STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675887	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bryan	2333 Manor Dr Bryan, TX 77802

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on observations, interviews, and record reviews, the facility failed to ensure residents were informed orally of their rights for 10 confidential residents reviewed for resident rights.The facility failed to ensure residents were provided with ongoing communication of their rights during their stay at the facility. This failure could place residents at risk for a decreased quality of life and awareness and execution of their rights.The findings included:A record review of resident council minutes indicated resident rights were not reviewed or discussed for the resident council meetings dated 05/22/2025, 07/16/2025, 08/19/2025, 09/16/2025, 12/08/2025, 01/08/2026, 02/12/2026, 03/11/2026 or 04/08/2026. The resident council minutes for October and November 2025 were not included in the records.During an observation on 05/12/2026 at 7:33 AM of the facility bulletin board revealed the resident rights posting was observed on the wall. During a confidential interview at an undisclosed date and time, 10 confidential residents indicated staff had not discussed or reviewed their rights with them. Seven of the 10 confidential residents stated they were unsure of which rights they had as a resident of the facility.During an interview on 05/14/2026 at 11:20 AM the AD indicated she was not aware she should have been reviewing and explaining residents' rights with residents until this morning. The AD stated she was unaware of the Ombudsman position, nor did she know the Ombudsman for the facility. The AD indicated she believed it was important for residents to know their rights. The AD indicated if residents did not know their rights, they would not be able to voice their concerns. During an interview on 05/14/2026 at 5:19 PM the SW stated she reviewed resident rights with residents and family members when they were unable to resolve a grievance. She stated she directed them to the Ombudsman. The SW stated she assumed the AD went over resident rights in the Resident Council meetings. The SW stated it was important for all residents to know their rights. During an interview on 05/14/2026 at 6:17 PM the ADM indicated the ADM trained all staff on resident rights. The ADM indicated his expectation was for the AD to review resident rights with the residents and provide them with ongoing information on the Ombudsman. The ADM indicated the risk to residents not knowing their rights could lead to resident rights being violated which could affect their psychosocial well-being and quality of life. A record review of the facility policy revised February 2021 titled Resident Rights indicated the following:Policy StatementEmployees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation:1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:H.be supported by the facility in exercising his or her rights;I. Exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. J. be informed about his or her rights and responsibilities.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 3 of 17 (Resident #19 Resident #51 and Resident #61) residents reviewed for activities. The facility failed to provide a sufficient variety of activities, including evening and weekend activities to meet resident interests and psychosocial needs. This failure could place residents at risks of boredom, depression, behavior, diminished quality of life and decreased cognitive function.Findings included:Review of Resident #19's face sheet dated 5/12/2026 reflected an admission date of 12/12/2023 with diagnoses of major depressive disorder (sadness), psychotic disorder with hallucinations (seeing, hearing, or believing things that are not actually there), and generalized weakness. Review of Resident #19's MDS assessment dated [DATE], reflected Resident #19 had a BIMS score of 13 out of 15, and was cognitively intact. The MDS did not have any information on activities. Review of Resident #19's comprehensive care plan dated 01/29/2026, reflected resident has an activity focus area, with interventions of encourage participation in activities, assist to activities as needed, encourage engagement in meaningful activities and socialization, have activities that meet my physical and/or mental abilities, provide a program of activities that is of interest and accommodates residents. Interview conducted on 05/12/2026 at 11:56 AM, Resident #19 stated, she only participated in BINGO because they do not have any other activities, the Activity Director never tells them what is going on and does not invite them to any activities. The Mother's Day event never happened, and residents did not even know about Cinco De Mayo event because the calendar was not put up in time and nobody knew about the event.During another interview with Resident #19 on 05/14/2026 at 5:15 PM, she said they were supposed to have resident council meeting but that did not happen. Resident #19 stated the resident council meeting was the second Thursday of the month. Resident #19 stated not having activities makes her feel bad, bored, and left out. Record review of Resident #19's progress notes reflected the AD documentation of Resident #19 participating in only BINGO. Interview conducted on 05/14/2026 at 1:58 PM with LVN C stated they have BINGO every day except Sunday. The Activity Director has different volunteers that come in and call BINGO, they have a store for the residents to spend their winnings in. They have small activities like coloring. LVN C stated, the residents do not have enough activities to do, she had bed bound residents that have nothing to do. LVN C stated she did not see the Activity Director go to the residents to remind or encourage them to go to upcoming activities. Interview conducted on 05/14/2026 at 2:58 PM with AD, stated they have 4 activities a day, a lot of BINGO, activities involving food, music, and daily chronicles. For the bed bound residents, they like music and sometimes sensory bins. The AD stated she spends 30 - 40 minutes a couple times a week with bed bound residents. The AD said that the residents had music downstairs, and she said she did not know how the residents were to get downstairs for the activity. The AD stated the residents get to pick out what activities are done in their resident council meeting. The AD said a resident who did not have activities tailored to their needs could cause a decline in their health. She added most activities were tailored to the residents needs but not all of the activities. She said she would not like it if all she got to do was play BINGO. Interview conducted on 05/14/2026 at 4:56 PM, CNA F stated there is not enough for the residents to do and what they do have is dictated by 1 or 2 residents. CNA F stated the residents often state they are bored. CNA F stated the residents could have a decline in health if their needs are not met psychosocially. Interview conducted on 05/14/2026 at 5:30 PM with ADM stating expectations are to have activities tailored to meet every resident's needs, if not met the residents' health could decline as well as their psychosocial wellbeing. Review of Resident #51's face sheet (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 05/12/2026 reflected an admission date of 10/18/2024 with diagnoses of Parkinson's disease (condition that affects how a person moves), dysphagia (trouble swallowing), and generalized weakness. Review of Resident #51's MDS assessment dated [DATE], reflected Resident #51 had a BIMS score of 10, indicating moderate cognitive impairment. There was nothing on the MDS about activities. Review of Resident #51's comprehensive care plan dated 03/10/2026, reflected resident has an activity focus area, with interventions of encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, and the resident is dependent on staff for activities, cognitive stimulation, social interaction related to mobility. Interview conducted on 5/12/2026 at 8:02 AM, Resident #51 stated he had lived there for almost 2 years, he said he joined activities but not enough of activities. Resident #51 said he did not feel anything about activities but would like to see different activities besides BINGO. Review of Resident #61's Face sheet dated 05/12/2026 reflected an admission date of 03/31/2022 with diagnoses of end stage renal disease (final irreversible stage of kidney failure), legal blindness (disease of eye), Type II Diabetes Mellitus with Diabetic Retinopathy without macula edema (damage to blood vessels in retina), generalized muscle weakness. Review of Resident #61's MDS assessment, dated 04/09/2026, reflected Resident #61 had a BIMS score of 15 out of 15, and was cognitively intact. The MDS did not have any information about activities. Review of Resident #61's comprehensive care plan dated 05/12/2026, reflected resident has an activity focus area, with interventions of Have activities that meet my physical and/or mental abilities and Provide, invite and encourage my activity preferences. Interview conducted on 05/12/2026 at 10:43 AM, Resident #61, stated the facility mostly offers BINGO as an activity of choice. He stated he does not attend BINGO because he is blind and unable to participate in the activity. He stated one of the previous social workers ordered him blind friendly activity materials.Record review of the Facility Dignity Policy dated 02/2021 revealed When assisting with care, residents are supported in exercising their rights. Residents are: encouraged to attend the activities of their choice, including religious, political, civic, recreational, or social activities.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview, and record review, the facility failed to make sure that drugs are stored in locked compartments and only authorized persons have access for 3 of 9 medication carts (MC #1, MC #2, and MC #3) reviewed for drug storage and labeling.The facility failed to ensure MC #1, MC #2 and MC #3 were locked, medications secured, and not accessible to other staff, residents, or visitors.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings included:Observation of the initial walk through of the facility on 05/12/2026 at 5:54a.m., revealed the ADON left MC #1 and MC #2 unlocked and unattended. Observation of the initial walk through of the facility on 05/12/2026 at 6:01a.m., revealed RN H left MC #3 unlocked and unattended. During an interview with the ADON on 05/12/2026 at 6:03a.m., she said she had been trained on medication storage. She said the policy for the medication carts was the carts were to be always locked. She said the person on the medication cart was responsible for locking the medication cart. She said if the medication cart was left unlocked and unattended a resident could get the medication; medication could come up missing. She said all staff monitored to ensure the medication carts were locked. She said staff monitored through observation. She said she left the medication cart unlocked because she got distracted. During an interview with RN H on 05/12/2026 at 6:16a.m., she said she had been trained on resident rights. She said the policy for the medication carts was any time staff walked away from the cart it should be locked. She said the nurse was responsible for locking the medication cart. She said if the medication cart was left unlocked and unattended a resident could access the medication and ingest the medications and cause harm, or medications could be stolen. She said the ADON and DON monitored to ensure staff were locking the medication carts. She said the ADON and DON monitored through observation. She said she was running around and she said she had a lot of things going on at one time and she forgot to lock the medication carts. During an interview with the DON on 05/14/2026 at 10:10a.m., she said she had been trained on medication storage. She said the policy for medication carts was that the carts should always be locked. She said the nurses were responsible for locking the medication carts. She said if the medication cart was left unlocked and unattended a resident or visitor could get into the cart and take medication. She said the DON monitored to ensure the carts were locked. She said the DON monitored through observation. She said she did not know why the ADON and RN H left the medication carts unlocked and unattended. During an interview with the ADM on 05/14/2026 at 11:38a.m, he said he had been trained on medication storage. He said the policy for the medication carts was that the cart was to be locked when the nurses were not working on the carts. He said the nurse primarily was responsible for ensuring the medication cart was locked, but anyone walking by the cart should lock the cart if it was unlocked. He said if the medication cart was left unlocked and unattended it could cause drug diversion; missing medication and the residents could rummage through the carts. He said the nurse manager, the ADM and DON monitored to ensure the medication carts were locked. He said the nurse manager, ADM and DON monitored by doing routine rounds and spot checks. He said he did not know why the ADON and RN H left the medication carts unlocked and unattended. Record review of Medication Labeling and Storage Policy dated 02/2023 revealed The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish an infection prevention and control program (IPCP) that included, at a minimum, an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for 3 of 3 residents (Resident # 17, #28, and #93) reviewed for antibiotic stewardship program.1. The facility failed to follow antibiotic stewardship policy by failing to include all required information per facility policy on their infection tracking log for Resident #17, Resident #28 and Resident #93.2. The facility failed to follow antibiotic stewardship policy for Resident #17, Resident #28, and Resident #93 by not ensuring an infection surveillance assessment was performed for all antibiotic orders.This deficient practice could place residents at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased multi drug resistant organisms.Findings included:Review of Resident #17's face sheet, dated 05/14/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: metabolic encephalopathy (a brain dysfunction caused by chemical imbalances in the body such as electrolyte imbalances, organ failure, nutritional deficiencies, or toxins in the blood), sepsis due to other specified staphylococcus (a serious medical condition characterized by a systemic infection caused by specific strains of staphylococcus bacteria), and bacteremia (the presence of bacteria in the bloodstream).Review of Resident #17's comprehensive MDS, dated [DATE], reflected a BIMS score of 13, which indicated no cognitive impairment. Section I - Active Diagnoses indicated Resident #17 had septicemia (an infection that occurs when germs get into the bloodstream and spread). Section N - Medications reflected Resident #17 had not received an antibiotic in the seven days prior to the assessment on 04/13/2026.Review of Resident #17's order summary, dated 05/14/2026, reflected the following order for an antibiotic: INVanz Injection Solution Reconstituted (Ertapenem Sodium) Use 0.5 gram intravenously one time a day related to METABOLIC ENCEPHALOPATHY for 8 Days INFUSE 50 ML OF SOLUTION ONLY TO EQUAL 500 MG TOTAL OVER 30 MINUTES DISCARD REMAINING with a start date of 05/13/2026 and stop date of 05/21/2026.Review of Resident #17's facility assessments reflected no infection screening evaluation assessment completed on or around 05/13/2026.Review of Resident #17's care plan on 05/14/2026 reflected no care plan related to metabolic encephalopathy or antibiotic to treat it.Review of Resident #28's face sheet, dated 05/14/2026, reflected a [AGE] year-old female, admitted to the facility on [DATE] with most recent readmission on [DATE], with diagnoses that included: nontraumatic intracerebral hemorrhage (spontaneous bleeding into the brain tissue), personal history of malignant neoplasm of brain (history of cancer in the brain), and laceration without foreign body of scalp (a cut or tear in the scalp tissue where no debris or foreign material are embedded).Review of Resident #28's quarterly MDS, dated [DATE], reflected a BIMS score of 00, which indicated severe cognitive impairment. Section N - Medications reflected Resident #28 had received an antibiotic within the seven days prior to the assessment on 04/22/2026.Review of Resident #28's order summary, dated 05/14/2026 reflected the following order for an antibiotic: Cefepime HCl Intravenous Solution 1 GM/50ML Use 1 gram intravenously every 12 hours for scalp infection for 5 days with a start date of 05/12/2026 and a stop date of 05/17/2026.Review of Resident #28's facility