G stated she was not working on the night Resident #2 punched Resident #3. However, she documented in both residents' clinical records that, on 7/7/26, Resident #2 made a verbal threat toward Resident #3. The threat was witnessed and reported to her by CNA K. LVN G stated she did not report the verbal threat to the Administrator, who served as the facility's Abuse Coordinator, because she believed the incident was verbal only. She stated she documented the incident in the residents' clinical records, and the CNAs separated the residents. During an interview on 7/26/26 at 6:45pm CNA K stated she could not recall the exact date of the incident but reported that she and CNA L witnessed Resident #2 make verbal threats toward Resident #3. CNA K stated the incident was reported to LVN G. CNA K stated she heard yelling coming from the residents' room and heard Resident #2 tell Resident #3 that he was going to beat him up. She also heard Resident #2 make statements about using a gun. CNA K stated Resident #2 did not possess a gun or any other weapon. As an immediate intervention, she removed Resident #3 from the room and accompanied him to the common area. CNA K stated she frequently had to separate the two residents because they did not get along; however, she was not aware of any previous physical altercations between them. CNA K further stated Resident #3 reportedly heard voices and would sometimes go into the bathroom to scream or release his frustration, which bothered Resident #2. Telephone interview attempt was made on 7/27/26 at 11:51am to contact CNA J no return call. Telephone interview attempt was made on 7/27/26 at 11:56am to contact LVN H no return call. Telephone interview attempts were made on 7/27/26 at 1:38pm and 1:47pm to contact CNA L no return call. Telephone interview attempt was made on 7/27/26 at 1:47pm to contact LVN C no return call. Record review of secure unit policy dated July 2025 indicated the following: The Secure Unit is designed to provide a safe and structured environment for residents who are at risk of elopement or harm due to cognitive impairment (e.g., dementia, Alzheimer's disease, or other behavioral health concerns). This policy ensures that all residents' rights, safety, and dignity are protected while maintaining compliance with federal and state regulations. 6. Discharge or Transfer from Secure Unit. Reasons for discharge from the unit: a. Resident(s) aggression is unmanageable. Record review of revised resident -to- resident altercation policy dated September 2022 indicated the following: All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. Policy Interpretation and Implementation:1. Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to the staff .2. Behaviors that may provoke a reaction by residents or others include:a. verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating;b. physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;c. sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing;d. taking, touching, or rummaging through other's property; ande. wandering into others' rooms/space.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents with dementia received appropriate treatment and services to maintain their highest practicable well-being for 2 of 10 residents reviewed for dementia care. (Resident #'s 2 and 3) The facility failed to identify and address the causes and triggers of Resident #2's behaviors and failed to implement effective, individualized dementia-care interventions, resulting in Resident #2 punching Resident #3 in the eye on July 10, 2026, causing bruising and blackened discoloration. This failure could place residents with dementia at risk for increased behaviors and decreased quality of life. Findings included: 1. Record review of an admission record dated 7/25/26 indicated Resident #2 was an [AGE] year-old male who initially admitted to the facility on to the secured unit on 3/11/26 and readmitted on [DATE] with diagnoses including Dementia without behavioral disturbance (a decline in memory and thinking skills without accompanying agitation, aggression, psychosis, or mood changes), depression (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and low energy that interferes with daily life), mood disorder (mental health conditions that affect your everyday emotional state, primarily involving persistent sadness, extreme highs, or intense mood shift to anger), and anxiety disorder (group of mental health conditions involving persistent, excessive fear or worry that interferes with daily life). Record review of quarterly MDS assessment dated [DATE] indicated Resident #2 admitted on [DATE] from an inpatient rehabilitation facility and had clear speech, was able to make him self-understood by expressing ideas and wants; had clear comprehension. He had BIMS score of 4 out of 15 indicating he had severe cognitive impairment, meaning the person had serious trouble with memory, attention, and knowing the date or year. Section E - Behaviors was marked indicating he had hallucinations and delusions but no physical, no verbal and no other behavioral symptoms directed towards others; He and required supervision or touching assist with most ADLs and no DME required. Resident #2 was frequently incontinent of bladder and continent of bowel. The MDS assessment indicated Resident #2 had no fractures and/or other multiple traumas, and no skin condition, no skin injury/wound or treatment, and no recent falls since admission. Record review of Resident #2's undated Care plan initiated on 4/22/26 indicated Resident #2 had