| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675881 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at Pecos | 1819 Memorial Drive<br>Pecos, TX 79772 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week, for 3 days of 30 days reviewed for nursing services.The facility failed to have a registered nurse working on [DATE], [DATE], and [DATE].This failure could place residents at risk of not receiving advanced nursing skill of a registered nurse.The findings included:Record review of the Nursing Facility's Daily Staffing dated [DATE], [DATE], and [DATE], revealed there was no RN assigned during those shifts.In an interview on [DATE] at 05:49 PM with the DON, she stated there were potential risks to residents not having an RN to provide services at least 8 hours a day, every day. The DON stated the potential risks to residents included the example of LVN's unable to call time of death, only an RN could, and if a resident was DNR (Do not Resuscitate), the LVN would still have to perform CPR.In an interview on [DATE] at 7:00 PM with the Administrator, he stated the Nursing Facility was attempting to contract Registered Nurses via advertisement. The Administrator stated the Nursing Facility was currently short of Registered Nurses now, which was why there were documented days of not having an RN daily in 05/2026. He stated the potential risk of the Nursing Facility not having an RN on-site was having the lack of a higher trained nursing staff that could pronounce time of death, for example.Record review of Nursing Facility's Staffing, Sufficient and Competent Nursing policy, with revision date 08/2022, read in part under Policy Interpretation and Implementation, Sufficient Staffing: 3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.CFR 483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 1 facility reviewed for dignity.-The facility failed to maintain a working air conditioner in the facility van impeding the residents from being able to be taken out into the comunity to do activities. This failure could place residents at risk of diminished quality of life and compromise residents' dignity. Findings included:In a confidential group interview 4 of 6 residents voiced that they were not able to be taken into the community to do activities due to the air conditioner in the van not working. They stated that it had been about 6 months that it had been broken. They stated that it would be nice to be able to go out to the store or to do activities in the community.In an interview on 5/14/2026 at 3:24 PM with the Maintenance Director he stated that the air conditioner in the van had not been working for a year now. He stated that he has taken the van on 2 occasions out to a shop in Midland, he could not recall the name, but that the owner told him that he had too much work and to bring it back another day. There was no documentation provided because the van was not touched by the shop. It was taken for an estimate but again on both occasions that it was taken the van was not touched due to the shop having too much work. He stated that he was able to find another person on Monday 05/11/2026 that was able to pick up the van and take it to be fixed. He stated that the van would be returned with a fixed air conditioner by either today 05/14 or tomorrow 05/15. He stated that at that time the invoice would be provided. He stated that he did not remember the name of the shop that was fixing it and that the administrator would know. He stated that since residents weren't being taken out they may feel like they do not have the means to be taken out to have fun. He stated it was his responsibility and the responsibility of the administrator to ensure that the equipment was working.In an interview on 05/14/26 at 4:38 PM with the DON she stated that she did not know since when the air conditioner was broken. She stated that to her knowledge the van was taken to a shop to be fixed but it was sent back due to the shop having too much work. She stated that the van wasis getting fixed this week and should be back by tomorrow with a new air conditioner. She stated that they stopped using it in the hot months because of the risk to the residents health and possibility of heat stroke. She stated that they could potentially feel sad because they were not able to go out to do activities. She stated that it was the responsibility of the maintenance director and the administrator to ensure equipment was working properly. The option was for residents to have an outing early in the morning before the temperature was too hot. She stated that appointments were kept via ambulance transportation.In an interview on 05/14/26 at 6:03 PM with the Administrator he stated that the air conditioner had not been working for 5 months now. He stated that the maintenance director reported it to him and at that time the van was placed out of commission for resident safety. He stated that the van was taken for air conditioner repair estimate a couple of times out to Midland. He stated that there was no documentation of that because the van was not touched. He stated that the van was taken on 5/11 for repair of the air conditioner and at the time that it was brought back the invoice would be given to them. He did not know the name of the shop. He stated that the maintenance director would know. He stated that it was his responsibility and the maintenance director to ensure that the air conditioner was in working condition for residents. He stated that the residents had a right to go out to the community and this could affect the way they felt. Record review of the Nursing Facility's Resident Rights Policy with revision date 02/2021, read in part: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. dignified existence. |

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| F 0574<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The resident has the right to receive notices in a format and a language he or she understands.<br><br>Based on observation and interview the facility failed to post in a location available for all residents, contact information including telephone numbers of the Long-Term Care Ombudsman program for the facility's postings for 53 residents reviewed for resident rights. The facility's single Ombudsman Program sign was posted on a posterboard on a sticker with small print in the hallway that led to the 200 hall and was not viewable to residents. This failure could place residents at risk of not having access to signs informing them of their rights and resident advocacy groups.The findings include: Observation on 05/12/2026 at 3:00 PM revealed, the ombudsman contact information was posted on the wall leading into the 200 hallway, the contact information was small print on a white sticker. In a confidential interview, 4 of 6 residents did not know how to contact their ombudsman and did not know where they could find her information in the facility. An interview on 05/14/26 at 5:38 PM with the DON, she stated that postings had to be in a visible area where residents and family members could see it. She stated that it had to be large enough for the residents to see and at eye level. She stated that the ombudsman information might be too small for residents to see, but they could always ask any staff member, and they could provide that information to them. She stated that a potential risk would be residents feeling as if they were not able to voice concerns and get the help needed. In an interview on 05/14/26 at 6:07 PM with the Administrator, he stated that the posting had to be posted in an area where it was easily accessible to residents. He stated that the print should be large enough for residents to see, and it should be at eye level for residents in wheelchairs as well. He stated that the current ombudsman information was potentially too small and that it was something that could be fixed. He stated that a potential risk to the residents would be the residents not being able to exercise the right to contact the ombudsman if needed. At 05/14/2026 at 5:11 PM, the DON stated the Nursing Facility did not have a policy regarding the Ombudsman posting. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents had the right to a safe, clean, comfortable and homelike environment, for 2 of 4 halls observed for environment.The facility failed to ensure the shower room in the 300 hall was clean and free from black particles on the floor of the shower. The facility failed to ensure that the shower room in the memory care unit was free from exposed piping under the sink.The facility failed to ensure that four resident rooms were free from exposed piping under the sink.The facility failed to ensure that one resident room did not have a closet door off its hinge.This failure could place residents, who resided on the 300 and memory care unit, at risk for injury due to exposed piping and missing tiles and decrease in quality of life.Finding included:Resident #5 Record review of Resident # 5's admission record dated 05/13/2026 revealed a [AGE] year-old male with an initial admission date of 05/05/21 and a readmission date of 12/29/25. Record review of Resident # 5's diagnosis list dated 05/13/26 revealed a diagnosis of unspecified dementia with other behavioral disturbances (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed and is accompanied by disruptive behavioral symptoms.) Record review of Resident #5's Quarterly MDS assessment dated [DATE] revealed no BIMS score. Record review of Resident #5's care plan revised 02/17/26 revealed Resident #5 had a communication problem related to dementia. Interventions included Ensuring/providing a safe environment, Call light in reach, Adequate low glare light. An observation on 05/12/26 at 9:36 a.m. revealed missing tiles under the sink in the resident #5's restroom leaving exposed piping. Resident #23Record review of Resident # 23's admission record dated 05/13/26 revealed an [AGE] year-old female with an initial admission date of 09/01/25 and a readmission date of 10/06/25. Record review of Resident #23's diagnosis list dated 05/13/26 revealed a diagnosis of dementia without behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed). Record review of Resident # 23's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. Record review of Resident #23's care plan revised 02/17/26 revealed Resident #23 had memory loss related to dementia. Goals included living in a safe, nurturing, and stimulating environment. An observation on 05/12/26 at 10:53 a.m. revealed missing tiles under the sink in the resident #23's restroom leaving exposed piping. Resident # 27 Record review of Resident # 27's admission record dated 05/14/2026 revealed a [AGE] year-old female with an initial admission date of 06/12/24 and a readmission date of 12/08/24. Record review of Resident # 27's diagnosis list dated 05/14/2026 revealed a diagnosis of vascular dementia (changes to memory, thinking and behavior resulting from conditions that affect the blood vessels in the brain). Record review of Resident # 27's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment. Record review of Resident #27's care plan revised 04/12/2026 revealed risk for falls related to impaired cognitive function and physical limitations. Interventions included providing a safe environment with: (Ex: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide fails as ordered, handrails on walls, personal items within reach). An observation on 05/12/26 at 11:01 a.m. revealed missing tiles under the sink in the resident #27's restroom leaving exposed piping. Resident #33 Record review of Resident # 33's admission record dated 05/13/2026 revealed a [AGE] year-old female with an initial admission date of 02/21/2023 and a readmission of 11/11/2025. Record review of Resident #33's diagnosis list dated 05/13/2026 revealed a diagnosis of dementia without behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed). Record review of Resident #33's Quarterly MDS dated [DATE] revealed a BIMS score of 04 indicating severe cognitive impairment. Record review of Resident #33's Care plan revised<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 04/12/26 revealed a communication problem related to impaired cognition. Interventions included to anticipate and meet needs. An observation on 05/12/26 at 11:06 a.m. revealed missing tiles under the sink in the resident's #33 restroom leaving exposed piping. Resident # 44 Record review of Resident # 44's admission record dated 05/13/2026 revealed a [AGE] year-old female with an initial admission date of 09/02/2008 and a readmission of 12/09/2024. Record review of Resident #44's diagnosis list dated 05/13/2026 revealed a diagnosis of dementia without behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed). Record review of Resident #44's Quarterly MDS dated [DATE] revealed no BIMS score. Record review of Resident #44's Care plan revised 04/12/26 revealed a communication problem related to Alzheimer's dementia and depression. Interventions included to anticipate and meet needs. An observation on 05/12/26 at 10:18 a.m. revealed the closet door off the hinge impeding it from opening and closing properly in Resident #44's room. An observation of the shower room in the 300 hallway on 05/12/26 at 10:27a.m., revealed unknown black particles on