assessment titled, Infection Screening Evaluation, dated 05/01/2026, reflected McGeer's Criteria (standardized guidance for infection surveillance) Met: Cellulitis (a bacterial infection of the skin), Soft Tissue or Wound Infection. No other Infection Screening Evaluations were completed for the month of May 2026.Review of Resident #28's care plan, dated 06/11/2025 and last revised 01/29/2026, reflected focus: I have a surgical wound related to recent surgery and I need support to promote healing and prevent complications. Location: Scalp. with interventions that included If antibiotics are prescribed, I will receive them as ordered and be monitored for effectiveness and side effects.Review of Resident #93's face sheet, dated 05/14/2026, reflected a [AGE] year-old male, admitted to the facility on (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] with diagnoses that included: sepsis due to methicillin susceptible staphylococcus aureus (a bloodstream infection caused by a type of bacteria that is sensitive to methicillin antibiotics), urinary tract infection, and bacteremia.Review of Resident #93's MDS assessments reflected a comprehensive MDS had not yet been completed as of 05/14/2026.Review of Resident #93's order summary, dated 05/14/2026, reflected the following orders for antibiotics: ceFAZolin Sodium Injection Solution Reconstituted 2 GM Use 2 gram intravenously every 8 hours for sepsis for 22 days with a start date of 05/07/2026 and stop date of 05/29/2026 and Clindamycin HCl Oral Capsule 300 MG Give 1 capsule by mouth three times a day for PNA [an infection that inflames the lung sacs in one or both lungs] for 7 days with a start date of 05/08/2026 and stop date of 05/15/2026.Review of Resident #93's facility assessment titled, Infection Screening Evaluation, dated 05/07/2026, reflected Loeb's Criteria(evidence-based guidance for starting antibiotics): Suspected Lower respiratory tract infection and a recent chest x-ray had been complete that reflected new infiltrates consistent with pneumonia. No other infection screening evaluations were completed for May 2026.Review of Resident #93's care plan, dated 05/07/2026, reflected a focus The resident has infection SEPSIS/UTI/MSSA bacteremia with interventions that included Administer antibiotics as per MD orders.Review of Resident #93's care plan, dated 05/07/2026, reflected a focus The resident has Pneumonia with interventions that included Give medications as ordered. Monitor/document for side effects and effectiveness.Review of facility Infection Control and Antibiotic Review, dated May 2026, reflected a table with the following titles for the columns, Resident Name, Room #, Antibiotic ordered, Diagnosis, # of days, Start Date, Stop Date, MD notified, Family notified, Acute care plan, Type of isolation, Water pictures [sic] are sanitized at least 2 times a week. Interview of staff reveals they are aware of the, Ice carts, resident equipment, enteral pumps, oxygen filters suction machine, nebulizers, Hskp. Disinfects rooms with d-diff[sic], blue top disinfectant being used for glucometers, The glucometer is sanitized between use using the purple tope [sic] disinfectant wipe, NO alcohol, Signage/PPE in place. Resident #28 was listed with her last name and first initial in the first column, her room number in the second column, Cefepime in the third column, wound infection in the fourth column, 10 in the fifth column, 5/2 in the sixth column, 5/12 in the seventh column, the eighth, ninth and tenth columns were marked with a check mark, Standard was under the eleventh column, and yes was in the remaining columns. Resident #93 was listed two times. The first appearance for Resident #93 reflected his last name in the first column, his room number in the second column, Clindamycin in the third column, PNA in the fourth column, 7 in the fifth column, 5/8 in the sixth column, 5/15 in the seventh column, the eighth, ninth and tenth columns were marked with a check mark, Standard was under the eleventh column, and yes was in the remaining columns. The second appearance for Resident #93 reflected his last name in the first column, his room number in the second column, Cefazolin in the third column, PNA in the fourth column, 22 in the fifth column, 5/7 in the sixth column, 5/29 in the seventh column, the eighth, ninth and tenth columns were marked with a check mark, Standard was under the eleventh column, and yes was in the remaining columns. Resident #17 was listed with her last name and first initial in the first column, her room number in the second column, Ertapenem in the third column, Metabolic Encephalopathy in the fourth column, the fifth column was left blank, 5/12 in the sixth column, the seventh and eighth column was left blank, the ninth and tenth columns were marked with a check mark, Standard was under the eleventh column, and yes was in the remaining columns.During a phone interview on 05/14/2026 at 04:15 PM, the DON stated she was certified and responsible for the infection prevention and control program until the ADON completed her training. She stated the ADON was supposed to complete the training by 05/17/2026. She stated antibiotic stewardship fell under the infection prevention and control program, so she was responsible for monitoring antibiotic stewardship. The DON stated when a new order for antibiotics was received, she ensured the infection met criteria, according to the infection screening evaluation. The DON stated if the infection did not meet the criteria, then she would contact the provider to discuss the use of antibiotics. When asked about the infection surveillance evaluation for Resident #17, she (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated it should be in her assessments, if it is not there the charge nurse should have completed it. She stated the ADON was responsible for completing the infection surveillance evaluation if the charge nurse failed to complete it. The DON stated she followed up on the infection surveillance evaluations once they were completed. The DON stated she had not followed up on Resident #17's evaluation because she had only been in the position for a couple of weeks and had been busy working on chart reviews and staffing concerns. The DON stated she had delegated Infection Control and Antibiotic Review tracker to the ADON. While reviewing the Infection Control and Antibiotic Review tracker, the DON stated the tracker did not list the resident's medical record number, the date the symptoms appeared, the pathogen identified, an outcome to the antibiotic or any adverse events that may have occurred due to taking the antibiotics that was required per the facility's Antibiotic Stewardship policy. She stated not having the documentation per the facility policy could affect residents by residents having possible unknown adverse effects to the antibiotics or increase in symptoms from the infection. She stated if the infection screening evaluation was not completed, then the resident might not get treated with the right antibiotic or the resident could have a poor outcome.During an interview on 05/14/2026 at 05:39 PM, the ADON stated she was working on completing the training for the infection prevention and control certification and planned to complete the training by 05/17/2026. The ADON stated when an antibiotic order was received, she would check to see what the resident was on the antibiotic for and place the information on the Infection Control and Antibiotic Review tracker then updated the care plan. She stated she kept a log for when the residents completed their antibiotics. The ADON stated the DON gave her a mapping tool to track the antibiotics administered in the facility last week, but she had not had time to initiate the process yet. She stated she had reviewed the antibiotic stewardship policy maybe one time, but it was in her job duties. While reviewing the Infection Control and Antibiotic Review tracker, she stated the tracker did not include the resident's medical record number, the date the symptoms first appeared, the pathogen identified, the site of the infection, the date of the culture, the outcome, or any adverse event that occurred. She stated the tracker provided was not compliant with the antibiotic stewardship policy. The ADON stated the missing information could affect the resident because it could lead to another infection. She stated the nurse who received the order for the antibiotic was