the potential to be physically aggressive towards others r/t Dementia, Poor impulse control. Goal: will not harm self or others through the review date. Interventions: The resident's triggers for physical aggression: others using or touching his personal belongings. The resident's behaviors is de-escalated by keeping other residents away from his belongings; Assess and anticipate [Resident #2's] needs: food, thirst, toileting needs, comfort level, body positioning, pain etc.; If physical aggression towards others place on one on one; Monitor/document/report PRN any s/sx of resident posing danger to self and others; When [Resident #2] becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #2 progress notes indicated the following:-On 7/7/26 at 4:23am; completed by LVN G: CNA informed this writer [LVN G] that [Resident #2 was observed telling roommate [Resident #3] that he is going to beat him up, roommate [Resident #3] was removed from room and assisted to another room.-On 7/10/26 at 6:11am; completed by LVN H: 5:50am went to secured unit after hearing yelling and noted [Resident #2] standing in doorway with staff. Staff stated [Resident #2] pushed and hit his roommate [Resident #3] in the left eye. Both residents [Resident #2 and #3] separated at [that] time. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident #2] place on one on one. Administrator notified. Record review of Resident #2's physical aggression initiated incident report dated 7/10/26 completed by LVN H, indicated the incident happened in [Resident #2's] room. Incident Description: Nursing Description - CNA reported that [Resident #2] pushed and hit roommate [Resident #3] in the face because he used his bathroom. Resident Description: Resident unable to give description. Immediate Action Taken: Resident separated from other resident and placed on one. Labs ordered. Placed in room by himself, referrals sent out to behavioral units for psych stay if indicated. Mental Status: Oriented to Person. Other Info: [Resident #2] possessive over his items. Agencies/People Notified: Administrator and physician. During an observation and attempted interview on 7/25/26 at 5:35 p.m., Resident #2 was in his room on the secured memory care unit, resting in bed he did not respond to questions asked. Resident #2 was clean, well-groomed with no unpleasant odor and there were no visible bruising, skin tears or marks. 2. Record review of an admission record dated 7/25/26 indicated Resident #3 was an [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on to the secured unit on 4/24/26 and passed away in facility on 7/20/26 unrelated to incident with diagnoses including Schizoaffective disorder bipolar type (is a mental health condition that combines symptoms of schizophrenia (such as hallucinations or delusions) with extreme mood swings, including both high energy mania and low energy depression), Dementia without behavioral disturbance (a decline in memory and thinking skills without accompanying agitation, aggression, psychosis, or mood changes), delusional disorder (is a mental health condition defined by holding one or more false, fixed beliefs for at least one month, while otherwise maintaining normal daily behavior and functioning), anxiety disorder (group of mental health conditions involving persistent, excessive fear or worry that interferes with daily life) and cognitive communication deficit (trouble with talking and listening caused by problems with thinking skills like attention, memory, and problem-solving, rather than a basic physical speech problem). Record review of quarterly MDS assessment dated [DATE] indicated Resident #3 had clear speech, difficulty communicating some words or finishing thoughts but was able if prompted or given time and comprehended most conversations. He had BIMS score of 7 out of 15 indicating he had severe cognitive impairment, meaning the person had serious trouble with memory, attention, and knowing the date or year. Section E - Behaviors was marked indicating he had hallucinations and delusions but no physical, no verbal and no other behavioral symptoms directed towards others; He and required supervision or touching assist with most ADLs and no DME required. Resident #2 was frequently incontinent of bladder and continent of bowel. Record review of Resident #3's physical aggression received incident report dated 7/10/26 completed by LVN H indicated the incident happened in [Resident #3's] room. Incident Description: Nursing Description - [Resident #3] was pushed and hit in the left eye by roommate. Roommate [Resident #2] was being obsessive over shared bathroom. Resident Description- [Resident #3] stated , Roommate hit me in left eye. Immediate Action Taken: Description- [Resident #2 and #3] were separated. Head to toe assessment done. No redness or bruising noted at that time, Neuros checked. [Resident #3] was offered x-rays by DON and declined stated I'm fine. Injuries Observed at Time of incident: No Injuries observed at time of incident. Level of pain - 0. Predisposing situation/physiological factors: Wanderer and confused. Other information: Roommates; [Resident #3] often pees on floor. Record review of Resident #3's progress note indicated the following:-On 7/7/26 at 4:24am; completed by LVN G: CNA informed this writer [LVN G] that resident's roommate [Resident #2] was observed telling resident [Resident #3] that he is going to beat him up, [Resident #3] was removed from room and assisted to another room.-On 7/10/26 at 5:50am; completed by LVN H: [Resident #3] pushed and hit in left eye by roommate [Resident #2].