the tiles of the shower floor. An observation of the shower room in the memory care unit on 05/12/26 at 11:13am revealed missing sheetrock under the sink leaving the pipes exposed. In an interview on 05/14/26 at 3:24 PM with the Maintenance Director he stated the holes under the sink had been there for 6 months or more due to the pipelines being repaired on that side of the building. He stated the missing sheet rock and tiles were never replaced. He stated the pipes had been repaired about one year ago. He stated that he was responsible for ensuring that the holes were repaired. He stated that exposed piping in the bathrooms posed no risk to the resident. He stated that the shower room in the 300 hall had mold on the tiles of the shower room floor. He stated it had been there for about one week. He stated that housekeeping was responsible for cleaning this up. Regarding the off hinged closet door, he stated that this had not been reported to him. He stated he has a book where all requests for repair were logged in he stated that he looks at the book on every start of the shift daily. He stated that any employee was able to log in what needed repair. He stated that the mold in the shower could potentially affect residents by causing infection. He stated that there had not been any tests conducted to determine if it was mold. In an interview on 05/14/26 at 3:50 PM with Housekeeping Director, she stated that the shower room in the 300-hallway has had mold for more than 3 months. She stated that she has reported this to the administrator in morning meetings. She stated that she has tried non harsh chemicals to try and clean it up but it has not worked. She stated that the residents were at risk for infections. She stated that she was responsible for ensuring that the environment was clean, but that the administrator was also in charge of ensuring that proper cleaning measures were in place. She stated that to her knowledge there had not been any tests conducted to determine if it was mold. In an interview on 05/14/2026 at 4:38 PM with the DON, she stated that the black particles on the tiles and the wall of the 300-hallway shower room were hard water stains. She stated that the tiles from the shower room were changed in 2023 and they needed to be changed again. She stated that the shower rooms were cleaned daily by housekeeping, and housekeeping was responsible for ensuring that all shower rooms were cleaned. She stated that the staff had not reported these hard water stains to her. She stated that these hard water stains posed a risk to the residents as they could cause infection and skin irritation. She stated that there have not been any tests done to determine if it was mold since it was hard water stains. She stated that that shower room was still in use and no residents had been affected. In an interview on 05/14/2026 at 6:07 PM with the Administrator, he stated that he did not know what the black particles on the tiles of the shower room floor and wall were. He stated that the house keeping director has reported that the tiles had some kind of black particles, but that she had tried chemicals to try to clean it up and it had not worked. He stated that the unknown black particle stain had been present for about 5 months. He stated that there was a possible risk to residents as they could be harmed by breathing this in. He stated that it was the responsibility of housekeeping to ensure the shower rooms were maintained clean. He stated that the missing tiles and sheet rock were because a couple of months ago the plumbing was fixed on that side of the building, and they needed access to<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | pipes. He stated that the tiles and sheet rock had to be replaced as soon as the plumbing was fixed. He stated that not having the environment in good repair put the residents at risk for a non-homelike environment, He stated that he and maintenance were responsible for ensuring that these repairs were done. He stated that there have not been any tests done to determine if it was mold. He stated that that shower room was still in use and no residents had been affected. Review of the Nursing Facility's Resident Rights policy, with no date, read in part: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existense; b. be treated with respect, kindness, and dignity. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 3 of 7 residents reviewed for care plans. (Resident #4, Resident#37 and #49)The facility failed to ensure Resident #4's care plan included ADLs.The facility failed to ensure Resident #49's care plan addressed smoking,The facility failed to ensure Resident # 37's care plan addressed oxygen use This failure had the potential to affect residents by placing them at risk for unmet care needs.<br><br>Record review of Resident #37's admission Record dated 05/12/2026 revealed a [AGE] year-old male with admission date 04/22/2026.<br><br>Record review of Resident #37's history and physical dated 05/12/2026 revealed a medical history of the following: Acute Respiratory Failure with Hypoxia (where the lungs fail to deliver sufficient oxygen to the blood, leading to low oxygen levels in tissues).<br><br>Record review of Resident #37's Comprehensive MDS dated [DATE], revealed a BIMS of 05, indicating the resident had severe cognitive impairment. Under Section O-Special Treatments, indicated Resident #37 had Oxygen Therapy.<br><br>Record review of Resident #37's Care Plan did not address Oxygen Therapy.<br><br>Record review of Resident #37's Order Summary Report as of 05/14/2026, revealed a Physician Order for Oxygen Continuously via Nasal Cannula (a thin, flexible tube with two prongs that fit into the nostrils, delivering oxygen from a source such as an oxygen concentrator), may titrate 2 Liters- 5 Liters for Shortness of Breath or pulse oximetry less than 90 percent.<br><br>An observation of Resident #37's room on 05/12/2026 at 1:43 p.m. revealed an oxygen concentrator at bedside. There was no oxygen signage posted outside the door.<br><br>Record review of Resident # 49's admission record dated 05/13/2026 revealed an initial admission date of 07/19/2019 and a readmission date of 06/12/2025.<br><br>Record review of Resident # 49's diagnosis list dated 05/13/2026 revealed a diagnosis of unspecified dementia with other behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed and is accompanied by disruptive behavioral symptoms.)<br><br>Record review of Resident #49's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment.<br><br>Record review of Resident #49's care plan revised on 02/17/2026 did not address Resident #49's smoking.<br><br>An observation on 05/12/2026 at 11:15AM revealed Resident #49 outside in the smoking area smoking<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | a cigarette.<br><br>In an interview on 05/14/2026 at 4:38 PM with the DON she stated that the purpose of the care plan was so that staff knew the needs of the resident and how to take care of them. She stated that the facility had transitioned from one system to another and that she assumed that everything in the care plan transferred over. She stated that smoking should be a part of the care plan so that the staff could be aware for safety reasons. She stated that the facility does not have a current in house MDS nurse but corporate MDS nurse has been taking over until new MDS nurse was done training. She stated that care plans were reviewed by nursing and corporate MDS weekly. She stated that Resident #49 was the only resident that smoked at the facility.<br><br>In a phone interview on 05/14/2026 at 5:00PM with the MDS Regional Nurse, she stated that the purpose of the care plan was to provide information on how to care for the residents. She stated that smoking should be included in the care plan so that staff was aware that resident was a smoker and any adaptive equipment that would be needed for safety. She stated that a potential risk would be miscommunication about residents care. She stated that nursing and herself were responsible for ensuring care plans were up to date. She stated care plans were reviewed quarterly and as needed.<br><br>In an interview on 05/14/2026 at 6:03 PM with the Administrator he stated that the purpose of the care plan was a way to show what care the Resident was receiving. He stated that if the resident was a smoker, that would have needed to be included in the care plan for safety purposes. He stated that nurses, social worker and the DON were responsible for ensuring that the care plans were updated. He stated that these care plans were reviewed quarterly and as needed. He stated that the potential risk of not including smoking in the care plan would be that the new staff would not be aware of the care needed. He stated that Resident #49 was the only resident at the facility that smoked.<br><br>Record review of the Nursing Facility's Care Planning Policy, with revision date 12/2024, read in part: The Interdisciplinary team is responsible for the development of resident care plans. It continued, 1. Resident care plans are developed according to the timeframes and criteria established by [state regulation] 483.21<br><br>Record review of State Regulation 483.21(b) Comprehensive Care Plans, read in part, (b)(1) The facility must develop and implement a comprehensive care plan for each resident, consistent with the resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>Findings included:<br><br>Record review of Resident #4's face sheet dated 05/13/2026, revealed the resident was a [AGE] year-old male with an admission date 04/24/2026.<br><br>Record review of Resident #4's Physician progress note dated 05/04/2026 revealed a past medical history of the following: Peripheral Vascular Disease (a condition that develops when the arteries that supply oxygen-rich blood to the internal organs, arms, and legs become completely or partially blocked).<br><br>Record review of Resident #4's Comprehensive MDS dated [DATE], revealed Resident #4 had a BIMS<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of 15, indicating the resident was cognitively intact. Under Section GG- Functional Abilities – Admission, it was noted Resident #4 was completely Dependent, meaning the helper does all the work to complete the task, for personal hygiene.<br><br>Record review of Resident #4's care plan with revision date 05/12/2026 did not include ADLs.<br><br>In an interview and observation on 05/12/2026 at 11:45 AM with Resident #4, he stated he would like his nails cut or trimmed since it was becoming long and uncomfortable. Resident #4 stated he had not been offered a nail trim or cut since being in the Nursing Facility. Resident #4's jagged nails were observed a quarter inch long.<br><br>In an interview on 05/14/2026 at 09:06 AM with LVN C, she stated MDS nursing or an RN was responsible for the initial care plan which was completed within 48 hours of admission. She stated nursing was responsible for monitoring care plans. She stated the potential risk to residents not having their baseline care plan included not addressing a resident's ADL needs. She stated this could cause a resident to not have the assistance they need. LVN C stated this could also affect the resident's self-esteem or mobility.<br><br>In an interview on 05/14/2026 at 10:07 AM with RN D, she stated the floor RN would be responsible for the initial care plan. RN D stated if the RN was unavailable, the ADON also assisted and was responsible for the residents' initial care plan and monitoring it, though she was unsure how often it was monitored. RN D stated the potential risks for a resident not having an initial care plan included not addressing a resident's plan of care and the assistance required for ADLs which is a safety concern. |

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| | 675881 | A. Building<br>B. Wing | 05/14/2026 |