responsible for completing the infection screening evaluation. She stated she pulled the antibiotic report to ensure the infection screening evaluations were completed. She stated by not having the infection screening evaluation completed, the facility would have difficulty tracking when symptoms started and ensuring the correct tests were ordered. She stated it was the responsibility of the DON to ensure the Infection Control and Antibiotic Review tracker was completed correctly.During an interview on 05/14/2026 at 05:57 PM, the ADM stated he was filling in between administrators but was also the regional vice president of operations. He stated the DON was the infection preventionist, but the ADON was responsible for the antibiotic stewardship program. The ADM stated the antibiotic stewardship program was to ensure the facility had appropriate uses of antibiotics, they were not prescribed in overabundance and the antibiotics were effective. After reviewing the Infection Control and Antibiotic Review tracker, the ADM stated the following was not included per the facility policy for antibiotic stewardship: the medical record number, the date the symptoms appeared, the pathogen identified, the site of the infection, the date of the culture, the outcome, and the adverse effects. He stated the Infection Control and Antibiotic Review tracker did not meet his expectations to match the facility policy. The ADM stated he was unsure how the resident could be affected by the Infection Control and Antibiotic Review tracker not being completed per facility policy. He stated he was unaware of the procedure that occurred when an antibiotic order was received. The ADM stated if the use of antibiotic did not meet the criteria, then a resident could develop a multi drug resistant organism and potentially other infections.Record review of the facility's policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, dated 2001 and last revised 2016, reflected Policy StatementAntibiotic usage and outcome data will be collected and documented using a (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.Policy Interpretation and Implementation1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee.2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics.a. Therapy may require further review and possible changes if:(1) the organism is not susceptible to antibiotic chosen;(2) the organism is susceptible to narrower spectrum antibiotic;(3) therapy was ordered for prolonged surgical prophylaxis; or(4) therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics.4. All resident antibiotic regimes[sic] will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. resident name and medical record number; b. unit and room number; c. date symptoms appeared; d. name of antibiotic (see approved surveillance list); e. start date of antibiotic; f. pathogen identified (see approved surveillance list); g. site of infection; h. date of culture; i. stop date; j. total days of therapy; k. outcome; and l. adverse events.

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	675887	A. Building B. Wing	05/14/2026

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Avir at Bryan	2333 Manor Dr Bryan, TX 77802

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interviews and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 6 of 8 confidential residents reviewed for homelike environment. The facility failed to ensure resident's wheelchairs were cleaned, free from dirt and debris. This failure could place residents at risk of diminished quality of life by living in an unsanitary and uncomfortable environment .Findings included: During a confidential interview at an undisclosed date and time, 1 confidential resident indicated the wheelchair locks do not work, the chairs are filthy and the staff never clean them. Seven additional residents of the 10 confidential residents stated their chairs have not been cleaned, one stated she had a toileting accident one day in her chair, and it did not get cleaned. Observation on 5/14/2026 at 10:34 AM of 8 wheelchairs revealed 6 wheelchairs to be unclean with significant accumulation of dust, hair, and other debris particles on the frames, between seat cushions and wheels of the wheelchairs. In an interview conducted on 05/14/2026 at 11:04 AM, The ADM stated the CNAs typically clean the wheelchairs; however, he will verify the facility's process. He stated he felt anyone who observed something dirty could clean it. The ADM stated he would check with the nursing administration regarding staff cleaning assignments and responsibilities.In an interview conducted on 05/14/2026 at 12:17 PM, LVN B stated the CNAs on the night shift typically clean the wheelchairs. She stated there is also a hospitality aide who passes out water, cleans wheelchairs, and answers call lights. LVN B stated some wheelchairs are clean and some are not. She stated staff make notes when wheelchairs are not clean and they are supposed to clean the wheelchairs when providing residents with showers. LVN B stated she has not personally cleaned any wheelchairs. She stated residents would not feel-good sitting in dirty wheelchairs and could be affected by the unclean conditions.In an interview conducted via phone on 05/14/2026 at 1:11 PM, hospitality aide stated she cleans wheelchairs at night on units 2 and 4. She stated she cleans the chairs with a blue spray. She stated she is mostly assigned to the secured unit downstairs.In an interview conducted on 05/14/2026 at 1:30 PM, RN A stated when she is working, she cleans wheelchairs as she works because she likes things to be clean. She stated that anyone can clean the wheelchairs; however, she feels all wheelchairs could use a deep pressure washing because food is frequently dropped in the chairs. RN A stated unclean wheelchairs can make residents feel uncomfortable.In an additional interview conducted on 05/14/2026 at 6:32 PM, The ADM stated the CNAs on the night shift are assigned responsibility for cleaning the wheelchairs. He stated staff had slacked in following the facility process for wheelchair cleaning. The ADM stated residents could experience some negative effects from the unsanitary conditions.Review of facility's policy named Homelike Environment revised February 2021 reflected: Policy StatementResidents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.Policy Interpretation and Implementation2. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.3. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:6. clean, sanitary, and orderly environment;.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 2 of 25 residents (Resident #29 and Resident #63) reviewed for resident rights.The facility failed to ensure CNA D knocked on Resident #63's door before entering the resident's room.The facility failed to ensure staff assisted Resident #29 with removing his hospital gown and putting on his clothing as preferred on .5/13/2026 and 5/14/2026. This failure could place residents at risk of feeling like their privacy was invaded, cause emotional distress, diminished feelings of self-worth and/or diminished quality of life. Findings Included:1. Record review of Resident #29's MDS Assessment, dated 03/17/2026, reflected he was an [AGE] year-old male, admitted [DATE] with a BIMS score of 03, which indicated severe cognitive impairment. The resident's diagnoses included Transient Cerebral Ischemic attack (temporary blockage of blood flow to brain), Non-Alzheimer's Dementia (cognitive decline, confusion), muscle weakness, and hypertension (high blood pressure).Observation/Interview conducted with Resident #29 on 5/12/2026, at 9:04 AM, revealed the resident was observed sitting in bed with his gown on. He stated he was doing fine.Observation conducted with Resident #29 on 5/13/2026, at 10:15 AM, revealed the resident was observed in bed with his gown on.Observation/Interview conducted with Resident #29 on 05/13/2026, at 3:13 PM revealed Resident #29 was observed in his bed with his gown on. The resident mumbled words to the surveyor, holding his gown, and it was noted to have feces on it. The surveyor notified staff of the resident's condition, and the DON went to the room with another nursing staff to assist resident in being changed Observation/Interview conducted with Resident # 29 on 05/14/2026, at 12:22 PM revealed the resident was observed to be in bed with his hospital type gown on. The resident stated he wanted to