STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675908	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante Rehabilitation Center	225 N Sowers Rd Irving, TX 75061

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months for review for 1 of 5 residents (Resident #6) reviewed for assessments. The facility failed to complete a quarterly assessment for Resident #1 every 3 months since [DATE]. This failure could place residents at risk for not getting an accurate assessment and could result in lack of care. Findings included:Record review of Resident #6's electronic health record MDS tab reflected Resident #6 received a quarterly assessment on [DATE] and had no reassessment as of [DATE]. Resident#6's re-admission assessment [DATE] reflected BIMS 12 and medical conditions included: Cerebral Palsy, Generalized Anxiety Disorder, and Major Depressive Disorder. In an interview on [DATE] at 12:09 pm, the DON stated the MDS nurse handled the MDS assessments, and the one in the system dated [DATE] for Resident #6 was the last one she saw in the system. She stated the MDS nurse was not in the office today, but she may be able to provide a more recent copy or update. She stated that she did not know the exact dates MDS assessments were due, but she expected them to be completed on time. She stated the MDS reports helped guide services the residents received.In an interview on [DATE] at 12:45 pm the MDS coordinator stated the MDS RUG had not expired, and the resident was on the list for reassessment in August. She confirmed the last MDS was completed on [DATE]. She stated that she believed the assessment was valid as the RUG was still open. She stated that they follow computer system to determine the dates for MDS reviews. She stated that she believed they had 180 days for this re-evaluation.Record review of the facility policy dated [DATE] titled MDS Completion and Submission Timeframes reflected: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.1. The Assessment Coordinator or designee shall be responsible for ensuring that resident assessments are submitted to _ [CMS database] system in accordance with current federal and state guidelines.2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it was free of a medication rate of five percent (5%) or greater. There were three medication errors observed out of 31 opportunities resulting in an 9% medication error rate. One (LVN B) of two staff observed made two errors during the medication pass for one (Resident #81) of two residents observed. 1. LVN B on 07/29/2025 administered Resident #81 MiraLAX Oral powder 17grm (for constipation) without the appropriate amount of fluid. 2. LVN B on 07/29/2025 failed to administer Advair HFA Inhalation Aerosol 115-21 mcg to Resident #81. 3. LVN B on 07/29/2025 failed to administer Isosorbide Mononitrate ER oral tablets 60mg to Resident #81. These failures could affect the residents, by placing them at risk for not receiving their therapeutic dosage medications as ordered by the physician and decreased health status. Findings included: Review of Resident #81's in progress admission assessment dated [DATE] revealed she was an[AGE] year-old-female admitted on [DATE] with diagnosis to include: Hypertension (increased blood pressure), constipation, blood clots, and generalized weakness. Review of Resident #81's current physician orders, dated 07/29/2025, revealed MiraLAX Oral Powder17gm give one packet by mouth daily with 4-6 ounces of fluid was ordered to be given every morning at 9:00 a.m., Advair HFA inhalation aerosol 115-21 mcg 2 puffs inhale orally was ordered to be given two times a day at 9:00 a.m. and 9:00 p.m., and Isosorbide Mononitrate ER oral tablet extended release 24 hour 60 mg give one tablet by mouth was ordered to be given two times a day at 9:00 a.m. and 9:00 p.m. Review of Resident #81's MAR dated 07/29/2025 revealed the MiraLAX oral powder 17 gm give one packet by mouth daily with 4-6 ounces of fluid was given at 9:00 a.m., Advair HFA inhalation aerosol 115-21 mcg 2 puffs inhale orally was not given at 9:00 a.m., and isosorbide mononitrate ER oral tablet extended release 24 hours 60 mg give one tablet was not given at 9:00 a.m. Observation on 07/29/2025 at 10:00 a.m. during a medication pass revealed LVN B administered Resident #81's MiraLAX Oral powder 17gm (for constipation) in an unmarked cup, without the appropriate amount of fluid (recommended 4- 8 ounces of fluid). Further observation during the medication pass revealed, LVN B failed to administer Advair HFA Inhalation Aerosol 115-21 mcg (for lung disease) to Resident #81 and failed to administer Isosorbide Mononitrate ER oral tablets 60mg (used to help with chest pain). Interview with LVN B on 07/29/2025 at 10:42 a.m. revealed Resident #81 was a new admit and the resident had admitted on the night shift the night before (07/28/2025). LVN B stated the night nurse had ordered the medications, but none