-On 7/10/26 at 6:07am; completed by LVN H: Heard yelling in secured unit, on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entering staff standing in hallway with [Resident #3] and stated roommate [Resident #2] this resident in left eye. Separated at that time with assessment done. No redness or swelling at that time. [Resident #3] stated roommate [Resident #2] hit him in left eye.-On 7/10/26 at 7:03am; completed by LVN H: [Resident #3] noted with slight redness and faint bruising below left eye at that time. Record review of Resident #3's undated care plan indicated the following:-Revised on 3/14/26 indicated Resident #3 resides in the Secure/ Memory unit and am at risk for injury from wandering in an un- safe environment AEB impaired safety awareness. The resident is at risk for injury from others while residing in secure/memory unit D/T altered cognition, history of elopement. Goal: Dignity will be maintained, and [Resident #3] will wander about the unit without the occurrence of any injury through the next review date. Intervention: Anticipate behavior(s) and redirect when in close proximity to others that might invoke aggression; Ensure family/ MD aware of behaviors and/or any increase in behaviors noted; Explain all procedure using terms/ gestures I can understand- repeat as needed; Monitor and chart behaviors qshift and PRN and report to MD; Monitor for early warning signs of any behaviors- approach in calm manner, call by name, remove from unwanted stimuli; Redirect behaviors as [Resident #3] display them. -Revised on 6/9/26 indicated Resident #3 had a behavior problem of urinating on the floor no matter where he is. Goal: will have fewer episodes of urinating on the floor by review date. Interventions: Anticipate and meet [Resident #3's] needs; Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by; If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, people involved, and situations. Document behavior and potential causes. Record review of facility's typed post investigation submission report dated 7/9/26 Incident Type: Other- Resident to Resident Altercation. Agency Immediate Response to prevent recurrence/protect individuals: Agency contacted the local police department and self-reported the incident to HHS. Notified RP, the MD, Ombudsman and Administrator. [Resident #2 and Resident #3] were roommates, they were put in separate rooms;[Resident #2] was on increased monitoring until released by psychiatric services; Neuro checks and x-ray for [Resident #3]; The court denied an emergency detention warrant for [Resident #2]; seeking placement in a psychiatric facility for [Resident #2]. Description of the Allegation: [Resident #2] punched [Resident #3] in the eyes. Injury: Black eye; [Resident #3] reports no pain. Description of Assessment: Initially [Resident #3] left eye looked fine, then about 30 minutes later a bruise started to form underneath his eye. Investigation Summary: [Resident #2] pushed [Resident #3] in the bedroom doorway and had his fists ready to hit [Resident #3]. The CNA asked [Resident #2] what was his reason for all of this and [Resident #2] said he told [Resident #3] where the rest room was, and then he hit [Resident #3]. Both residents were separated and the nurse was notified. Increased supervision for [Resident #2] began immediately. Investigation Findings: Confirmed. Agency Actions Post Investigations: [Resident #2] given a room to himself and increased supervision. Labs were ordered and pain assessment was done. Inservices: abuse and neglect reporting requirements; deescalation tactics and increase supervision expectations and rationale. Record review of incident and accident log from 4/1/2026 to 7/25/2026 indicated Resident #2 was the physical aggressor for two previous incidents with other residents on 4/22/26 and on 5/10/26. On 4/22/26:Resident #2 hit a resident in the mouth. On 5/10/26 Resident #2 hit another seated near him and displayed physical aggression toward staff. During an interview on 7/26/26 at 5:30pm, DON stated that Resident #2 was discharged from Behavioral Hospital #1 on May 27, 2026, following inpatient psychiatric treatment. Upon his return, medication adjustments were implemented, including an increase in divalproex sodium to 250 mg and the addition of metformin. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior monitoring was documented on the nurse MAR, and direct-care staff were instructed to report behavioral concerns to the charge nurse. The DON stated that, following Resident #2's 4/22/26 incident with another resident on the secured unit, staff identified that he displayed possessive behavior regarding his belongings. Care-plan interventions were implemented to keep other residents away from his personal items and to redirect or de-escalate him when needed. The psychiatric provider subsequently ordered sertraline 50 mg daily and Depakote sprinkles 125 mg twice daily for mood regulation. Additional medication changes were made after the 5/10/26 and 5/11/26 incidents and during his later inpatient psychiatric treatment. The DON said Resident #3 was selected as a potential roommate after Resident #2 returned from the psychiatric hospital because Resident #3 was considered private and was not known to enter other residents' personal spaces or disturb their belongings. Resident #2 also had an order for one-to-one supervision until cleared by psychiatric services. The DON stated that one-to-one monitoring was initiated after incidents, communicated verbally during shift-to-shift reports, and