get out of bed, and when asked if he wanted to put on clothes, he responded, yes. The resident's closet was noted to have clean clothes hanging inside.In an interview conducted with Resident #29's family member on 05/13/2026, at 09:42 AM. The resident's family member stated she had concerns regarding Resident #29 remaining in bed all the time. The family member stated the facility did not get Resident #29 out of bed regularly. She stated the resident had previously been receiving therapy services; however, therapy was discontinued and the resident had since declined. The family member stated staff informed her they did not place the resident in his wheelchair because he frequently rolled into other residents' rooms and staff stated to her, they did not have enough staff to only keep up with him. The family member stated her concern was that leaving the resident in bed all day could place the resident at risk for bed sores, further decline in mobility, and decreased quality of life.2. Record review of Resident #63's face sheet, dated 05/14/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #63 had diagnoses which included type 2 diabetes mellitus without complications (high blood sugar), muscle weakness, difficulty in walking, lack of coordination, cognitive communication deficit (problems with communication), hyperlipidemia (high cholesterol), and hypertension (high blood pressure).Record review of Resident #63's quarterly MDS assessment dated [DATE] revealed Resident #63 had a BIMS score of 4, which indicated severe cognitive impairment.Observation on 300-hall on 05/12/2026 at 7:47a.m., revealed CNA D did not knock on Resident #63's door before entering the room.During an interview conducted with the DOR on 5/14/2026, at 9:25 AM, the DOR stated the therapy department got Resident #29 out of bed 5 days a week when he was completing physical therapy. She stated Resident #29 reached his 100 days and it ended after no progress. The DOR stated it was now up to the nursing department to get the resident up and out of bed.During an interview with the DON on 05/14/2026 at 9:58a.m., revealed she had been trained on resident rights. She said the policy for knocking was that staff were to knock on the door and wait to enter. She said (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if the resident did not answer, staff should knock again. She said everyone was responsible for knocking on the resident's door. She said if staff did not knock residents may feel like their privacy or rights were not being respected. She said the DON monitored to ensure staff were knocking. She said the DON monitored through observation. She said she did not know why CNA D did not knock before going into Resident #63's room. During an interview with CNA D on 05/14/2026 at 10:18a.m., she said she had been trained on resident rights. She said the policy was to knock before entering the room and wait until the resident answered before going in. She said all employees were responsible for knocking before entering the resident's room. She said if staff did not knock the resident may feel violated. She said the nurses and management monitored to ensure staff were knocking. She said the nurses and management monitored through observation. She said she did not knock on Resident #63's door because she just moving fast sometimes. During an interview with Resident #63 on 05/14/2026 at 11:10a.m., she said that staff never knocked on her door before entering. She said she wanted staff to knock all the time. She said she felt like she was being violated when staff did not knock. She said staff would come in and she would not know why they would be there. During an interview with the ADM on 05/14/2026 at 11:21a.m., he said he had been trained on resident rights. He said the policy for knocking was staff were to knock before entering and wait for a response. He said everyone was responsible for knocking on the resident's door. He said depending on the resident it may not bother some if staff did not knock. He added it might bother other residents. He said the resident may feel like they do not have a sense of privacy. He said the leaders and peers monitored to ensure staff were knocking. He said leaders and peers monitored through observation. He said he did not know why CNA D did not knock on Resident #63's door before entering.During an interview conducted with LVN B on 5/14/2026, at 12:26 PM, LVN B stated she did not believe Resident #29 remained in bed all the time during her shift rotation. LVN B stated the resident was often up and entered other residents' rooms. She stated the CNAs were responsible for dressing the resident and that Resident # 29 required assistance from two to three staff members. LVN B stated one reason the resident may not be dressed was because his clothes may not have been washed or returned from laundry services. She further stated there were times when the resident was asleep and remained in bed. LVN B stated it was not appropriate for residents to remain in a gown all day unless there was a laundry issue. She stated at the time of the interview the resident remained in bed because she was unable to safely get him up by herself and was not comfortable attempting to transfer him alone while the aide was at an appointment.During an interview conducted with CNA D on 5/14/2026, at 12:44 PM, CNA D stated Resident #29 required assistance from two to three staff members for transfers and changes. CNA D stated the resident got up sometimes; however, she was unsure how the resident felt about wearing a gown throughout the day. She stated, long as he is covered, she believed it was acceptable because the resident had not made any complaints regarding wearing a gown all day. During an interview conducted with CNA E on 5/14/2026 at 3:51 PM, CNA E stated she worked for the facility 26 years come July 30, 2026. CNA E stated there was no particular reason why Resident #29 was not assisted with getting out of bed. CNA E stated Resident #29 went from room to room and other residents complained about him entering their rooms, so staff often kept him in bed because female residents scream and holler. CNA E stated this information had been discussed with the resident's family member. CNA E further stated there are times when staffing was limited, and with only three staff members available, they were unable to continuously redirect or monitor the resident from entering other residents' rooms. CNA E stated Resident #29 frequently wore a gown because his shirts were dirty and it was easier to leave him in the gown. CNA E stated she would rather not wrestle with the resident and it was easier for him to remain in the gown. She stated she did not know of any potential effect on the resident. During an additional interview conducted with Resident #29's family member on 05/14/2026, at 04:14 PM, the family member stated the facility washed Resident #29's clothes. She stated he had clean clothes in his closet and on a shelf in his restroom. The family member stated Resident #29 went to the doctor on Tuesday,05/12/2026 and the doctor gave orders for him to be (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressed daily to prevent him from pulling his catheter. The family member stated she had spoken to LVN C and the Social Worker about the orders and concerns.In an interview conducted with DON on 5/14/2026, at 4:56 PM the DON stated she was not aware of any physician's order for clothing. She stated she would not have accepted an order of such nature as there was no reason a resident should not put on clothes. The DON stated her expectation was for the nursing staff to assist residents out of bed and ensure residents were dressed in regular clothing. She stated it was not acceptable for a resident to remain in a gown every day. The DON further stated keeping Resident #29 in bed to prevent him from entering other residents' rooms was not an acceptable reason, and staff should redirect the resident instead. The DON stated she was new to the facility and was in the process of implementing multiple changes. She stated that anyone having to remain in a gown every day would likely not feel good about themselves. In an interview conducted with LVN C on 5/14/2026, at 5:08 PM. LVN C stated Resident #29 was dressed in pants during her rotations and the pants kept the resident from pulling at his Foley catheter. She stated being in a gown all the time could make a person feel bad. Record review of the facility policy Activities of Daily Living (ADL), Supporting, revision date of February 2025 revealed the following [in part]:Policy StatementResidents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Policy Interpretation and ImplementationResidents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable.The existence of a clinical diagnosis or condition does not alone justify a decline in a resident's ability to perform ADLs. Unavoidable decline may occur if he or she:a natural progression of a debilitating disease with known functional declinehas suffered the onset of an acute episode that caused physical or mental disability and is receiving care to restore or maintain functional abilities; and/orDepression is a potential cause of excess disability, and, where appropriate, therapeutic interventions should be initiated.refuses care and treatment to restore or maintain functional abilities and:the resident and or representative has been informed of the risk and benefits of the proposed care or treatment; andhe or she has been offered alternative interventions to minimize further decline; andthe refusal and information are documented in the resident's clinical record.