of them had come in on the morning delivery from the pharmacy. LVN B stated she could administer most of the medications that had been ordered, by taking the meds out of the pharmacy provided stock machine, but these two medications (Advair and isosorbide) were not in the machine. The LVN stated she would follow-up with the physician and check with the pharmacy. The LVN stated she had told the resident during the morning medication pass. The LVN stated she had let the DON know about the lack of medications and how none of the medications had been delivered. Interview with the DON on 07/31/2025 at 10:30 a.m. revealed that the problem was with the pharmacy, when the facility had late admissions, the medications do not arrive timely. The DON stated she had spoken to the Administrator about this problem and possibly changing pharmacies, but nothing had been decided yet. The DON stated she had been working at the facility for two months. The DON stated her expectations of the nursing staff, concerning new admissions, was the nurses were to complete their own admissions, and order the medications from the pharmacy then the medications must be here in a timely manner so they can be given as ordered by the physician. The DON stated the nursing staff was to contact the physician and myself to inform them that the meds were unavailable. The nursing staff is to call the pharmacy to follow-up on the medications. The DON stated if the residents did not receive their meds as ordered, it could affect their physical conditions. Interview with the Administrator on 07/31/2025 at1:00 p.m. revealed he was unaware of any problems related to medication delivery and late (after 5pm) admissions. He stated he thought the pharmacy could be contacted for medications twenty-four hours a day. The Administrator stated the residents needed to have the meds the doctor had ordered for the treatment of their medical conditions. Review of the facility's policy and procedure titled Medication Administration Schedule dated December 2024 reflected, 1. Medications shall be administered according to the established schedules. 3. A physician ‘s order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 the facility's only kitchen reviewed for food safety. 1.The facility failed to ensure food items in the freezer were stored sealed and not exposed to air in accordance with the professional standards for food service.2. The facility failed to ensure food items in the refrigerators and freezer were labeled with the item description (handwritten or manufacturer's label), had the received by date, the opened date and/or the consume by or expiration by dates.These failures could place residents at risk for food-borne illness and cross contamination.Findings Include:Observation of the freezer in the rear of the kitchen by the sink on 07/29/2025 at 9:14 am revealed the following:- 4 large pizzas wrapped and sealed with no item description label or distinguishing date.- 5 bags with tater tots (shredded potatoes) sealed with no item description label or distinguishing date.- 4 bags with triangular hash browns (shredded potatoes) sealed with no item description label or distinguishing date.- 1 bag with triangular hash browns (shredded potatoes) with no item description label or distinguishing date, opened was exposed to air. - Left side of walk-in refrigerator, 3 shelves down from top, 4 hardboiled eggs in storage bag, sealed with no item description label, dated July 2025, the day of item was indistinguishable. In an interview with the Kitchen Supervisor on 07/29/2025 at 9:26 am, said the facility labels their frozen items with a label maker and sometimes the label falls off. In an interview with the Kitchen Supervisor on 07/31/2025 at 10:11 am, she said if a label falls off an item in the refrigerator or freezer, they would relabel the item with the date of an identical item currently stored in the refrigerator or freezer. In the event there is no identical item present, the item would be labeled with the date it was found to be without a label. In an interview with Kitchen Supervisor on 07/31/2025 at 10:11 am, she said the PM Kitchen Aide was responsible for labeling the items in dry storage, the AM Kitchen Aide was responsible for labeling the walk-in refrigerator, and the cook was responsible for labeling the items in the freezer. She stated she would do the labeling for all areas if other staff wasn't available, and whoever used the food or took it out was responsible for updating the label.In an interview with [NAME] A on 07/31/2025 at 10:25 am, she stated everybody labeled the food and they put the open date on the label.Record review of the facility's Food Storage Policy, dated December 2023, revealed, All food stored in the refrigerator or freezer will be covered, labeled, and dated (use by date).Review of the U.S. FDA Food Code 2022, Chapter 3 Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated.