STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Meadow Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 4343 Oak Grove Blvd San Angelo, TX 76904	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents (Resident #1) reviewed for pressure ulcer treatment.The facility failed to ensure Resident #1's wound care treatments were implemented according to physician orders and wound care recommendations.This failure could place residents at risk of delayed wound healing, increased risk of infection, and further skin breakdown.Findings included:During a record review of Resident #1's face sheet, dated 03/12/2026, revealed a [AGE] year-old female, admitted [DATE], with diagnoses of displaced fracture of lateral condyle of left femur, subsequent encounter for closed fracture with routine healing (follow up care after initial surgery of left hip fracture), type 2 diabetes (chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), pressure ulcer of left heel, unstageable (stage cannot be determined because the wound base is completely covered by dead or dying tissue).During a record review of Resident #1's admission MDS assessment, dated 02/17/2026, revealed BIMS score was 05 which indicated severe cognitive impairment. The MDS further revealed Section M, Skin Conditions, indicated Resident #1 had pressure ulcer upon admission/entry to the facility and was receiving pressure ulcer/injury care.During a record review of Resident #1's care plan, dated 03/11/2026, revealed a focus area indicating Resident #1 had a pressure injury to her left heel related to impaired mobility. Care planned interventions: included follow the facility's policies/protocols, monitor/document/report PRN any changes in skin status, weekly treatment documentation to include measurement width, length, depth, type of tissue and exudate(fluid that leaks out of blood vessels into nearby tissue). Care plan also revealed Resident #1 required maximum assistance to turn and reposition in bed, and maximum assistance for transfers.During a record review of Resident #1's Initial Wound Evaluation and Management Summary, dated 02/17/2026 completed by Wound NP, reflected the following Treatment Plan/Orders: Left heel pressure ulcer injury: 1.cleanse with soap and water, pat dry 2.apply betadine to base of the wound(the bottom layer of wound) 3.leave open to air 4.change daily.During a record review of Resident #1's eTAR for February 2026 revealed orders were put in the system and wound care was not provided until 02/18/26. There were no signatures on 2/21/2026, 2/25/2026, 2/26/2026 indicating wound care was completed. Record review revealed the eTAR did not indicate a wound care treatment order from 2/11/2026 through 2/17/2026.During a record review of Resident #1's Wound Evaluation and Management Summary, dated 3/3/2026, revealed an order change: Left heel pressure ulcer injury: 1. Cleanse with soap and water, pat dry 2.apply collagen hydrogel (three-dimensional structure formed by self-assembly or crosslinking of collagen fibrils which can serve as supportive matrix for tissue regeneration) 3. Secure with silicone bordered dressing 4. Change three times a week.During a record review of Resident #1's eTAR for March 2026, reviewed on 3/12/2026, revealed the order was not updated and the wound care order was still the existing one from 2/18/2026 to apply betadine and leave open to air.During a record review of Resident #1's Wound evaluation and Management Summary, dated 3/10/2026, revealed another order change: Left (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Meadow Creek	4343 Oak Grove Blvd San Angelo, TX 76904

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heel pressure ulcer: 1. Cleanse with soap and water, pat dry. 2. Apply honey hydrogel sheet dressing to base of the wound. 3. Secure with silicone bordered dressing. 4. Change 3 times per week.During a record review of Resident #1's eTAR for March 2026, reviewed on 3/12/2026, did not reflect an order change. During an observation on 3/12/2026 at 10:50 a.m., Resident #1 was lying in bed on her back. RN E entered Resident #1's room to perform treatment on her left heel. RN E explained the procedure to Resident #1 and stated the treatment order was to cleanse with soap and water, pat dry, apply betadine and leave open to air. RN E performed hand hygiene and applied gloves. RN E was observed pulling the covers back and Resident #1 had a soft heel protector on and RN E removed it. The wound had a loose bandage on it only attached on one side. There was brownish red colored drainage on the bandage. RN E discarded the bandage and performed hand hygiene and reapplied gloves. RN E then cleansed the wound, applied betadine, and left open to air with heel floating on heel protector. During an interview on 3/12/2026 at 11:10 a.m., RN E stated the DON updated the wound care orders in the computer after the Wound Nurse Practitioner visited. RN E stated she was unaware of the order changes. She stated she just followed the orders that were in the eTAR. RN E stated the Wound Nurse Practitioner would sometimes update the charge nurse if there were any negative findings. RN E stated wound care for Resident #1's pressure ulcer was normally done on night shift. RN E stated she was trained to do wound care and had competency done annually for wound care. RN E stated the risk of not following ordered wound care could be delayed healing. RN E stated Resident #1's wound had not worsened.During an interview on 3/12/2026 at 11:45 a.m., the DON stated the Wound Care Nurse Practitioner made rounds once a week, updated the Charge Nurses with findings, and emailed her (the DON) an updated report. The DON stated she was responsible for updating orders until a new ADON was hired. The DON stated the ADON was overseeing the wound program but there was no ADON currently. The DON stated she was not aware orders were not input into the system until 2/17/2026. The DON was not aware the order in the computer was not the most recent order or that it was changed. The DON stated the risk in not updating orders per NP recommendations could be delay in wound healing and infection. The DON stated, to her knowledge, the wound had not deteriorated or gotten worse. During an interview on 3/12/2026 at 3:12 p.m., the Wound Care Nurse Practitioner stated she noticed that the orders had not been updated to her most recent recommendation on 3/10/2026. The Wound Care NP stated she sent the DON an email and reported the updated wound care orders were not implemented. The Wound Care NP stated her expectations were for the facility to follow her wound care orders. She stated the risk of not following order changes could be deterioration in wound or infection. The NP stated she was not aware of any harm caused to Resident #1 by not following orders. She stated Resident #1's wound had not worsened. During an interview on 3/12/2026 at 3:30 p.m., the Corporate Regional Nurse stated it was the DON's responsibility to update the orders. She stated her expectation was the orders were updated 24-48 hours as a reasonable time frame. She stated she expected the DON to review orders and update them as needed. Corporate Regional Nurse stated training is done annually with every nurse. She stated this facility does not have a treatment nurse and charge nurses did all wound care. She stated the DON was responsible for updating the wound care orders. She stated a risk of not updating orders is delayed wound healing and infection.During an interview on 3/12/2026 at 3:45 p.m., the Administrator stated it was the DON's responsibility to update wound care physician orders because the reports were emailed to her. The Administrator stated the risk of not updating the orders could be delayed healing, infection, and deterioration. During a record review on 3/12/2026 at 4:00 p.m. of the facility's current policy, dated October 2010, titled Wound Care, revealed, Preparation1.Verify that there is a physician's order for this procedure2.Review residents care plan to assess any special needs of the resident.Steps in Procedure12.Apply treatments as indicatedDocumentationThe following information should be recorded in the residents' medical record:1.The date the wound care was given2. The initials of the individual performing wound care.6.The signature and the title of the person recording the data.Reporting2. Report other information in accordance with facility policy and professional standards of practice.