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| Avir at Pecos | 1819 Memorial Drive<br>Pecos, TX 79772 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident's environment was as free of accident hazards as possible for 1 of 2 shower rooms reviewed for accidents.-The facility failed to properly store/dispose razors in the community shower room in the 300-hallway on 5/12/26.This deficient practice could place residents at risk of harm or injury and contribute to avoidable accidents.Findings included:300 hallway community showerAn observation on 5/12/2026 at 10:28AM revealed a white plastic trash bag tied closed containing multiple disposable razors sitting on top of a container mounted on the wall in the 300 hallway community shower room. In an interview on 05/14/2026 at 8:30 AM with CNA B, she stated aides or the nursing staff were responsible for disposing razors in the sharps containers which were in the shower. CNA B stated the CNAs, and the aides were trained to notify the floor nurse if the sharps containers were filled or closed to be filled so they could be replaced. CNA B stated the potential risk of having exposed razors that were not properly disposed of, including residents wandering in and grabbing the razors and possibly injuring themselves. In an interview on 05/14/2026 at 9:00 AM with LVN C, she stated razors were to be disposed of in the sharps box in the shower room- the aides should dispose of them . She stated if the share containers were overfilled they should notify nursing or other staff to have it removed she stated that this was a risk for injury and infection. In an interview on 05/14/2026 at 10:10 AM with RN D, she stated CNAs were to dispose of razors in the Sharps Container after a one time use on the residents. RN D stated if a Sharps container was observed full or close to full, the CNAs were to notify nursing so it could be replaced. RN D stated not having razors disposed of properly in the Sharps container would put residents at risk for injury to themselves or other residents.In an interview on 05/14/26 at 6:03PM with the Administrator, he stated that all disposable razors were to be disposed of in the sharps container for safety of the residents and saftey of the staff. He stated that it was not acceptable to dispose of them in a plastic bag and to have left them in a place where they were easily accessible to residents because they could potentially hurt themselves. He stated that nursing was responsible for ensuring that razors were disposed of properly. Record review of Nursing Facility's Sharps Disposal policy, dated 2001, read in part: Policy Statement- This facility shall discard contaminated sharps into designated containers. Policy interpretation and Implementation- 1. Whoever uses contaminated sharps will discard them immediately or as soon as feasible into the designated containers. 2. Contaminated sharps will be discarded containers that are: a. closable; b, puncture resistant; c. leakproof on sides and bottom; c. leakproof on sides and bottom; d. labeled or color-coded in accordance with our established labeling system; and, e. impermeable and capable of maintaining impermeability through final waste disposal. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure the resident was offered sufficient fluid intake to maintain proper hydration and health for 3 (Resident #23, #27, #33) of 3 residents reviewed for access to hydration. The facility failed to ensure staff provided access to hydration and provide fresh water and ice at bedside for Residents (#23, #27, and #33) .This deficient practice could place residents at risk of being dehydrated.Findings include:Resident # 23Record review of Resident # 23's admission record dated 05/13/26 revealed an [AGE] year-old female with an initial admission date of 09/01/25 and a readmission date of 10/06/25. Record review of Resident #23's diagnosis list dated 05/13/26 revealed a diagnosis of dementia without behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed). Record review of Resident # 23's Quarterly MDS assessment dated [DATE] revealed a BIMS of 03 indicating severe cognitive impairment. Section GG-Functional Abilities revealed Resident # 23 needed setup or clean up assistance meaning the helper set up or cleaned up, resident completed activity, helper assists only prior to or following the activity while performing eating activity. Record review of Resident #23's care plan revised 02/17/26 revealed Resident #23 had memory loss related to dementia. Goals included living in a safe, nurturing, and stimulating environment. Care plan also stated that Resident # 23 had a self- care performance deficit. Interventions included that resident was able to feed self. An observation on 05/13/26 at 11:42 a.m. revealed no hydration jug in room, available for resident.An observation on 05/13/26 at 1:47PM revealed no hydration jug in room available for resident.An observation on 5/14/26 at 10:30AM and at 11:12 AM revealed no hydration jug in room available for resident. In an interview, Resident #23 could not express if she received water other than with medications, she stated she received water with her pills sometimes.Resident # 27 Record review of Resident # 27's admission record dated 05/14/2026 revealed a [AGE] year-old female with an initial admission date of 06/12/24 and a readmission date of 12/08/24. Record review of Resident # 27's diagnosis list dated 05/14/2026 revealed a diagnosis of vascular dementia (changes to memory, thinking and behavior resulting from conditions that affect the blood vessels in the brain). Record review of Resident # 27's Comprehensive MDS assessment dated [DATE] revealed a BIMS of 00 indicating severe cognitive impairment. Section GG-Functional Abilities revealed Resident # 27 needed setup or clean up assistance meaning the helper set up or cleaned up, resident completed activity, helper assists only prior to or following the activity while performing eating activity. Record review of Resident #27's care plan revised 04/12/2026 revealed risk for falls related to impaired cognitive function and physical limitations. Interventions included providing a safe environment with: (Ex: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide fails as ordered, handrails on walls, personal items within reach). Care plan also stated that Resident # 27 had a self- care performance deficit. Interventions included that resident was able to feed self. An observation on 05/13/26 at 11:42 a.m. revealed no hydration jug or cup of water in room, available for resident.An observation on 05/13/26 at 1:47PM revealed no hydration jug or cup of water in room available for resident.An observation on 5/14/26 at 10:30AM and at 11:12 AM revealed no hydration jug or cup of water in room available for resident.Resident #33Record review of Resident # 33's admission record dated 05/13/2026 revealed a [AGE] year-old female with an initial admission date of 02/21/2023 and a readmission of 11/11/2025. Record review of Resident #33's diagnosis list dated 05/13/2026 revealed a diagnosis of dementia without behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed). Record review of Resident #33's Quarterly MDS dated [DATE] revealed a BIMS of 04 indicating severe cognitive impairment. Section GG-Functional Abilities revealed Resident # 33 needed setup or clean up assistance meaning the helper set up or cleaned up, resident completed activity, helper assists only prior to or following<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the activity while performing eating activity. Record review of Resident #33's Care plan revised 04/12/26 revealed a communication problem related to impaired cognition. Interventions included to anticipate and meet needs. Care plan also stated that Resident # 33 had a self- care performance deficit. Interventions included that resident was able to feed self. An observation on 05/13/26 at 11:42 a.m. revealed no hydration jug in room, available for resident.An observation on 05/13/26 at 1:47PM revealed no hydration jug in room available for resident.An observation on 5/14/26 at 10:30AM and at 11:12 AM revealed no hydration jug in room available for resident.In an interview on 05/14/26 at 10:30 AM with Ombudsman, she stated that in the memory care unit, residents did not receive drinks regularly, she stated that they kept one pitcher and it would take a while for Residents to receive more water if the pitcher was empty, because the staff would have to walk out of the memory care unit and go to the hydration room to fill up the water and bring it back. She stated that residents in the memory care unit were at risk for dehydration because they could not voice needs as other residents could.In an interview on 05/14/26 at 10:50AM with CNA A, revealed that the unit had one pitcher of water and they would provide water for the residents in plastic cups if they asked for it. She stated that they were provided other types of drinks during activities if they asked for them. She stated that the water pitchers were washed out and refilled with fresh water on Monday, Wednesday and Friday. She stated that Residents were provided fluids with breakfast lunch and dinner and when taking medications. She stated that if they wanted something else to drink between that then they could ask the staff and they would pour them the cup of water. She stated that it was the responsibility of the CNAs and nurses to ensure the residents were provided with water or fluids to prevent dehydration.In aan interview on 05/14/26 at 11:17 AM with RN D, she stated that the water pitchers were passed out three days out of the week on Monday Wednesday and Friday. She stated that Residents should be provided with fresh water and ice daily or multiple times a day, but that she was told by supervisors that water pitchers were to only be filled on Monday, Wednesday and Fridays. She stated that other than that residents received fluids with meals and with mediations. She stated that residents were at risk of dehydration because a lot of them took medications that could cause dehydration as well such as diuretic. She stated that CNAs were responsible for passing out fresh water but that she believed that all staff were responsible for ensuring the residents had water readily available.In an interview on 05/14/2026 at 5:38PM with the DON, she stated fresh water was passed Monday, Wednesday and Friday by CNAs. She stated that the pitchers were brought out Monday morning and on the Tuesday night they were taken to the kitchen by night staff for them to be washed and refilled on Wednesday morning and so on. She stated that Residents were provided with fluid with meals, medications and if they asked for water. She stated that of course water could be refilled throughout the day if needed she stated that the Monday, Wednesday and Friday schedule was only for washing the pitchers. She stated that she would have to provide clarification to her staff. She stated that the risk of not offering fluids regularly would be dehydration. She stated that it was the responsibility of the CNAs and nurses to ensure residents were receiving water.In an interview on 05/14/2026 at 6:03 PM with the Administrator, he stated that water was provided to residents with meals and CNAs would pass water to residents throughout their shift. He staedstated that water was provided in the grey jugs for each resident to have available to them. He stated that it was the responsibility of nursing and CNAs to ensure water was being passed daily. He stated that a risk would be dehydration and urinary tract infections. Record review of the Nursing Facility's Resident Hydration and Prevention of Dehydration policy dated 10/2017, read in part: This facility will strive to provide adequate hydration and to prevent and treat dehydration. Under Policy Interpretation and Implementation, it read in part: 6. Nurses' aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 3 (Residents #37, Resident #39 and #49) of 6 residents observed for oxygen management. The facility failed to ensure Oxygen (O2) in use signage was posted on the doorways of Resident #37, Resident #39 and Resident #49 to ensure smoking was prohibited. This failure could place residents at risk of This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health and at risk of fire hazards by not posting oxygen signs outside the residents' rooms. Resident #37Record review of Resident #37's admission Record dated 05/12/2026 revealed a [AGE] year-old male with admission date 04/22/2026. Record review of Resident #37's history and physical dated 05/12/2026 revealed a medical history of the following: Acute Respiratory Failure with Hypoxia (where the lungs fail to deliver sufficient oxygen to the blood, leading to low oxygen levels in tissues). Record review of Resident #37's Comprehensive MDS dated [DATE], revealed a BIMS of 05, indicating the resident had severe cognitive impairment. Under Section O-Special Treatments, indicated Resident #37 had Oxygen Therapy. Record review of Resident #37's Care Plan did not address Oxygen Therapy. Record review of Resident #37's Order Summary Report as of 05/14/2026, revealed a Physician Order for Oxygen Continuously via Nasal Cannula (a thin, flexible tube with two prongs that fit into the nostrils, delivering oxygen from a source such as an oxygen concentrator), may titrate 2 Liters- 5 Liters for Shortness of Breath or pulse oximetry less than 90 percent. An observation of Resident #37's room on 05/12/2026 at 1:43 p.m. revealed an oxygen concentrator at bedside. There was no oxygen signage posted outside the door. Resident # 39 Record review of Resident # 39's admission Record dated 05/13/2026 revealed a [AGE] year old female with an initial admission date of 06/06/2023 and a readmission date of 02/05/25. Record review of Resident #39's history and physical dated 02/04/26 revealed a diagnosis of chronic obstructive pulmonary disease (progressive, irreversible lung disease that restricts airflow and makes breathing difficult). Record review of Resident #39's Comprehensive MDS assessment dated [DATE] revealed a BIMS of 12 indicating moderate cognitive impairment. Section O- special treatments, indicated use of oxygen therapy.Record review of Resident # 39's Care plan revised on 04/01/26 revealed Resident #39 had chronic obstructive pulmonary disease with history of pneumonia. Interventions included to give nebulizer treatments and oxygen therapy as ordered. Record review of Resident # 39's Physician Orders with a start date of 04/10/2025 revealed an active order for oxygen at 2 liters per minute via nasal canula. An observation and interview with Resident #39's room on 05/12/2026 at 1:30 p.m., revealed a oxygen concentrator at bedside and a nebulizer machine on bedside table, resident was able to verbalize that she used oxygen throughout the day. There was no oxygen signage posted outside the door. Resident # 49Record review of Resident # 49's admission record dated 05/13/2026 revealed an initial admission date of 07/19/2019 and a readmission date of 06/12/2025.Record review of Resident # 49's diagnosis list dated 05/13/2026 revealed a diagnosis of chronic obstructive pulmonary disease (progressive, irreversible lung disease that restricts airflow and makes breathing difficult). Record review of Resident #49's Quarterly MDS assessment dated [DATE] revealed a BIMS of 00 indicating severe cognitive impairment. Section O-Special Treatments, indicated use of oxygen therapy. Record review of Resident #49's care plan revised on 02/17/2026 revealed Resident #49 had a cough related to chronic obstructive pulmonary disorder. Interventions included administering oxygen as ordered. Record review of Resident #49's Physician Orders with a start date of 04/11/25, revealed an active order for oxygen therapy at 2-4 liters per minute via nasal canula.An observation of Resident #49's room on 05/12/2026 at 1:40 p.m. revealed an oxygen concentrator at bedside. There was no oxygen signage posted outside the door. In an interview on 05/12/2026 at 2:41 PM with CNA A, she stated residents on oxygen should have aan<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Oxygen sign posted outside of their room. CNA A stated she believed the Administration or Nursing supervisors were responsible for ensuring Oxygen signs were posted outside of the rooms of residents with oxygen. CNA A stated the potential risk of not having Oxygen signs posted included staff not being aware of who was at risk in case of an emergency such as a fire. In an interview on 05/14/2026 at 10:00 AM with LVN C, she stated the DON was responsible for ensuring Oxygen signs were posted outside of the rooms with oxygen. LVN C stated the potential risk to residents was Oxygen being a fire hazard. In an interview on 05/14/2026 at 10:59 AM with RN D, she stated the oxygen signs were fixed on the walls and were not removable. RN D stated the oxygen signs had been fixed on the wall for years. She stated all staff were responsible for making sure residents with oxygen had a sign posted outside of their room. RN D stated the potential risks for residents not having oxygen signs posted outside of the rooms; it was potential fire hazard. In an interview on 05/14/2026 at 5:53 PM with the DON, she stated the nursing staff were responsible for the oxygen postings outside of resident rooms who were ordered oxygen. The DON stated that the purpose of the Oxygen postings was to inform others of oxygen being in the room. The DON stated that the Nursing Facility staff noticed the oxygen signs were not placed correctly and had them removed on 05/13/26. The DON stated that it was a potential fire hazard for not having oxygen signs posted on the rooms of the residents with oxygen. Record review of the Nursing Facility's Oxygen Storage policy, with no date, read in part: It is the policy of this center to maintain appropriate and safe storage of oxygen. Under Procedure- Exterior, 5. No smoking signage will be posted to prohibit smoking within fifty (50) feet of the storage area. Under Procedure- Interior, it read 1. Storage areas will be clearly identified with a no smoking sign posted on the door. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>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 for 1 of 4 medication carts (200-hall) viewed for pharmacy services.-The facility failed to maintain a locked medication cart in the 200-hallway on 5/12/26.This deficient practice could place residents at risk of harm or injury and contribute to avoidable accidents.Findings included:An observation on 05/12/2026 at 8:36 AM of an unlocked medication cart on the 200-hall There were no residents or staff observed in the hall.In an interview on 05/14/26 at 09:05 AM LVN C stated the Nurse or the Medication Aide administering medications at the time were responsible for making sure their Medication Cart was locked when left unattended. LVN C stated the potential risks of leaving medication carts unlocked include HIPAA or privacy violations. LVN C also stated other potential risk of leaving a medication cart unlocked included confused residents taking unknown medications and having different potential reactions.In an interview on 05/14/26 at 10:10 AM with RN D, she stated nursing staff were responsible for ensuring their assigned medication cart was locked. RN D stated all staff were also responsible for locking it if it was observed open. RN D stated the potential risk of unlocked medication carts included residents taking unknown medications, or staff taking residents' medications which would make the medications unavailable for the residents.In an interview on 05/14/26 at 5:39 PM with the DON, she stated that the medication aides and the nurses assigned to the medication carts were responsible for making sure they were locked when not in use. The DON stated that the ADON and herself as the DON were responsible for monitoring the medication carts which were done daily. The DON stated the potential risks of the Nursing Facility having medication carts unlocked included residents potentially consuming medications that were not theirs which was a medication error.In an interview on 05/14/26 at 6:04PM with the Administrator, He stated that medication carts were to be locked anytime the nurse would be stepping away from it. He stated that this was done to prevent anyone that was not authorized from handling medication from being able to easily access it. He stated that this was a potential risk for residents as well because they could possibly get into the medication cart and accidentally ingest medications or get a hold of sharps. He stated that it was the responsibility of the nurse using the cart to ensure it was locked. Record review of the Nursing Facility's Security of Medication Cart, revised 04/2007, read in part: Policy statement- The medication cart shall be secured during medication passes. It continued to read, Policy Interpretation and Implementation- 1. The nurse must secure the medication can during the medication pass to prevent unauthorized entry. Also, it read, 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen.-The facility failed to label food items in the refrigerator and in the freezer on 5/12/2026 -The facility failed to keep containers of food in the refrigerator free of dried drippings on 5/12/2026-The facility failed to keep lids of containers free of dust in the dried food storage area on 05/12/2026-The facility failed to ensure kitchen staff used hair nets properly on 05/13/26 and 05/14/26-The facility failed to keep overflowing garbage in a container away from clean dishes on 05/12/2026 These failures could place residents at risk of food-borne illnesses from cross-contaminated food and beverages. Findings included: In an observation on 5/12/2026 at 8:32 AM a container of soy sauce located in the refrigerator had an unknown yellow jelly substance smeared on the container. In an observation on 5/12/2026 at 8:33AM a container of ranch dressing and a container of salad dressing located in the refrigerator were observed to have dried drippings around the lid of the containers.In an observation on 5/12/2026 at 8:34AM a tray of prepared fruit desserts, a tray of glasses full of tea and a tray with glasses of milk located in the refrigerator were observed to not be dated or labeled. In an observation on 5/12/2026 at 8:38AM the lid of a storage container in the dry storage room was observed to have dust on the lid. In an observation on 5/12/2026 at 8:46AM a container of vanilla ice cream located in the freezer was observed to have dried drippings on the side of the container. In an observation on 5/12/2026 at 8:47AM a package of pork loin meat and 4 packages of red meat and a bag of chopped broccoli was observed in the freezer to not be labeled or dated. In an observation on 05/12/2026 at 8:49AM a box of potatoes was observed in the dry food storage area, there was a potato that was sprouting roots mixed in the same box with other potatoes. In an observation on 5/12/26 at 8:49 red peppers located in the drawers of the refrigerator were observed to not be labeled or dated and were not in original packaging. In an observation on 5/12/26 at 8:53 AM the drink dispenser was observed to have dried residue on the handle and the nozzle.In an observation on 05/12/26 at 8:54 AM revealed an overflowing garbage container that was in the dish washing area next to a cart of clean dishes.In an observation on 5/13/2026 at 10:50AM and 5/14/2026 at 9:57AM [NAME] E was observed to be in the kitchen with her hair net not fully covering her hair. In an interview on 5/14/26 at 1:36PM with [NAME] E, she stated that all food needed to be dated and labeled with the expiration date, usually 3 days after opening. She stated that this was done to ensure that they were not using expired ingredients. The foods like the desserts that were prepared forth day should be labeled and dated as well for staff to know when they were made, she stated that if this was not done it could make the resident sick. She stated that all containers were to be wiped down after use to prevent cross contamination. She stated the hair nets needed to be holding back all of the hair to prevent any from falling into the food and contaminating the food. She stated that the dietary manager was responsible for ensuring that the food was labeled and dated she stated that the dietary manager was also responsible of discarding any foods that were not good to be used and to clean the containers in the dry food storage. In an interview on 5/14/26 at 1:56 PM with the Dietary Manager, she stated that all the kitchen staff was responsible for ensuring that all food was dated and labeled. It was also everyone's responsibility to ensure cleanliness of the kitchen to include the drink dispenser and the dry food storage. She stated that all staff in the kitchen needed to wear hairnets to prevent hair falling into the food and being contaminated and hair needed to be secured under the hair net. She stated that it was her responsibility to ensure that all of this was being completed by the kitchen staff. she stated that it was unacceptable for the trash to be overflowing in any area of the kitchen but especially where clean dishes were being placed. She stated that all the kitchen staff were responsible for ensuring that the trash was disposed of properly meaning the trash was placed in the trash can and not overflowing. She stated that if the can was getting full, staff was supposed to<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | throw that bag away and replace it with a new bag. She stated that the trash overflowing in an area where clean dishes were was a risk of contaminating the clean dishes that residents use. She stated that she verbally reminded the staff to ensure that the trash was thrown away before the can became full, but she could not be consistently telling them all the time. she stated that it was something that the staff should know to do. In an interview on 05/14/26 at 6:03 PM with the Administrator, he stated that the staff was supposed to date and labeled all food items upon receiving them to ensure that it was used by the appropriate date to prevent residents getting sick. He stated that all staff needed to be wearing hair nets to restrain their hair to prevent it from falling into the food and contaminating the food. He stated that the overall cleanliness of the kitchen was the responsibility of all the staff and should be over seen by the dietary manager. He stated that trash should be disposed of in a timely manner before it overfills the trash can. He stated that it was the responsibility of the Dietary Manager to ensure that the trash is properly disposed of. He stated that a risk would be cross contamination of clean dishes and residents were at risk of becoming sick if they used those dishes. Review of the facility policy titled Food Receiving and Storage revised on 11/2022 read in part . food services or other designated staff, maintain clean and temperature/ humidity- appropriate food storage area at all times Dry foods that are stored in bins are removed from original packaging, labeled and dated ( use by date) . Review of facility policy titled Waste Disposal dated 2023 read in part containers will be emptied as often as necessary throughout the day and at the end of each day .TFER S228.43 states that food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. It does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on interview and record review the facility failed to develop a QAPI (Quality Assurance and Performance Improvement) plan that described the process for conducting quality assessment and assurance activities, including the process on how the committee would identify and correct quality deficiencies. The facility failed to have documentation and evidence of its QAPI plan being ongoing and comprehensive.This failure could affect all residents and result in quality deficiencies not being recognized and corrected.Findings included: Record review of the Nursing Facility's QAPI plan, the Nursing Facility's meeting template documents for 02/2026, 03/2026, and 04/2026, revealed the areas documented: Goal, Interventions, and Progress, were blank. The PIP (Performance Improvement Plan) for the mentioned 3 months had the same handwritten notes that read, past LSC (Life Safety Code) and Annual Surveys from 03/25/25-03/28/25, all deficiencies were identified with no current issues. The PIP also included ANE in-services were completed for the months mentioned.In an interview and observation on 05/14/2026 at 11:30 AM with the DON, she stated that the facility was unable to provide the requested in-services that were noted on the PIP. The DON reviewed handwritten notes from QAPI. The DON stated those were the Administrator's notes, and he copied and pasted from one month to the next. The DON stated that it could be considered false documentation which could affect the residents because the QAPI notes do not reflect current monthly training or progress on issues. She stated there was no trending and tracking identified in the plan. In an interview on 05/14/2026 at 11:31 AM with the Regional Corporate Nurse, she stated she had just started her role in 03/2026, and there were no action plans until 04/2026. In an interview on 05/14/2026 at 6:20 PM with the Administrator, he stated he was responsible for QAPI. He stated the department supervisors, self as the Administrator, the DON, and the Medical director, participated in QAPI meetings on a monthly basis. The Administrator stated any identified concerns or trends regarding residents and the Nursing Facility was discussed and identified. Record review of the Nursing Facility's Quality Assurance and Performance Improvement (QAPI) Program with revision date 02/2020, read in part: Policy Statement- This Facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Under Policy Interpretation and Implementation, it read in part: The objective of the QAPI program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Under Implementation, it read in part: 1. The QAPI committee oversees implementation of our QAPI plan, which is written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee. 2. The Qapi plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performances measurement; c. identifying and prioritizing quality deficiencies; d. systematically analyzing underlying causes of systematic quality deficiencies; e. developing and implementing corrective action or performance improvement activities; and, f. monitoring or evaluating the effectiveness of corrective action or performance improvements activities and revising as needed. Under Coordination, the policy read: 1. The QAPI coordinator manages QAPI committee activities and changes to the QAPI plan. 2. The QAPI coordinator assists other committees, individuals, departments, and/or services in developing quality indicators, monitoring tools, assessment methodologies and documentation, and in making adjustments to the plan. 3. The QAPI coordinator serves as a liaison between the QAPI committee and indiciduals, services, and/or departments regarding QAPI activities. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on interview and record review, the facility failed to implement the facility's Quality Assessment and Performance Improvement (QAPI) plan and program, in which data was to be gathered and analyzed, and plans of action were to be developed, implemented, and evaluated to address adverse events related to potential deficient practice for 1 of 1 QAPI programs reviewed.The facility failed to conduct at least one performance improvement project (PIP) annually that focused on high risk or problem prone areas identified by the facility, through data collection and analysis.This failure could place residents of the facility at risk of the facility not developing, monitoring and implementing corrective actions for identified areas of improvement.Findings included: Record review of the Nursing Facility's QAPI plan, the Nursing Facility's meeting template documents for 02/2026, 03/2026, and 04/2026, revealed the areas documented: Goal, Interventions, and Progress, were blank. The PIP (Performance Improvement Plan) for the mentioned 3 months had the same handwritten notes that read, past LSC (Life Safety Code) and Annual Surveys from 03/25/25-03/28/25, all deficiencies were identified with no current issues. The PIP also included ANE in-services were completed for the months mentioned.In an interview and observation on 05/14/2026 at 11:30 AM with the DON, she stated that the facility was unable to provide the requested in-services that were noted on the PIP. The DON reviewed handwritten notes from QAPI. The DON stated those were the Administrator's notes, and he copied and pasted from one month to the next. The DON stated that it could be considered false documentation which could affect the residents because the QAPI notes do not reflect current monthly training or progress on issues. She stated there was no trending and tracking identified in the plan. In an interview on 05/14/2026 at 11:31 AM with the Regional Corporate Nurse, she stated she had just started her role in 03/2026, and there were no action plans until 04/2026. In an interview on 05/14/2026 at 6:20 PM with the Administrator, he stated he was responsible for QAPI. He stated the department supervisors, self as the Administrator, the DON, and the Medical director, participated in QAPI meetings on a monthly basis. The Administrator stated any identified concerns or trends regarding residents and the Nursing Facility was discussed and identified. Record review of the Nursing Facility's Quality Assurance and Performance Improvement (QAPI) Program with revision date 02/2020, read in part: Policy Statement- This Facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Under Policy Interpretation and Implementation, it read in part: The objective of the QAPI program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Under Implementation, it read in part: 1. The QAPI committee oversees implementation of our QAPI plan, which is written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee. 2. The Qapi plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performances measurement; c. identifying and prioritizing quality deficiencies; d. systematically analyzing underlying causes of systematic quality deficiencies; e. developing and implementing corrective action or performance improvement activities; and, f. monitoring or evaluating the effectiveness of corrective action or performance improvements activities and revising as needed. Under Coordination, the policy read: 1. The QAPI coordinator manages QAPI committee activities and changes to the QAPI plan. 2. The QAPI coordinator assists other committees, individuals, departments, and/or services in developing quality indicators, monitoring tools, assessment methodologies and documentation, and in making adjustments to the plan. 3. The QAPI coordinator serves as a liaison between the QAPI committee and individuals, services, and/or departments regarding QAPI activities. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report an injury of unknown source, immediately, but not later than 2 hours after the allegation was made, to other officials in accordance with State law, including to the State Survey Agency for 2 of 5 residents reviewed for falls. (Residents #7, #44)The facility investigated but failed to report to the State Survey Agency when Resident #7 had an unwitnessed fall on 05/02/2026 that resulted in a laceration on the left side of the resident's forehead, and left wrist.The facility failed to report to the State Survey Agency when Resident #44 sustained an unwitnessed bruise to right eye and a laceration to forehead and was unable to state how the injury occurred on 05/09/2026.The facility failed to report when a pipe burst, and the sprinkler system malfunctioned on 01/27/2026. These failures could place residents who require assistance with mobility at risk for non-reported serious bodily injury.<br><br>Resident #44<br><br>Record review of Resident # 44's admission record dated 05/13/2026 revealed a [AGE] year-old female with an initial admission date of 09/02/2008 and a readmission of 12/09/2024.<br><br>Record review of Resident #44's diagnosis list dated 05/13/2026 revealed a diagnosis of dementia without behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed).<br><br>Record review of Resident #44's Quarterly MDS dated [DATE] revealed no BIMS score. Section GG-Functional Abilities revealed Resident #44 needed substantial/ maximal assistance meaning helper did more than half the effort. Helper lifts or holds or supports trunk or limbs, but provides more than half the effort for rolling left and right, sit to lying position and sit to standing position.<br><br>Record review of Resident #44's Care plan revised 04/12/26 revealed a communication problem related to Alzheimer's dementia and depression. Interventions included to anticipate and meet needs. Resident #44 had the potential for injury related to history of falls and was at riskfor further falls related to cognitive impairment due to short term memory deficit and impaired safety awareness. Interventions included Ensure staff was aware of safety needs of the resident.<br><br>Record review of incident progress note dated 05/09/26 stated that the CNA entered the room to provide incontinent care and noticed that the resident had brusing to right eye and a small skin tear above the right eyebrow and on the side of the right eye. It also stated that resident had hit head on bedside dresser.<br><br>Record review of Incident Report dated 5/9/2026 stated a skin tear above right eyebrow and side of right eye was cleansed with normal saline and it was reported to the DON and Physician.<br><br>Record review of 15 minute Neurological Evaluations dated 05/09/2026 and 05/10/2026 revealed Resident #44 did not have any neurological changes.<br><br>Record review of 30 minute Neurological Evaluations dated 05/10/2026 revealed Resident #44 did not have any neurological changes<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of 1 hour Neurological Evaluation dated 05/10/2026 revealed Resident #44 did not have any neurological changes<br><br>Record review of 4 hour Neurological Evaluation dated 05/10/2026 and 05/11/2026 revealed Resident #44 did not have any neurological changes.<br><br>Record review of 8 hour Neurological Evaluation dated 05/11/2026, and 05/12/2026 revealed Resident #44 did not have any neurological changes<br><br>An observation on 5/12/2026 at 12:15 p.m., of Resident #44 in the dining room revealed she had bruising around the right eye and a small laceration above the right eyebrow. She was not able to verbalize to surveyor what had happened or how she had obtained these injuries.<br><br>Findings include:<br><br>Record review of Resident #7's face sheet revealed resident was [AGE] year-old male with initial admission date of 11/21/24 and re-admission date of 10/10/25.<br><br>Record review of Resident #7's Quarterly MDS dated [DATE], revealed a BIMS score of 0, indicating Resident #7 was severely cognitively impaired.<br><br>Record review of Resident #7's Health and Physical dated 09/18/25, revealed a medical history of: Alzheimer's disease with behavioral disturbance (a form of dementia, a progressive brain disorder that primarily affects memory, thinking, and behavior); and, Generalized muscle weakness.<br><br>Record review of Resident #7's Care Plan revision date 05/13/26 revealed Resident #7 was at risk for falls due to his Alzheimer's disease and generalized muscle weakness, which included staff interventions of fall mat on the floor, call light within reach, and bed in lowest position.<br><br>Record review of Resident #7's Incident Report (IR) dated 05/02/26, completed by LVN C, noted she was alerted by Nurse Aide that Resident #7 was found on the floor in the middle of his room facing his bed (Bed A, closest to the resident's room door). He was found with a 1 cm approximation facial laceration to his left side of forehead and a small laceration on his left wrist with bleeding observed from both sites. LVN C completed a physical assessment and treated Resident #7's bleeding per IR. LVN C notified Responsible Part of Resident #7, ADON, DON, Administrator, and Resident #7's physician. Resident #7 was ordered to be further evaluated and treated at the Hospital for post-fall.<br><br>Record review of Resident #7's Progress notes revealed Resident #7 returned to Nursing Facility 05/02/26. Hospital documentation dated 05/02/26 revealed Resident #7 was negative for acute findings for CT scan of Head and Left Arm. There were no new orders noted related to Resident #7's fall.<br><br>An observation was made on 05/12/26 at 9:10 AM of Resident #7 who was lying in bed covering his face, upper body, and most of his lower body. A fall mat was observed placed on the floor next to his bed, resident had call light within reach. Resident #7 did not answer this Surveyor during an interview attempt. Resident #7 did not have a roommate during incident or during HHSC State Survey 05/12/2026.<br><br>In an interview on 05/14/26 at 10:15 AM with LVN C, she stated she was notified by a Nurse Aide<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that she heard a noise and went to Resident #7's room and found Resident #7 in the middle of his room floor. LVN C stated the Nurse Aide notified her immediately while still staying with him and not moving the resident. LVN C stated Resident #7 was assessed and there was a small amount, drops of blood, on Resident #7's left side of his forehead, and left wrist. LVN C stated the ADON, DON, Administrator, Physician, and Resident #7's Responsible Party were notified after the fall. She stated Resident #7 was sent to the E.R. via ambulance and came back that day with no acute findings or acute physical injuries. LVN C stated Resident #7 does not communicate or able to explain what caused the fall. She stated Resident #7 was a fall risk and was rounded every 2 hours or as needed.<br><br>In an interview on 05/14/2026 at 12:40 PM with LVN G she stated that on the night of 05/09/26 she was called by one of the CNAs to Resident #44's room. The CNA stated to her that she had hit her head on the night stand that was on the right side of her bed because she was restless and moving a lot. She stated that this was told to her by the CNA, however this incident was unwitnessed and the CNA believed this had happened since the injuries were on the right-side of the residents face. She stated that neurological checks were initiated, the physician, DON, and administrator were contacted. Resident was to be monitored and no other orders given. She stated that resident was not capable of stating what had happened due to her cognition.<br><br>In an interview on 05/14/2026 at 4:38 PM with the DON she stated that LVN G reported to her that Resident #44 had hit her head on the side table to the right of the residents bed. She stated that the incident was unwitnessed but it was the only thing that could have caused it because it was the closest object to the resident that could have caused injury because resident's head was positioned towards bedside table. She stated that the resident did not have a fall. She stated that she investigated the situation by asking the staff present that night what had happened and based on their knowledge of the resident she stated that she knows that the resident moves in bed a lot and tries to get out of bed. This was the reason why she did not believe at the time that it had to be reported to State Survey Agency. She stated that based on the Abuse and Neglect policy, this incident would have had to have been reported to the State Survey agency due to the incident being unwitnessed and the Resident not being capable of voicing what had happened due to her cognition. She stated that a risk for the residents would be a safety issue. The DON stated Resident #7 was unable to explain what happened and answers with guidance, such as answering yes or no questions, but he will not always answer. The DON stated a CNA found Resident #7 on the floor in his room and notified the floor nurse. The DON stated Resident #7 was assessed and sent to the hospital for further evaluation or treatment. There were no acute physical injuries reported including fractures. The DON stated Resident #7 was found by himself in the room and he was unable to explain what happened. The DON stated for unwitnessed falls, it was to be reported to their Administration including herself, and to HHSC.<br><br>In an interview on 05/14/2026 at 6:03 PM with the Administrator he stated that this incident was not reported to him, he did not know that Resident #44 had an incident. He stated that when an unwitnessed incident happens, the staff was to report to DON and to himself, as he was the Nursing Facility's Abuse Coordinator, so that they can initiate an investigation. He stated that he would have needed to report this incident to the State Survey Agency because it was unwitnessed, and the resident could not verbalize what had happened. He stated that lack of investigation and reporting could potentially put the resident at risk further for potential abuse if there was a perpetrator. The Administrator stated he was notified of Resident #7's fall incident by the nurse on shift via phone. He stated he recalled Resident #7 did not have fractures or acute injuries. The Administrator stated Resident #7 could not explain what happened to him when found in the floor, and Resident #7 did not have a roommate. The Administrator stated Resident #7 needs redirection during conversations. The (continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administrator stated it was an unwitnessed fall so it warranted for an investigation. The administrator stated if Resident #7's fall resulted in injury, it would be reported to HHSC but was unsure if unwitnessed falls were to be reported to HHSC.<br><br>Sprinkler system<br><br>In an interview on 05/13/26 at 1:50 PM with the Administrator, he stated the sprinklers froze and burst over a weekend in January 2026. He stated he called in to report it to HHSC and followed the Nursing Facility protocol. The Administrator stated he left a message regarding the incident and when that happened, he typically received a call back the following Monday if a message was left but he did not receive a callback. The Administrator stated he did not follow up with the incident report with HHSC and he could not recall on why not.<br><br>In an interview on 05/14/2026 at 3:24PM with the maintenance director, he stated that in January the sprinkler pipes froze due to weather and they burst. He stated that the alarms went off and the fire department came. He stated that the issue was fixed the next day and fire watches were initiated. He stated that he was not sure if the administrator reported this incident to the State Survey Agency, but he stated that it would have been something to report as malfunctioning of sprinklers could be a potential hazard to resident safety.<br><br>In a follow up interview on 05/14/2026 at 6:05PM with the Administrator, he stated that regarding the sprinkler system, this incident happened back in January during freezing temperatures. He stated that one of the pipes burst and water was leaking out affecting the sprinkler system in the facility. The fire department was called to help with the situation, and the alarm company also sent someone out to shut off the alarm. He stated that he did report the incident via phone call, to the State Survey Agency but he did not follow up with it when he did not receive a phone call back because he was busy doing fire watches. He stated it took a total of 3 days to fix the issue. He stated that none of the residents were affected and that they did not need to evacuate the building.<br><br>In a phone interview on 05/14/2026 at 3:51 PM with the Director of Regional Compliance, she stated she was notified of the Sprinkler system incident by the Administrator or a staff from the Regional team the day it happened. The Director of Regional Compliance stated it was repaired that day 01/27/2026, and no residents were evacuated. She stated there was no potential risk since the fire watch was initiated when the incident occurred that day.<br><br>Record review of Nursing Facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating Policy, dated 09/2022, read in part: All reports of resident abuse (including injuries of unknown origin),neglect . are reported to local, state and federal agencies (as required by current regulations)and thoroughly investigated by facility management. Findings of all investigations are documented and reported. It continue to read, Reporting Allegations to the Administrator and Authorities- 1. If resident abuse, neglect . or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 2. The administrator or the individual making the alllegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. |

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| | 675881 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Pecos | 1819 Memorial Drive<br>Pecos, TX 79772 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to show evidence that all alleged violations were thoroughly investigated and failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for 2 of 5 residents (Resident #7 and #44) reviewed for injuries of unknown origin.The facility investigated but failed to report to the State Survey Agency when Resident #7 had an unwitnessed fall on 05/02/2026 that resulted in a laceration on the left side of the resident's forehead, and left wrist. The facility failed to investigate an injury of unknown origin for Resident #44 resulting in bruising around the right eye and a laceration above the right eyebrow on 05/09/2026. These failures could place residents in the facility with dementia at risk of not receiving timely investigations and reporting of injuries of unknown origin.<br><br>Resident #44<br><br>Record review of Resident # 44's admission record dated 05/13/2026 revealed a [AGE] year-old female with an initial admission date of 09/02/2008 and a readmission of 12/09/2024.<br><br>Record review of Resident #44's diagnosis list dated 05/13/2026 revealed a diagnosis of dementia without behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed).<br><br>Record review of Resident #44's Quarterly MDS dated [DATE] revealed no BIMS score. Section GG-Functional Abilities revealed Resident #44 needed substantial/ maximal assistance meaning helper did more than half the effort. Helper lifts or holds or supports trunk or limbs, but provides more than half the effort for rolling left and right, sit to lying position and sit to standing position.<br><br>Record review of Resident #44's Care plan revised 04/12/26 revealed a communication problem related to Alzheimer's dementia and depression. Interventions included to anticipate and meet needs. Resident #44 had the potential for injury related to history of falls and was at risk<br><br>for further falls related to cognitive impairment due to short term memory deficit and impaired safety awareness. Interventions included Ensure staff was aware of safety needs of the resident<br><br>Record review of incident progress note dated 05/09/26 stated that the CNA entered the room to provide incontinent care and noticed that the resident had brusing to right eye and a small skin tear above the right eyebrow and on the side of the right eye. It also stated that resident had hit head on bedside dresser.<br><br>Record review of Incident Report dated 5/9/2026 stated a skin tear above right eyebrow and side of right eye was cleansed with normal saline and it was reported to the DON and Physician.<br><br>Record review of 15 minute Neurological Evaluations dated 05/09/2026 and 05/10/2026 revealed Resident #44 did not have any neurological changes.<br><br>Record review of 30 minute Neurological Evaluations dated 05/10/2026 revealed Resident #44 did not have any neurological changes<br>(continued on next page) |

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| Avir at Pecos | 1819 Memorial Drive<br>Pecos, TX 79772 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of 1 hour Neurological Evaluation dated 05/10/2026 revealed Resident #44 did not have any neurological changes<br><br>Record review of 4 hour Neurological Evaluation dated 05/10/2026 and 05/11/2026 revealed Resident #44 did not have any neurological changes.<br><br>Record review of 8 hour Neurological Evaluation dated 05/11/2026, and 05/12/2026 revealed Resident #44 did not have any neurological changes<br><br>An observation on 5/12/2026 at 12:15 p.m., of Resident #44 in the dining room revealed she had bruising around the right eye and a small laceration above the right eyebrow. She was not able to verbalize to surveyor what had happened or how she had obtained these injuries<br><br>Findings include:<br><br>Record review of Resident #7's face sheet revealed resident was [AGE] year-old male with initial admission date of 11/21/24 and re-admission date of 10/10/25.<br><br>Record review of Resident #7's Quarterly MDS dated [DATE], revealed a BIMS score of 0, indicating Resident #7 was severely cognitively impaired.<br><br>Record review of Resident #7's Health and Physical dated 09/18/25, revealed a medical history of: Alzheimer's disease with behavioral disturbance (a form of dementia, a progressive brain disorder that primarily affects memory, thinking, and behavior); and, Generalized muscle weakness.<br><br>Record review of Resident #7's Care Plan revision date 05/13/26 revealed Resident #7 was at risk for falls due to his Alzheimer's disease and generalized muscle weakness, which included staff interventions of fall mat on the floor, call light within reach, and bed in lowest position.<br><br>Record review of Resident #7's Incident Report (IR) dated 05/02/26, completed by LVN C, noted she was alerted by Nurse Aide that Resident #7 was found on the floor in the middle of his room facing his bed (Bed A, closest to the resident's room door). He was found with a 1 cm approximation facial laceration to his left side of forehead and a small laceration on his left wrist with bleeding observed from both sites. LVN C completed a physical assessment and treated Resident #7's bleeding per IR. LVN C notified Responsible Part of Resident #7, ADON, DON, Administrator, and Resident #7's physician. Resident #7 was ordered to be further evaluated and treated at the Hospital for post-fall.<br><br>Record review of Resident #7's Progress notes revealed Resident #7 returned to Nursing Facility 05/02/26. Hospital documentation dated 05/02/26 revealed Resident #7 was negative for acute findings for CT scan of Head and Left Arm. There were no new orders noted related to Resident #7's fall.<br><br>An observation was made on 05/12/26 at 9:10 AM of Resident #7 who was lying in bed covering his face, upper body, and most of his lower body. A fall mat was observed placed on the floor next to his bed, resident had call light within reach. Resident #7 did not answer this Surveyor during an interview attempt. Resident #7 did not have a roommate during incident or during HHSC State Survey 05/12/2026.<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 05/14/26 at 10:15 AM with LVN C, she stated she was notified by a Nurse Aide that she heard a noise and went to Resident #7's room when Resident #7 was found in the middle of his room's floor. LVN C stated the Nurse Aide notified her immediately while still staying with him and not moving the resident. LVN C stated Resident #7 was assessed and there was a small amount, drops of blood, on Resident #7's left side of his forehead, and left wrist. LVN C stated the ADON, DON, Administrator, Physician, and Resident #7's Responsible Party were notified after the fall. She stated Resident #7 was sent to the E.R. via ambulance and came back that day with no acute findings or acute physical injuries. LVN C stated Resident #7 does not communicate or able to explain what caused the fall. She stated Resident #7 was a fall risk and was rounded every 2 hours or as needed.<br><br>In an interview on 05/14/2026 at 12:40 PM with LVN G she stated that on the night of 05/09/26 she was called by one of the CNAs to Resident #44's room, the CNA stated to her that she had hit her head on the night stand that was on the right side of her bed because she was restless and moving a lot. She stated that this was told to her by the CNA, however this incident was unwitnessed and the CNA believed this had happened since the injuries were on the right-side of the residents face. She stated that neurological checks were initiated, the physician, DON, and administrator were contacted. Resident was to be monitored and no other orders given. She stated that resident was not capable of stating what had happened due to her cognition.<br><br>In an interview on 05/14/2026 at 4:38 PM with the DON she stated that LVN G reported to her that the resident #44 had hit her head on the side table to the right of the residents bed. She stated that the incident was unwitnessed but it was the only thing that could have caused it because it was the closest object to the resident that could have caused injury because residents head was positioned towards bedside table She stated that the resident did not have a fall. She stated that she investigated the situation by asking the staff present that night what had happened and based on their knowledge of the resident she stated that she knows that the resident moves in bed a lot and tries to get out of bed. This was the reason why she did not believe at the time that it had to be reported to State Survey Agency. She stated that based on the Abuse and Neglect policy, this incident would have had to have been reported to the State Survey agency due to the incident being unwitnessed and the Resident not being capable of voicing what had happened due to her cognition. She stated that a risk for the residents would be a safety issue. The DON stated Resident #7 was unable to explain what happened and answers with guidance, such as answering yes or no questions, but he will not always answer. The DON stated a CNA found Resident #7 on the floor in his room and notified the floor nurse. The DON stated Resident #7 was assessed and sent to the hospital for further evaluation or treatment. There were no acute physical injuries reported including fractures. The DON stated Resident #7 was found by himself in the room and he was unable to explain what happened. The DON stated for unwitnessed falls, it was to be reported to their Administration including herself, and to HHSC. She stated Administration was responsible for investigating allegations of abuse, neglect, and injuries of unknown origin.<br><br>In an interview on 05/14/2026 at 6:03 PM with Administrator he stated that this incident was not reported to him, he did not know that the Resident #44 had an incident. He stated that when an unwitnessed incident happens, the staff was to report to DON and to himself, as he was the Nursing Facility's Abuse Coordinator, so that they can initiate an investigation. He stated that he would have needed to report this incident to the State Survey Agency because it was unwitnessed, and the resident could not verbalize what had happened. He stated that lack of investigation and reporting could potentially put the resident at risk further for potential abuse if there was a perpetrator. The Administrator stated he was notified of Resident #7's fall incident by the nurse on shift via phone. He stated he recalled Resident #7 did not have fractures or acute injuries. The Administrator stated<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #7 could not explain what happened to the him when found in the floor, and Resident #7 did not have a roommate. The Administrator stated Resident #7 needs redirection during conversations. The Administrator stated it was an unwitnessed fall so it warranted for an investigation. The administrator stated if Resident #7's fall resulted in injury, it would be reported to HHSC but was unsure if unwitnessed falls were to be reported to HHSC.<br><br>Record review of Nursing Facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating Policy, dated 09/2022, read in part: All reports of resident abuse (including injuries of unknown origin),neglect . are reported to local, state and federal agencies (as required by current regulations)and thoroughly investigated by facility management. Findings of all investigations are documented and reported. It also read under Investigating Allegations, 7. All allegations are thoroughly investigated. The Administrator initiates the investigations. 8. Investigations may be assigned to an individal trained in reviewing, investigating and reporting such allegations. 9. The administrator provides supporting documents and evidence related to the alleged incident to the individual incharge of the investigation. Under Follow-Up Report, it read,1. Within five business days of the incident, the administrator will provide a follow-up investigation report. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 7 (Resident #4) residents reviewed for base line care plans.The facility failed to develop Resident #4's baseline care plan within 48 hours of admission.This failure placed newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission.Finding included:Record review of Resident #4's face sheet dated 05/13/2026, revealed the resident was a [AGE] year-old male with an admission date 04/24/2026.Record review of Resident #4's Physician progress note dated 05/04/2026 revealed a past medical history of the following: Wound to the right fingers, Peripheral Vascular Disease (condition characterized by narrowed arteries that reduce blood flow to the limbs, primarily the legs, leading to symptoms like leg pain and cramping), and GERD (a condition causing stomach acid flows back up into the esophagus and causes heartburn).Record review of Resident #4's Comprehensive MDS dated [DATE], revealed Resident #4 had a BIMS of 15, indicating the resident was cognitively intact. Under Section GG- Functional Abilities - Admission, it was noted Resident #4 required the following assistance for ADLs: Setup or cleanup assistance with eating; Partial/moderate assistance with oral hygiene; and Resident #4 was completely dependent, meaning the helper does all the work to complete the task, for personal hygiene, toilet hygiene, showering/bathing, upper and lower body dressing.Record review of Resident #4's care plan with revision date 05/12/2026, with 3 areas of focus which read: (1) resident will do in room and lobby activities, 3 times a week. (2) resident will do in room and lobby activities 3x week. Lastly, (3) the resident has actual impairment to skin integrity of the left lower extremity related to surgical wound (date initiated 05/12/2026, date of Survey Entrance). The care plan did not address resident's medical conditions or ADLs.In an observation and interview on 05/12/2026 at 11:45 AM with Resident #4, his nails of both hands were observed jagged and a quarter inch long from the nail bed. Resident #4 stated he would like his nails trimmed since it was becoming long and uncomfortable. Resident #4 stated he had not been had been offered to have his nails trimmed since being in the facility. Resident #4 stated he had not been offered a nail trim or cut since being in the Nursing Facility.In an interview on 05/14/2026 at 09:06 AM with LVN C, she stated MDS nursing or an RN was responsible for the initial care plan which was completed within 48 hours of admission. She stated nursing was responsible for monitoring care plans. She stated the potential risk to residents not having their baseline care plan included not addressing a resident's ADL needs. She stated this could cause a resident to not have the assistance they need. LVN C stated this could also affect the resident's self-esteem or mobility.In an interview on 05/14/2026 at 10:07 AM with RN D, she stated the floor RN would be responsible for the initial care plan. RN D stated if the RN was unavailable, the ADON also assisted and was responsible for the residents' initial care plan and monitoring it, though she was unsure how often it was monitored. RN D stated the potential risks for a resident not having an initial care plan included not addressing a resident's plan of care and the assistance required for ADLs which is a safety concern.In a phone interview on 05/14/2026 at 2:56 PM with the MDS Regional Nurse, she stated the initial care plan would be completed by the DON. She stated that the floor nursing staff would update as needed. She stated a resident's ADLs were to be included in a care plan. The MDS Regional Nurse stated the potential risk for residents not having their ADLs included in the care plan was a risk for staff improperly transferring to a resident.Record review of the Nursing Facility's Care Planning Policy, with revision date 12/2024, read in part: The Interdisciplinary team is responsible for the development of resident care plans. It continued, 1. Resident care plans are (continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | developed according to the timeframes and criteria established by [state regulation] S483.21Record review of State Regulation S483.21(a), read in part: Basline Care Plans (a)(1) The facility must develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) be developed in 48 hours of a Resident's admission. (ii) include the minimum healthcare information necessary to properly care for a resident including but not limited to- (A) initial goals based on admission orders. (B) Physician orders. (C) Dietary Orders. (D) Therapy Services. (E) Social Services. (F) PASARR recommendation, if applicable. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who was unable to carry out activities of daily living, received the necessary services to maintain good grooming, and personal hygiene, for 1 Resident of 7 residents (Resident #4) reviewed for activities of daily living.The facility failed to provide Resident #4 with nail care on 05/12/2026.This failure could place residents at risk for embarrassment, injury, and infections.The findings included:Record review of Resident #4's face sheet dated 05/13/2026, revealed the resident was a [AGE] year-old male with an admission date 04/24/2026.Record review of Resident #4's Physician progress note dated 05/04/2026 revealed a past medical history of the following: Peripheral Vascular Disease (a condition that develops when the arteries that supply oxygen-rich blood to the internal organs, arms, and legs become completely or partially blocked).Record review of Resident #4's Comprehensive MDS dated [DATE], revealed Resident #4 had a BIMS of 15, indicating the resident was cognitively intact. Under Section GG-Functional Abilities - Admission, it was noted Resident #4 was completely Dependent, meaning the helper does all the work to complete the task, for personal hygiene.Record review of Resident #4's care plan with revision date 05/12/2026 did not include ADLs.In an observation and interview on 05/12/2026 at 11:45 AM with Resident #4, his nails of both hands were observed jagged and a quarter inch long from the nail bed. Resident #4 stated he would like his nails trimmed since it was becoming long and uncomfortable. Resident #4 stated he had not been had been offered to have his nails trimmed since being in the facility. Resident #4 stated he had not been offered a nail trim or cut since being in the Nursing Facility.In an interview on 05/12/2026 at 3:41 PM with CNA A, she stated the nurses provided nail cutting or trims to residents. CNA A stated the nursing aides were to notify the Nurses if a resident was observed with long nails during shower days, which was twice a week or as needed, or if the resident requested a nail trim. CNA A stated the potential risk for residents having long nails or dirty nails included residents scratching themselves causing injury and possible bacteria under the nails, making it an infection control issue.In an interview on 05/14/2026 at 9:36 AM with LVN C, she stated resident fingernails were monitored by the nurses' aides during the residents' shower days. LVN C stated the residents shower 2-3 times a week or as needed. LVN C stated nurses were responsible for trimming diabetic resident nails. LVN C stated residents having long or dirty fingernails was an infection control issue as the residents use their hands to eat or touch their face.In an interview on 05/14/2026 at 11:05 AM with RN D, she stated she did not believe the nursing aides provided nail care. RN D stated nursing aides did notify the floor nurses if residents were observed with long and/or dirty nails so the nurses could follow up. RN D stated the potential risk of long nails included skin tears. RN D stated that if the resident nails were to be dirty, the debri observed under the nails was potentially bacteria which could place the resident at risk for infection.In an interview on 05/14/2026 at 5:41 PM with the DON, she stated that nursing staff were responsible for monitoring and grooming the residents' nails. The DON stated the Floor Nurses were to review the residents' fingernails during the weekly skin assessment, and the nursing aides should be monitoring resident nails daily. The DON stated the potential risks for residents having long fingernails included a cut or infection, if the nails were dirty.In an interview on 05/14/2026 at 6:03 PM with the Administrator, he stated that the residents' fingernails were trimmed as needed and that nursing was responsible for ensuring fingernails were. He stated this was true specifically for the charge of nurses as they monitor the nursing aides. He stated that resident s with long nails could hurt themselves by scratching themselves.Record review of the Nursing Facility's Care of Fingernails/Toenails policy with revision date 10/2010, read in part: Purpose: the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Under General Guidelines, it read in part: 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aide in the prevention of skin problems around the nail bed. and, 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health for 2 resident 12 residents (Resident #7 and Resident #49) reviewed for foot care.The facility staff CNAs and licensed nurses failed to provide foot care for Resident #7 and Resident # 49 on 05/12/2026This failure could affect residents by placing them at risk for poor foot health, decreased personal hygiene, and a decline in their quality of life.Findings included:Resident #7Record review of Resident #7's face sheet revealed resident was [AGE] year-old male with initial admission date 11/21/24 and re-admission date 10/10/25.Record review of Resident #7's Quarterly MDS dated [DATE], revealed a BIMS of 0, indicating Resident #7 was severely cognitively impaired. Under Section GG- Functional Abilities, it was noted Resident #7 was completely dependent with his personal hygiene, meaning the helper does all the effort to complete the task while the resident does none of the effort.Record review of Resident #7's Health and Physical dated 09/18/25, revealed a medical history of: Alzheimer's disease with behavioral disturbance and Generalized muscle weakness.Record review of Resident #7's care plan with dated 11/21/24 revealed he required assistance with ADL's including personal hygiene.Resident #49Record review of Resident # 49's admission record dated 05/13/2026 revealed an initial admission date of 07/19/2019 and a readmission date of 06/12/2025.Record review of Resident # 49's diagnosis list dated 05/13/2026 revealed a diagnosis of unspecified dementia with other behavioral disturbance (cognitive decline severe enough to impact daily functioning but exact cause cannot be definitively diagnosed and is accompanied by disruptive behavioral symptoms.)Record review of Resident #49's Quarterly MDS assessment dated [DATE] revealed a BIMS of 00 indicating severe cognitive impairment. Section GG- Functional Abilities revealed Resident #49 needed supervision or touching assistance meaning the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity when completing personal hygiene.Record review of Resident #49's care plan revised on 02/17/2026 revealed Resident #49 has an ADL self-care performance deficit. The interventions included assistance by 1 staff member with personal hygiene.An observation on 05/12/2026 at 10:43a.m., revealed resident #49's toenails to be long, extending about an inch from nail bed. He stated that he would like to get his toenails trimmed, he denied pain. Resident #49 stated he had not been offered to have his toenails trimmed since being in the facility.In an interview on 05/12/2026 at 3:41 PM with CNA A, she stated nursing aides monitor for residents' toenail length twice a week or more, during shower days. CNA A stated nursing aides were responsible for notifying the Nurses if residents' toenails were long or if the resident requested their toenails to be trimmed. CNA A stated the potential risk to the resident included pain and discomfort, especially when wearing shoes.In an interview on 05/14/2026 at 10:06 AM with RN D, she stated that a podiatrist came to the facility about four times a year but that there was no set schedule. She stated that if needed they can refer residents out to see a podiatrist as well. She stated that the risk of having long toenails were ingrown toenails and a potential for infection. She stated that it was the responsibility of the nurses to help schedule residents for these appointments.In an interview on 05/14/2026 at 6:03 PM the administrator stated that a podiatrist comes to the facility every 6 months. The Administrator stated the nurses monitor residents' nails and toenails but was unsure how often. He stated that long toenails can cause pain and shoes not fitting properly.Record review of the Nursing Facility's Care of Fingernails/Toenails policy with revision date 10/2010, read in part: Purpose: the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Under General Guidelines, it read in part: 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aide in the prevention of skin problems around the nail bed. and, 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675881 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at Pecos | 1819 Memorial Drive<br>Pecos, TX 79772 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 shower rooms reviewed for infection control. -The facility failed to ensure plastic urinal that was hanging in the community shower room/ bathroom in the 300 hall was not full of urine. This failure could place residents at risk for cross contamination and the spread of infection.Finding included: In an observation on 5/12/2026 at 10:27AM of community bathroom in the 300 hallway revealed a plastic urinal hanging from the grab bar next to the toilet, it contained yellow tinged urine. In an interview on 5/13/2026 at 10:17 AM with CNA A, she stated that urinals were emptied and rinsed out after each use and should not be left in the shower room. She stated that that it was the responsibility of the CNAs to ensure this was being done. She stated that the risk would be that residents might use the urinal with urine already in it; they might spill it in themselves; or drink it. In an interview on 5/14/2026 at 9:00AM with LVN she stated that urinals should not be left in the shower room due to cross contamination possibility. She stated that it was the responsibility of the CNAs and nurses to ensure that the urinals were either disposed of or in the residents room. In an interview on 5/14/2026 at 4:38 PM with the DON she stated that urinals were not to be left in the community shower room due to possibility of cross contamination. She stated that CNAS were to empty it , record output and document it, then rinse out the urinal and taken back to the residents room. She stated that it was the responsibility of the CNAs to ensure that the urinals were not left in the shower room. In an interview on 05/12/2026 at 6:03 PM with the Administrator he stated that urinals were not to be left in the shower room due to infection control. He stated that CNAs were responsible for ensuring that urinals were empty and returned to resident room. He stated that if it were left in the shower room any resident could get a hold of it and possibly ingest the urine.Review of the facility policy titled Infection Prevention and Control Policies and Procedures revised May 15th 2023, read in part . Health care workers will implement universal/standard precautions whenever there is occupational exposure to blood and bodily fluids . designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection |

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| F 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>Based on interview, and record review, the facility failed to provide training to their staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property, for 1 of 8 staff (DON) reviewed for abuse, neglect exploitation training. The facility failed to ensure the DON had completed their mandatory abuse annual training.This failure could place residents at risk of being cared for by untrained staff.findings included:Record review of the DONs Personnel file revealed the DON did not have current Abuse trainings completed.Record review of Personnel documents on 05/14/2026 at 11:00 AM with Human Resources revealed the DON's hire date 11/23/2009.In an interview with Human Resources on 05/14/2026 at 11:00 AM, she stated Nursing Management was responsible for making sure nursing staff was up to date with their trainings.In an interview on 05/14/2026 at 5:40 PM with the DON, she stated all staff were responsible for their own trainings. The DON stated all staff were aware of the importance of being kept up to date with trainings. She stated she was responsible as the DON for nursing staff and self. The DON stated the potential risk of the Nursing Facility staff not having their trainings up-to-date included patient care that was not up-to-date for residents.In an interview on 05/14/2026 at 7:00 PM with the Administrator, he stated Human Resources was responsible for monitoring facility staff's trainings. The Administrator stated the potential risks of staff not keeping up-to-date with their trainings included the staff not having the most current patient-care knowledge.Record review of the Nursing Facility's Staffing, Sufficient and Competent Nursing, dated 08/2022, under Policy Interpretation and Implementation- Competent Staff, it read in part: 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas: a. Resident Rights; b. Behavioral Heath; c. Psychosocial care; d. Dementia care; e. Person Centered Care; f. Communication. It also read, 5. Competency requirements and trainings for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that: a. programming for staff training results in nursing competency. |

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| F 0945<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.<br><br>Based on interview and record review, the facility failed to provide the mandatory training on standards, policies, and procedures for an infection prevention and control program for 1 of 8 staff (the DON) reviewed for training, in that:The facility failed to ensure infection prevention and control training was provided to the DON.This failure could place residents at risk of illness due to lack of staff training. Findings included:In an interview and Record review of Personnel files with Human Resources on 05/14/2026 at 11:00 AM, it was revealed the DON did not have current Enhanced Barrier training completed. She stated Nursing Management was responsible for making sure nursing staff was up to date with their trainings.In an interview on 05/14/2026 at 5:40 PM with the DON, she stated all staff were responsible for their own trainings. The DON stated all staff were aware of the importance of being kept up to date with trainings. She stated she was responsible as the DON for nursing staff and self. The DON stated the potential risk of the Nursing Facility staff not having their trainings up-to-date included patient care that is not up-to-date for residents.In an interview on 05/14/2026 at 7:00 PM with the Administrator, he stated Human Resources was responsible for monitoring facility staff's trainings. The Administrator stated the potential risks of staff not keeping up-to-date with their trainings included the staff not having the most current patient-care knowledge.Record review of the Nursing Facility's Staffing, Sufficient and Competent Nursing, dated 08/2022, under Policy Interpretation and Implementation- Competent Staff, it read in part: 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas: a. Resident Rights; b. Behavioral Heath; c. Psychosocial care; d. Dementia care; e. Person Centered Care; f. Communication. It also read, 5. Competency requirements and trainings for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that: a. programming for staff training results in nursing competency. |