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:hygiene (bathing, dressing, grooming, and oral care).mobility (transfer and ambulation, including walking).elimination (toileting).dining (meals and snacks); andcommunication (speech, language, and any functional communication systems).4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.Record review of the Dignity Policy dated 02/2021 revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff are expected to knock and request permission before entering residents' rooms.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to personal privacy and confidentiality of his or her personal and medical records for 2 (Residents #63 and #65) of 8 residents reviewed for privacy and confidentiality. The facility failed to ensure that the Resident Identifier sheet and corresponding survey containing PHI of Residents #63 and #65 were not left in the public survey binder in the lobby of the facility. The failure could place the residents at risk of their medical information being exposed to unauthorized individuals.Findings included: Record review of Resident #63's Face Sheet, dated 05/13/2026, reflected a [AGE] year old female admitted to the facility on [DATE] with the following diagnoses: dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Diabetes Mellitus (A condition results from insufficient production of insulin, causing high blood sugar.), and hypertension (High pressure in the arteries (vessels that carry blood from the heart to the rest of the body). Review of Resident #63's quarterly MDS dated [DATE] reflected Resident #63 was assessed to have a BIMS score of 04 indicating she had severe cognitive impairment. Review of Resident #65's face sheet dated 05/13/2026 reflected he was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: Ogilvie syndrome (An intestinal pseudo-obstruction feels like something is physically blocking your bowels. But they are not actually obstructed because they are paralyzed.), hemiplegia and hemiparesis (Hemiplegia is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body.) following a cerebral infarction (the pathological process that results in an area of necrotic tissue in the brain.) Review of Resident #65's annual MDS assessment dated [DATE] reflected Resident #2 was assessed to have a BIMS score of 14 indicating he was cognitively intact. Observation and review on 05/13/2026 at 8:45 a.m. of the public survey binder revealed it was in the foyer of the facility. Review of the binder revealed it contained a resident identifier sheet with a list of resident names and numbered identifiers as well as the survey/investigation for that identifier sheet with PHI (medical diagnoses) in the survey/investigation.During an interview with the DON on 5/14/2026 at 9:49 AM, the DON stated she had been with the facility for a month and was unsure who was responsible for maintaining the survey binder at the facility but at previous facilities it was the ADM. The DON stated PHI was information that was not available to the public as residents at the facility had a right to privacy. She stated the survey binder should not have residents' names inside. She stated if she was to discover that information in the binder, she would remove it immediately and she would in-service staff immediately to ensure staff were trained to safeguard the information. The DON stated having confidential information left out where the public could review could lead to legal issues. During an interview with the ADM on 05/14/2025 at 11:05 AM, he stated the survey binder as usually monitored by the ADM or the DON. He stated he was unaware of the confidential resident Identifier form, containing the residents' names and identifiers had been left in the survey binder. The ADM stated the potential effect of confidential information being accessible to visitors, residents, or others could affect residents' rights to confidentiality. He stated the document stapled to the report was likely the only indicator identifying the two residents to the report. He stated staff were trained as needed on confidentiality and its covered in orientation.A record review of the facility policy revised February 2021 titled Resident Rights indicated the following: Policy Interpretation and Implementation:1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: t. privacy and confidentiality;. Record review of the facility's policy Compliance Risks - Privacy, Security, and Breach Notifications, dated January 2025 indicated:Policy StatementThe facility complies with the laws governing privacy, security, and breach notification of protected health information as set forth in the Health Insurance Portability and Accountability Act (HIPAA) and other privacy and security rules.Policy Interpretation and Implementation1.^^The facility (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintains policies and practices protecting the use and disclosure of protected health information and breach notifications in accordance with the Health Insurance Portability and Accountability Act (HIPAA).2.^^The facility maintains policies and procedures ensuring resident privacy and confidentiality in accordance with the Requirements of Participation, including:a.^^maintaining the privacy and confidentiality of resident medical records (42 CFR 483.10(h) and 483.70(h)); 3.^^Personnel are trained in the policies and practices that protect the privacy, confidentiality, and security of resident-identifiable information throughout the facility

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the PASRR program for 1 of 5 residents (Resident #38) reviewed for PASRR assessments. The facility did not complete a 1012 form (used by the state nursing facilities to review residents with a negative PASRR Level 1 screening and determine if further evaluation for mental illness or dementia is needed) to update resident #38's PASRR Level 1 with the newly evident mental health diagnosis.The facility did not refer Resident #38 to the appropriate state-designated mental health authority for review when she received a new diagnosis of Major Depressive disorder, recurrent severe (condition where person experiences repeated episodes of very intense sadness, loss of interest, low energy, and feelings of hopelessness) during her stay at the facility on 03/06/2025.The failures could place residents who had a mental illness at risk of not being evaluated and receive needed PASRR services.Findings included:Record review of Resident #38's Face sheet printed on 05/13/2026 reflected a [AGE] year-old female, admitted to facility on 06/14/2024. Diagnoses included atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery), generalized anxiety disorder (a mental health condition where feelings of intense fear and worry are constant, overwhelming, and interfere with daily life), unspecified psychosis (a condition difficulty distinguishing what's real and what's false, symptoms do not fully match another psychotic disorder), and major depressive disorder(persistent low mood or lack of interest in activities, significantly affecting a person's ability to function in daily life . The diagnosis for Major Depressive disorder had an onset date of 03/06/2025. Record review of Resident #38's MDS dated [DATE] reflected the resident had a BIMS of 11, which indicated moderate cognitive impairment. Record review of Resident #38's Care Plan printed on 05/13/2026 reflected no focus area for Major Depressive Disorder with related person-centered goals and interventions. Record review of Resident #38's only PASRR Level I, dated 06/13/2024, reflected she did not have any mental illness. Record review of Resident #38's level 2 PASRR indicated it was completed 10/22/2015 and the resident had a mood disorder.In an interview conducted 5/13/2026 at 5:53 PM with the MDS RN and MDS LVN, they stated they realized PASRR Level II was outdated that was provided to the surveyor earlier in day. The MDS RN stated the PASRR II was completed during one of Resident #38's skilled stays many years ago prior to their employment at the facility. The MDS RN stated Resident #38's new mental health diagnosis had been missed regarding the PASRR review. She stated she completed form 1012 and it had been submitted and a new PASRR Level II evaluation would be completed. In an interview conducted 5/14/2026 at 9:49 AM, the DON stated the MDS nurses were responsible for PASRR referrals to the appropriate state-designated authority. She stated she was new to her role as the DON, and she as unsure of the process for referring residents with new mental health diagnosis acquired during their stay. The DON stated the nursing department did monitor and make observations for new behaviors and they would notify the doctor of any changes and complete psychological referrals as needed. An additional interview conducted 5/14/2026 at 1:45 PM, the MDS RN stated when asked how the facility identified residents with newly evident possible mental illness (MI), intellectual disability (ID), or related conditions after admission, that the nursing department was hands-on and should notify the physician or nurse practitioner of any changes in behaviors or condition. She stated the physician, nurse practitioner, and nursing staff were actively involved with residents. The MDS RN stated historically the MDS department completed referrals to the appropriate state designated authority when a resident was identified as having a mental health diagnosis. She stated if a resident was identified as having a newly evident mental health diagnosis, the information is entered into SimpleLTC(portal used by nursing facilities to manage information) the MDS RN stated she and the MDS LVN spoke with the corporate consultant the previous night and developed a new process that morning to help (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identify new diagnoses and establish a referral system. She stated they had already reviewed 24-hour reports for new orders. The MDS RN stated they had a contracted Counseling Service that visited the facility monthly and residents were referred through social services. She stated the physician, nurse practitioner, and nursing staff make referrals to social services, who then submit referrals for psychological services. She stated moving forward, when the contracted Counseling Service visits the facility, an interdisciplinary conference would be completed that includes the DON and SW to discuss any changes and determine needed interventions. She stated any new diagnosis would require completion of Form 1012. The MDS RN stated prior to the process there had been no formal notification system in place. She stated failure to complete the proper PASRR assessments could result in residents missing specialized services.Review of the facility's policy titled, PASRR dated 1/20/2026 reflected: PurposeThe aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID), or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD. ProcedureThe PASRR Level 1 Screen (PL1) The facility Admissions Coordinator or designee will ensure the referring entity provides a copy of the PL1 upon admission. The MDS Coordinator or designee will input all other PL1s into the online portal on admission. This includes negative preadmission PL1s, and PL1s for residents who qualify for exempted or expedited status. In the event of a positive PL1 that indicates the individual may have ID/DD or MI;1. The MDS Coordinator, Social Worker, or designee will.a. Notify the LIDDA or LMHA/LBHA within 2 calendar days of admission to schedule the IDT and initiate the PE process.b. Monitor the Simple portal daily for the PEc. Will review the PE, print the form and place in the medical record.3. When it is determined that an individual's diagnosis was changed and/or a state surveyor determines the PL1 was incorrect, the social worker or designee will complete and submit a form 1012 (MI) or new PL1 (ID/DD). A subsequent positive PL1 will be entered according to 1012 findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675887	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bryan	2333 Manor Dr Bryan, TX 77802

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with a mental illness was completed correctly and were provided with a PASRR Level II assessment for one (Resident #7) of 8 residents reviewed for PASRR assessments.The facility failed to ensure the MDS RN entered Resident #7's PASRR Level I correctly into SimpleLTC portal (portal used by nursing facilities to manage resident's information) the PASRR entered did not indicate a diagnosis of mental illness, although diagnosis was present upon admission. This failure could place all residents who had a mental illness at risk for not receiving needed assessment, care, and services to meet their needs.Findings included: Record review of Resident #7's Annual MDS Assessment, dated 02/10/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was 05, indicative his cognitive skills were significantly impaired. His diagnoses included stroke, anxiety disorder (excessive, uncontrollable worry), and depression (feelings of sadness, loss of interest).Record review of Resident #7's PASRR Level 1 screening, completed 06/10/2024 by the SW of referring facility, reflected the resident had a mental illness. Record review of Resident #7's PASRR Level 1 screening entered by the facility's MDS RN on 6/10/2024 reflected the resident did not have a mental illness. In an interview on 04/28/26 at 10:31 AM, the MDS Coordinator said the resident had a negative PASRR Level 1 and it was not correct based on the resident's diagnosis. The MDS Coordinator said she missed the diagnosis and did not submit a new PASRR Level 1 screening. The MDS Coordinator said a negative PASRR Level 1 screening could cause residents to miss PASRR services.In an interview conducted 5/14/2026 at 9:49 AM, the DON stated the MDS nurses were responsible for PASRR referrals to the appropriate state-designated authority when a resident was identified with a mental health diagnosis. The DON stated the nursing department did monitor and make observations for new behaviors and they would notify the doctor of any changes and complete psychological referrals as needed. In an interview conducted 5/14/2026 at 1:40 PM, the MDS RN clarified the first PASRR Level 1 screening prepared by Resident #7's referring nursing facility was correct, if that resident had a mental health diagnosis. The MDS RN further stated it was her fault that the mental health diagnosis was not on the second copy of the PASSR Level 1 that she inputted into SimpleLTC. She stated she would complete form 1012 (used by the state nursing facilities to review residents with a negative PASRR Level 1 screening and determine if further evaluation for mental illness is needed) for Resident #7 on that day. The MDS RN stated a negative PASRR Level 1 screening could cause residents to miss PASRR services.Review of the facility's policy titled, PASRR dated 1/20/2026 reflected: PurposeThe aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID), or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD. ProcedureThe PASRR Level 1 Screen (PL1)The facility Admissions Coordinator or designee will ensure the referring entity provides a copy of the PL1 upon admission. The MDS Coordinator or designee will input all other PL1s into the online portal on admission. This includes negative preadmission PL1s, and PL1s for residents who qualify for exempted or expedited status. In the event of a positive PL1 that indicates the individual may have ID/DD or MI.2. The MDS Coordinator, Social Worker, or designee will.d. Notify the LIDDA or LMHA/LBHA within 2 calendar days of admission to schedule the IDT and initiate the PE process.2.When it is determined that a PL1 was filled out incorrectly, the MDS Coordinator, Social Worker or designee will reach out to the hospital/responsible case worker and ask them to correct the form. a. If the referring case worker is unwilling/unable to correct the PL1 that contains a potential error, the social worker or designee will complete and submit a form 1012 (MI) or new PL1 (ID/DD). A subsequent positive PL1 will be entered according to 1012 findings (MI).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews 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 for 1 of 17 (Resident #23) residents reviewed for medication administration. The facility failed to ensure staff did not leave medication with Resident #23 when there was not a self-administer assessment completed. This failure could place residents at risk of not accurately receiving their medications, which could cause a change in condition.Findings Included: Record review of Resident #23's face sheet dated 05/14/2026 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #23 had diagnoses which included seizures, difficulty in walking, anxiety (feeling of uneasiness or worry), major depressive disorder (mental health disorder characterized by persistent depressed mood), headaches, cancer, and hypertension (high blood pressure). Record review of Resident #23's admission MDS dated [DATE] revealed Resident #23 had a BIMS score of 13, which indicated intact cognitive response. The MDS indicated Resident #23 did not have any swallowing issues with medications. Record review of Resident #23's care plan dated 5/11/2026 revealed [Resident #23] was at risk for falls related to unsteady gait, history of falls, muscle weakness, cognitive impairment, medication side effects, poor vision, or incontinence. Staff will monitor [Resident #23] more closely, especially during high-risk times such as shift changes, night hours, or after medications. The care plan did not say Resident #23 could self-administer medications. Record review of Resident #23's assessments on 05/12/2026 revealed that Resident #23 did not have a self-administration assessment completed. Observation of Resident #23's room on 05/12/2026 at 8:34a.m., revealed that he had a medication cup with a white liquid in it, another medication cup with a green gel capsule in it and a prescription nasal spray. During an interview with Resident #23 on 05/12/2026 at 8:49a.m., he said staff did not always leave his medication with him. He said the facility told him that he could not self-administer his medication. He said the medication the nurse left was medication that he had to take right after he ate breakfast. He said the medication was medication he needed for his stomach he did not know the names of the medication. He said the medication was left at times when the nurse does not have time to come back and give him his medication on time. During an interview with the DON on 05/14/2026 at 10:14a.m., she said she had been trained on medication administration. She said the policy for medication administration was staff were not to leave medication with a resident. She said the nurse or the MA who was giving the medication was responsible for ensuring the resident took the medication. She said if the medication was left with the resident and the nurse did not watch the resident take the medication the resident could throw the medication away. She also added another resident could get ahold of the medication and take it. She said the DON monitored to ensure that staff were not leaving medication with the residents. She said the DON monitored through observations. She said she did not know why left the medication with Resident #23. During an interview with the ADM on 05/14/2026 at 11:41a.m., he said he had been trained on medication administration. He said the policy for medication administration was staff were to watch the resident take medication and not leave any medication with the resident. He said the nurse was responsible for ensuring medication was not left with the resident. He said if medication was left with a resident, the resident may not take the medication. He said the ADM and DON monitored to ensure staff were not leaving medication with residents. He said the ADM and the DON monitored through daily rounds. He said he did not know why left medication with Resident #23. An interview was attempted with LVN I on 05/14/2026 at 2:33p.m., via telephone was unsuccessful. An interview was attempted with LVN I on 05/14/2026 at 3:19p.m., via telephone was unsuccessful. Record review of Administering Medications Policy dated 04/2019 revealed Medications are administered in a safe and timely manner, and as prescribed. Residents' may (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 dining rooms reviewed for infection control. ˆ The facility failed to ensure CNA D washed and sanitized her hands between passing breakfast trays to the residents. The facility failed to ensure CNA E washed and sanitized her hands between passing breakfast trays to the residents. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: During an observation of dining services for breakfast meal services on 05/12/2026 at 7:44a.m., revealed CNA D and CNA E did not wash or sanitize their hands while passing meal trays to residents in the dining room. During an interview with the DON on 05/14/2026 at 10:02a.m., she said she had been trained on hand hygiene. She said the policy for hand hygiene during meal services was staff were to wash their hands before they started passing the meal trays. She also said staff were to sanitize their hands between each meal tray. She said anyone who was touching the meal trays should be washing and sanitizing their hands. She said if staff were not performing hand hygiene the staff could spread infection or cause someone to get sick. She said the nurse monitored to ensure staff were sanitizing their hands. She said the nurse monitored through observation. She said she did not know why CNA D and CNA E did not wash or sanitize their hands before or during meal tray pass. During an interview with CNA E on 05/14/2026 at 10:21a.m., she said she had been trained on hand hygiene. She said the policy for meal tray pass was staff were to sanitize their hands between each meal tray. She also added that if staff's hands were physically dirty the staff was to wash their hands with soap and water. She said anyone handing out the meal trays was responsible for sanitizing their hands. She said if staff did not perform hand hygiene, the staff could pass an infection that another resident may have to other residents. She said the nurses or management monitored to ensure staff were washing and sanitizing their hands. She said the nurses or management monitored by observation. She said she did not wash or sanitize her hands because she was just moving fast. During an interview with the ADM on 05/14/2026 at 11:34a.m., he said he had been trained on hand hygiene. He said his expectation was for staff to use an alcohol-based sanitizer between each meal tray. He said all staff who were assisting with passing trays must sanitize their hands. He said if staff did not perform hand hygiene between meal trays it could put the resident at risk of cross contamination. He said the department heads monitored to ensure staff were sanitizing hands between meal trays. He said the department heads monitored through observation. He said he did not know why CNA D and CNA E were not washing or sanitizing their hands between meal trays. During an interview with CNA D on 05/14/2026 at 3:55p.m., she said she had been trained on hand hygiene. She said the policy was that staff were to wash their hands between each meal tray and keep their hand sanitizer in their pocket. She said the CNAs were responsible for sanitizing their hands between each meal tray. She said if staff did not perform hand hygiene the residents could get an infection. She said the nurse monitored to ensure staff were washing and sanitizing their hands. She said the nurse monitored through observation. When asked why she did not wash or sanitize her hands before meal trays were passed or between each resident she said she got sanitizer from the nurse to sanitize her hands. Record review of Handwashing/Hand Hygiene Policy dated 01/2025 revealed This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.