discontinued after in-house psychiatric evaluation on 7/15/26. She said after Resident #2 threatened to beat up Resident #3 on 7/7/6, Resident #3 was moved to another room. However, he reportedly continued attempting to return to Resident #2's room despite staff redirection. The DON stated that the facility did not intentionally place the residents back together and that the 7/10/26 altercation occurred when Resident #3 entered Resident #2's room to use the restroom. She said following the 7/10/26 incident, the facility reviewed Resident #2's behaviors, laboratory results, and staff interviews. Staff determined that he appeared especially irritable during the morning. Laboratory testing, including an A1C, was ordered to determine whether blood-glucose concerns contributed to the irritability; however, no new medical orders resulted from the findings. Resident #2 was placed in a private room without a roommate. The facility attempted to transfer him to a psychiatric facility, but the emergency detention order was declined. He was later evaluated by the psychiatric provider, who continued Depakote 250 mg twice daily, started sertraline 25 mg daily for anxiety, and prescribed donepezil 10 mg at bedtime for dementia. The DON further stated that Resident #3 received neurological checks and an incident assessment following the injury; however, no photographs were taken. Facility policies regarding abuse prevention, resident-to-resident altercations, behavioral emergencies, and supervision were provided. The facility did not have a specific room-change policy and instead discussed room-placement decisions with department heads during morning meetings. During an interview on 7/26/26 at 6:15 p.m., the Administrator stated he was not informed of the verbal threat that occurred on 7/7/26 until after the resident-to-resident altercation on 7/9/26 had already occurred. The Administrator stated he expected LVN G to have notified him of the verbal threat. The Administrator stated he was aware that Resident #2 had a history of conflicts with previous roommates and other residents. However, because Resident #3 generally did not interfere with other residents, he believed the two residents would be compatible as roommates. The Administrator stated he did not recognize until after the altercation that Resident #2 became agitated when others entered or remained within his personal space, which was identified as a behavioral trigger. He further stated that, based on this information, he believed another resident should not be assigned to Resident #2's room. The Administrator stated Resident #2's previous Resident -to- Resident incidents on 4/22/26 and on 5/10/26 listed on the incident and accident log was called in to the State and had already been investigated. During an interview on 7/26/26 at 6:32 p.m., LVN G stated she had worked at the facility since November 2025 as a charge nurse on the 6:00 p.m. to 6:00 a.m. shift. LVN G stated she had been assigned to the secured unit approximately two to three weeks earlier and was not yet familiar with all residents residing on the unit. LVN G stated she was not working on the night Resident #2 punched Resident #3. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, she documented in both residents' clinical records that, on 7/7/26, Resident #2 made a verbal threat toward Resident #3. The threat was witnessed and reported to her by CNA K. LVN G stated she did not report the verbal threat to the Administrator, who served as the facility's Abuse Coordinator, because she believed the incident was verbal only. She stated she documented the incident in the residents' clinical records, and the CNAs separated the residents. During an interview on 7/26/26 at 6:45 p.m. CNA K stated she could not recall the exact date of the incident but reported that she and CNA L witnessed Resident #2 make verbal threats toward Resident #3. CNA K stated the incident was reported to LVN G. CNA K stated she heard yelling coming from the residents' room and heard Resident #2 tell Resident #3 that he was going to beat him up. She also heard Resident #2 make statements about using a gun. CNA K stated Resident #2 did not possess a gun or any other weapon. As an immediate intervention, she removed Resident #3 from the room and accompanied him to the common area. CNA K stated she frequently had to separate the two residents because they did not get along; however, she was not aware of any previous physical altercations between them. CNA K further stated Resident #3 reportedly heard voices and would sometimes go into the bathroom to scream or release his frustration, which bothered Resident #2. During an interview on 7/27/26 at 3:33pm CNA M and CNA N stated they worked the 6:00 a.m. to 6:00 p.m. shift on the secured unit. Both CNAs reported that Resident #2 had a history of physical aggression toward other residents and staff and did not tolerate other residents entering his room or personal space. They stated Resident #3 was Resident #2's second roommate and that Resident #2 had physically assaulted both roommates. CNA M and CNA N further stated they did not understand why Resident #2 continued to be assigned roommates despite staff's knowledge of his aggressive behaviors and intolerance of others being in his personal space. Record review of secure unit policy dated July 2025 indicated the following: The Secure Unit is designed to provide a safe and structured environment for residents who are at risk of elopement or harm due to cognitive impairment (e.g., dementia, Alzheimer's disease, or other behavioral health concerns). This policy ensures that all residents' rights, safety, and dignity are protected while maintaining compliance with federal and state regulations. 6. Discharge or Transfer from Secure Unit. Reasons for discharge from the unit: a. Resident(s) aggression is unmanageable. Record review of Dementia - Clinical Protocol dated 2001 indicated the following: .Treatment/Management: .5. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise.a. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools).b. Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the IDT. Monitoring and Follow-Up1. The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician/physician extender.2. The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors.3. The physician/physician extender and staff will review the effectiveness and complications of medications used to try to enhance cognition and manage behavioral and psychiatric symptoms and will adjust, stop, or change such medications as indicated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 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 to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident for 1 of 5 residents reviewed for pharmaceutical services. (Resident #1) The facility failed to ensure Resident #1's Lomotil was filled and available for administration from July 10 through July 13, 2026. Resident #1 missed 14 scheduled doses of Lomotil. The facility failed to ensure Resident #1's Lomotil prescription card was noted to have a direction change from scheduled to as needed. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings included: Record review of Resident #1's face sheet printed on 07/25/26 indicated Resident #1 was an [AGE] year-old female who admitted on [DATE] and with diagnoses including COPD (a term for lung and airway diseases that restrict your breathing), chronic AFib (a continuous irregular heart rhythm where the upper heart chambers quiver instead of beating effectively), Hypothyroidism (underactive thyroid, is a condition where the thyroid gland doesn't release enough thyroid hormone into the bloodstream), Anxiety Disorder (group of mental health conditions involving persistent, excessive fear or worry that interferes with daily life), Alzheimer's disease (is a progressive brain disorder characterized by memory loss, confusion, and personality changes, eventually impairing the ability to carry out the simplest tasks), and Bipolar II (a mental health condition defined by patterns of alternating mood states: major depressive episodes and milder elevated highs called hypomanic episodes. It differs from Bipolar 1 because the up moods never reach full-blown, severe mania). Record review of admission MDS assessment dated [DATE] indicated Resident #1 had clear speech and understood others. She had BIMS score of 6 out of 15 indicating she severe cognitive impairment, reflecting substantial difficulties with memory, orientation, and thinking skills. Resident #1 was continent with bowel and bladder and required supervision or touching assist with all ADLs. During an observation and interview on 7/25/26 at 5:15pm Resident #1 was observed in her room, alert, responsive, and able to communicate her needs. No signs of acute distress were observed. During the interview, Resident #1 stated that she experienced frequent loose stools and was informed that her routinely scheduled antidiarrheal medication was not available at the facility. Resident #1 stated that it took more than three days for the medication to become available. She further stated that the physician later changed the medication order from routine administration to as-needed administration. Resident #1 also stated that her undergarments were missing, which had been sent to the laundry after she soiled herself, were later located and returned. Resident #1 voiced no additional concerns at the time of the interview. Record review of Resident #1's undated revised care plan indicated the following:- initiated on 7/17/26 indicated Resident #1 was verbally aggressive at times r/t Dementia, Ineffective coping skills, Mental / Emotional illness, Poor impulse control. [Resident #1] gets upset and yells and cusses and threatens staff in various ways if she does not get her way on things such as medications. Goal: The resident will demonstrate effective coping skills through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness; Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation; Give the resident as many choices as possible about care and activities; and When the resident becomes agitated: Intervene before agitation escalates; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.- initiated on 7/9/26, Resident #1 was on anticoagulant therapy r/t Chronic AFib, history of MI, presence of cardiac and vascular implant and graft. Goal: [Resident #1] will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Interventions:. Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in v/s. Record review revealed a physician's telephone order dated 7/10/26, at 1:59 p.m., for Resident #1 to receive Lomotil 2.5 mg/0.025 mg, two tablets by mouth four times daily for diarrhea. The order was confirmed by LVN B and electronically signed by Resident #1's doctor on 7/13/26, at 5:59 p.m. Record review of Resident #1's physician order dated 7/13/26, at 12:04 p.m., directed staff to administer Lomotil 2.5 mg/0.025 mg, two tablets by mouth every four hours as needed for loose stools. The PRN order was confirmed by the DON and electronically signed by Resident #1's doctor on 7/13/26, at 5:59 p.m. Record review of Resident #1's physician order dated 7/14/26, at 4:12 a.m. listed Lomotil, two tablets by mouth four times daily for diarrhea, but documented the order as discontinued at the same date and time by LVN C. The record did not include a discontinuation reason or a prescriber's signature. The records therefore showed both scheduled and PRN Lomotil orders during the reviewed period and did not clearly establish when the scheduled order was discontinued in relation to the PRN order. Record review of grievance form dated 7/13/26 indicated Resident #1 submitted a verbal grievance to the DON regarding her antidiarrheal medication for not being available and missing undergarments after episodes of loose stools and incontinence. The investigation found that the medication had not been called in by the facility's agent and that the physician changed the medication order to as needed. A stool specimen was obtained for testing, and the medication was subsequently ordered, received, and administered. The resident's missing undergarments were located in the laundry. The grievance was documented as resolved. facility should have obtained medication labeled for the new PRN order and properly discarded the medication associated with the previous scheduled order. She also stated she was unaware that staff were using pink stickers to indicate medication-order changes and would follow up regarding this practice. Record review of Resident #1's MAR for July 2026 showed a scheduled Lomotil 2.5 mg/0.025 mg order for, two tablets by mouth four times daily for diarrhea, with scheduled administration times of 8:00 a.m., 1:00 p.m., 6:00 p.m., and 8:00 p.m. The order began on July 10, 2026, at 6:00 p.m. and was discontinued on July 14, 2026, at 4:12 a.m. On 7/10/26, 6:00pm and 8:00pm Dosage was marked 9. On 7/11/26: 8:00am, 1:00pm, 6:00pm Dosages were marked 9 and 8:00pm marked 2. On 7/12/26: 8:00am, 1:00pm, 6:00pm and 8:00pm Dosages were marked 9. On 7/13/26: 8:00am, 1:00pm, 6:00pm and 8:00pm Dosages were marked 9. Legend on the last page indicated 9 meant other/ refer to progress note, and 2 drug refused. Record review of Resident #1's Progress Notes revealed the following:- On 7/10/26 at 2:20pm; Completed by LVN B: Per [Resident #1's] request n/o received for Lomotil 2 tabs QID r/t diarrhea awaiting med delivery at this time.- On 7/10/26 at 7:02pm; Completed by BOM: Lomotil Oral Tablet 2.5-0.025 MG Give 2 tablet by mouth four times a day for Diarrhea; On order.- On 7/11/26 at 9:00am; Completed by BOM: Lomotil Oral Tablet 2.5-0.025 MG Give 2 tablet by mouth four times a day for Diarrhea; On order.- On 7/11/26 at 12:07pm; Completed by BOM: Lomotil Oral Tablet 2.5-0.025 MG Give 2 tablet by mouth four times a day for Diarrhea; On order.- On 7/11/26 at 7:05pm; Completed by LVN C: [Resident #1] went to the nurse's station saying she was coughing and had an accident on herself d/t having diarrhea. [LVN C] got up to get [Resident #1] Imodium and she started saying, I don't want the Imodium, I want the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescription kind. [LVN C] looked to see if [Resident #1's Lomotil prescription] had come in, even looked in the new red bags from pharmacy that had just came in and it wasn't in yet. [Resident #1] started yelling. [LVN C] got [BOM] because she had passed meds and [LVN C] wanted to see if [BOM] knew anything more.[BOM] said [Resident #1's Lomotil prescription] had not come in yet and [BOM] tried to give [Resident #1] night meds and [Resident #1] refused them. [Resident #1] began to yell and say she wasn't being taken care of, things [took] too long to come in. [LVN C] offered the Imodium again, and [Resident#1] finally took it.- On 7/12/26 at 8:36am; Completed by BOM: Lomotil Oral Tablet 2.5-0.025 MG, Give 2 tablet by mouth four times a day for Diarrhea; On order.- On 7/12/26 at 12:58pm; Completed by BOM: Lomotil Oral Tablet 2.5-0.025 MG, Give 2 tablet by mouth four times a day for Diarrhea; On order.- On 7/12/26 at 5:50pm; Completed by BOM: Lomotil Oral Tablet 2.5-0.025 MG, Give 2 tablet by mouth four times a day for Diarrhea; On order.- On 7/12/26 at 7:06pm; Completed by BOM: Lomotil Oral Tablet 2.5-0.025 MG, Give 2 tablet by mouth four times a day for Diarrhea; On order.- On 7/13/26 at 10:05am; Completed by DON: Late Entry - Lomotil medication clarified, med to be PRN not scheduled per Dr. D. Med called in by Agent. Pharmacy stated will be in today. Not available in e-kit. Imodium given with continues loose stools.- On 7/13/26 at 12:43pm & noted at 12:44pm; Completed by CMA E: Lomotil Oral Tablet 2.5-0.025 MG, Give 2 tablet by mouth four times a day for Diarrhea; med not here.- On 7/13/26 at 5:07pm; Completed by CMA E: Lomotil Oral Tablet 2.5-0.025 MG, Give 2 tablet by mouth four times a day for Diarrhea; med not here.- On 7/13/26 at 7:18pm; Completed by CMA E: Lomotil Oral Tablet 2.5-0.025 MG, Give 2 tablet by mouth four times a day for Diarrhea; med not here.-On 7/14/26 at 3:29am; Completed by LVN C: [Resident #1] went to the nurse station upset because the Lomotil that had been ordered for her diarrhea still had not been delivered. [Resident #1] had been told daily that it should be here on the next delivery. [LVN C] placed a call to [Name of Pharmacy] and spoke to someone in the pharmacy, the situation was explained, and [LVN C] requested a STAT delivery. At 3:46am - [Resident #1] had also reported soiling several pairs of her black leggings/tights and [Resident #1] stated she hasn't gotten them back from laundry. [LVN C] have spoken to laundry personnel, and she stated she will look for them. [LVN C] have also given [Resident #1] a collection hat for her toilet and instructed [Resident #1] to place it backwards in the toilet. [LVN C] also gave [Resident #1] a sample cup and instructed [Resident #1] to bring it to [LVN C] in the biohazard bag, and I [LVN C] will place it on ice. [Resident #1] voiced understanding. [Resident #1] had a male friend in the room as I [LVN C] gave these instructions.-On 7/14/26 at 4:21am; Completed by LVN C: Lomotil received in 4:00am delivery. [Resident #1] made aware. During an interview on 7/26/26 at 3:19 p.m., with DON stated Resident #1's original Lomotil order was written on July 10, 2026. The DON reported that during a clinical meeting held on Monday, July 13, 2026, she clarified the order with Dr. D, who directed that the medication be changed from scheduled administration to PRN use only. The DON stated an authorized agent subsequently called the medication order in to the pharmacy. She explained that Lomotil was not available in the facility's emergency medication kit because it was not classified as an emergency medication. According to the DON, the Lomotil was delivered to the facility on July 14, 2026, at approximately 4:00 a.m. The DON further stated that Imodium was administered to Resident #1 while the facility awaited delivery of the Lomotil because Imodium was available over the counter and was included in Dr. D's standing orders for the treatment of loose stools. During an interview and observation on 7/26/26 at 5:47 p.m., LVN B stated he had worked at the facility for approximately three years and served as the charge nurse for Halls 5 and 6 during the 6:00 a.m. to 6:00 p.m. shift. LVN B stated he was aware that Resident #1 had complained of diarrhea and that he obtained the new Lomotil order. He reported that on July 7, 2026, he received approval from Dr. D for Lomotil 2.5 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg/0.025 mg, two tablets by mouth four times daily for diarrhea. LVN B explained that Dr. D's preferred method of communicating new orders was by text message. Observation of LVN B's cellular phone confirmed text-message communication with Dr. D authorizing Lomotil as a scheduled medication to be administered by mouth four times daily. LVN B stated he believed the order had been forwarded to the pharmacy but did not know why the medication was not delivered sooner. He reported checking the facility's electronic system daily during his shifts for updates regarding the medication's status. LVN B further stated that on July 10, 2026, he instructed the ADON, who was an authorized agent, to place the order with the pharmacy because the medication's controlled-substance classification required an individual with agent privileges to submit the prescription. During an interview on 7/26/26 at 5:58 p.m., the ADON stated she was an authorized agent for Dr. D. She explained that this authorization permitted her and other designated individuals to communicate oral prescriptions by telephone to a pharmacist for Schedule III, IV, and V controlled substances. The ADON stated she was unaware that Resident #1's Lomotil prescription had not previously been called in to the pharmacy and had assumed the medication had already been ordered. She reported that on July 13, 2026, the Director of Nursing instructed her to order Resident #1's Lomotil. The ADON stated that on July 13, 2026, she contacted the pharmacy and provided a verbal prescription for Lomotil 2.5 mg/0.025 mg, two tablets by mouth four times daily for diarrhea. She explained that she submitted the prescription as a scheduled medication because the scheduled order was the only active Lomotil order documented in Resident #1's clinical record at that time. The ADON further stated that the order was apparently changed to PRN administration sometime after the medication was delivered. However, she emphasized that when she contacted the pharmacy, the active order was for scheduled administration, and she followed the order documented in the resident's record. During a telephone interview on 7/26/26 at 6:54 p.m., Dr. D stated that he expected the facility to notify him whenever a resident's prescribed medication was unavailable or delayed. Dr. D stated that he could not recall whether the facility notified him regarding the delay in obtaining Resident #1's Lomotil and would need to review his records. He stated that he was not overly concerned because Lomotil was not considered an emergency medication. Dr. D further stated that the facility had standing orders for Imodium to address residents' episodes of loose stools. During a telephone interview on 7/27/26 at 10:43 a.m., the contracted pharmacy representative stated the pharmacy received Resident #1's scheduled Lomotil order on 7/13/26 and delivered the medication to the facility on July 14, 2026. The representative stated this was the only Lomotil order the pharmacy received. The pharmacy did not receive an order changing Lomotil from scheduled administration to PRN. The representative said the facility needed to send a Lomotil PRN order, for it to reflect active in their system. During an interview on 7/27/26 at 2:12 p.m., CMA E stated she had worked at the facility for approximately five years and served as the CMA for Halls 4, 5, and 6 during the 7:00 a.m. to 7:00 p.m. shift. CMA E stated she worked on 7/13/26 as the CMA assigned to Hall 6, where Resident #1 resided. She reported that she followed the medication directions documented on the MAR. According to Resident #1's MAR, the resident was prescribed Lomotil 2.5 mg/0.025 mg, two tablets by mouth four times daily. CMA E stated the medication was not available in the facility for administration. She reported that she notified the charge nurse on duty and documented the medication's unavailability in Resident #1's clinical record. During an interview on 7/27/26 at 2:23pm, the BOM stated she had worked at the facility for approximately 23 years and, because she was certified as a medication aide, frequently filled in as a CMA when needed. The BOM stated she worked as the CMA for Halls 4, 5, and 6 from Friday, 7/10/26, through Sunday, 7/12/26. During that period, Resident #1 had an active order for Lomotil 2.5 mg/0.025 mg, two tablets by mouth four times (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily. She stated the medication was not available from 7/10/26 through 7/12/26. According to the BOM, the charge nurses informed her that the Lomotil had been ordered and that the facility was awaiting delivery from the pharmacy. She stated she was instructed to administer Imodium to Resident #1 until the Lomotil was delivered and available for administration. During an observation and interview on 7/27/26 at 2:33 p.m., LVN F stated he had worked at the facility in several positions, including ADON, and most recently served as the charge nurse on the 6:00 a.m. to 6:00 p.m. shift. LVN F stated he worked during the period when Resident #1's Lomotil was awaiting delivery from the pharmacy. He reported that Resident #1 expressed frustration because the medication was unavailable. LVN F stated he personally informed the resident that the medication had been ordered and that the facility was waiting for the pharmacy to deliver it. He said that he did not contact the pharmacy to verify the status of the Lomotil order and explained that the facility's electronic system displayed the order as received, which he understood to mean the pharmacy had received the order. He stated he was unaware at that time that the pharmacy had not actually received it. LVN F reported that the facility administered Imodium to Resident #1 until the Lomotil was delivered. He further stated that the Lomotil order was subsequently changed from scheduled administration to as needed, or PRN, and the medication remained secured on the medication cart after the change. During the observation, LVN F retrieved Resident #1's Lomotil from the narcotic lockbox. Two pharmacy-issued blister cards were observed for diphenoxylate/atropine 2.5 mg, generic for Lomotil. The pharmacy labels were dated July 13, 2026, and directed staff to administer two tablets by mouth four times daily. Each card originally contained 30 tablets. Card 1 of 4 had not been used and contained all 30 tablets. Card 2 of 4 contained eight tablets, indicating that 22 tablets, equivalent to 11 two-tablet doses, had been removed. LVN F stated he was unaware that the pharmacy labels on the two blister cards reflected a scheduled routine order rather than a PRN order. He explained that when the medication order was changed and the medication was secured on the cart, staff should have documented the change by applying the facility's pink Medication Change labels to both blister cards and handwriting the updated directions on the labels. LVN F was observed applying the pink labels to both blister cards to indicate that the medication had been changed to PRN administration. During an interview on 7/27/26 at 3:00 p.m., the DON and Administrator said they discussed the facility's medication-order and pharmacy-notification processes. The DON stated the facility's electronic system was intended to transmit medication orders to the pharmacy and allowed staff to submit orders and verify prescription status electronically. The DON stated that when an ordered medication was not delivered within 24 hours, staff were expected to notify her and the prescribing physician. She explained that medication-delivery concerns were typically identified during the facility's morning clinical meetings. However, the delay involving Resident #1's Lomotil prescription occurred over the weekend, and she was unaware of the issue until she returned to work on Monday, 7/13/26. The Administrator stated staff were expected to notify the DON by telephone whenever medication had not been delivered within 24 hours, as the DON was available by phone at any time, including weekends. The DON further stated she was unaware that the pharmacy had not been notified of the change in the Lomotil order from scheduled administration to as-needed administration. She believed the ADON had communicated the change to the pharmacy. The DON stated the facility should have obtained medication labeled for the new PRN order and properly discarded the medication associated with the previous scheduled order. She also stated she was unaware that staff were using pink stickers to indicate medication-order changes and would follow up regarding this practice. The DON said Dr. D called back following up on telephone interview and said facility did not notify him regarding Resident #1's medication not available. During attempted interview via phone on 7/27/26 at (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 1638 Vz Cr 1803 Grand Saline, TX 75140	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:47pm for LVN C, no answers, no return calls, left a voice message if available. Record review of revised administering medications policy dated April 2019 indicated the following: Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication		