

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2025
NAME OF PROVIDER OR SUPPLIER Avir at Kingsland		STREET ADDRESS, CITY, STATE, ZIP CODE 3727 W Ranch Rd 1431 Kingsland, TX 78639	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility failed in notifying Resident #1's physician right away when the resident had a significant change in condition. Resident #1 had was bleeding from skin tears on 09/13/25.) This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. Findings included:Record review of Resident #1's face sheet dated 10/08/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included shortness of breath, Alzheimer's disease, muscle weakness, chronic pain, hypertension and other abnormalities of gait and mobility. Record review of Resident #1's quarterly MDS dated [DATE] revealed that a BIMS interview could not be conducted as she rarely/never understood the interview questions. Record review of Resident #1's Care Plan dated 06/08/25 revealed Resident #1 had potential for impaired skin integrity and was at risk of bleeding. The relevant intervention was evaluating skin for integrity and impaired coagulation (Bruising, petechia (pinpoint red spots on skin from bleeding from capillaries) , bleeding from orifices) Record review of Resident #1's MAR of September 25 revealed Resident#1 was not blood thinners. Record review of the wound assessment profile revealed substantial improvement in healing. The dimensions of the wound during the assessment on 09/15/25 was 4cm L x 0.5cms W x 0.1cm D and on 10/06/25 it was 0.9cm L x 0.4cm W x UTD A phone call made to LVN A on 10/08/25 at 11:20am and left to VM to call back. No return call was received as on 10/08/25 at 5:00pm.During an interview on 10/08/25 at 12:30pm the RP stated she visited Resident #1 almost every day. She said Resident #1 was on prednisone (An anti-inflammatory drug) for a very long time and due to that she had very vulnerable skin (as side effect of prednisone medication) with bilateral edema (swelling on both legs). The RP said Resident #1's skin was prone to skin tears very easily . The RP reported on 09/13/25 early in the morning CNAs who took care of Resident #1 noticed she was bleeding from newly developed skin tears on her left leg. The RP said CNA B who noticed the bleeding threw a towel on the wound to stop the bleeding and reported to LVN A however she did not do any interventions and let Resident #1 bleed until a nurse from the next shift came and fixed it. She said LVN A left the facility without even look at Resident#1 to see what was going on. The RP stated Resident #1's condition is stable currently and there was no further complication from the wound and bleeding. During an observation on 10/08/25 at 1:15pm she was in her room in her wheelchair napping. She appeared calm and relaxed without any distress. The wound was covered by dressing. She could not answer any of the interview questions and responded with unrelated answers.During a phone interview on 10/08/25 at 1:33pm CNA B stated she was the night CNA who worked on the night shift on 09/12/25 and finished the next day at 7:00am. CNA B stated, on 09/13/25 at about 5:10am she and CNA E were changing Resident #1 and getting her for the day. She said, while separating Resident #1's crossed legs, a skin tear occurred on (continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>her right lower leg from rubbing her left leg on the other leg, as her skin was sensitive even to mild pressure. CNA B stated Resident #1 was bleeding from the skin tears. She said as the bleeding was not stopping, she reported immediately to LVN A who was in the same hall administering medications. CNA B reported that LVN A told her that she was busy with administering medications and would go and assess Resident #1 once she completed administering medications to the residents in the hall. CNA B said she returned to Resident #1 and wrapped a towel around the wound to minimize further damage until LVN A's visit and intervention. CNA B stated she clocked out at about 7:20am and went home thinking Resident #1's bleeding was taken care of by LVN A. She said, at around noon she received a phone call at her home from LVN A asking her how severe Resident #1's wound was and stated she got busy with administering medications and had forgotten to take care of Resident #1's bleeding. CNA B stated on 09/15/25 she attended Inservice on abuse and neglect, reporting to the oncoming nursing team and competent nursing. A phone call made to RN C on 10/08/25 at 2:05pm and left a VM to call back and she returned the call on 10/10/25 at 11:06am. RN C stated on 09/13/25 she worked in the day shift. She said, at about 7:20am CNA D reported to her that Resident #1 was bleeding profusely in her bed. RN C stated she rushed to Resident #1's room to take care of her bleeding. RN C stated on arrival she noticed Resident #1 was bleeding heavily from 3 skin tears on her right lower leg from knee to ankle and the bed sheet was visibly wet with blood. RN C stated she had to change 3 bandages that were saturated with blood and eventually managed to contain the bleeding. RN C stated Resident #1 lost copious amount of blood from the bleeding. She said, neither she nor CNA D received any handover in the morning from the previous shift regarding Resident #1. RN C stated CNA D found out about the bleeding when she entered Resident #1's room for the routine check at the beginning of the shift. RN C stated Resident #1 was a fragile person and had a very sensitive vulnerable skin that could be easily torn with minor stresses on the skin. She stated Resident #1 was on her observation the whole day and her vitals were within normal range. RN C stated she attended an in-service related to the incident , few days after the incident and could not remember exactly what day it was. A phone call made to CNA E on 10/08/25 at 2:15pm and left a VM to call back. She returned the call on 10/10/25 at 3: 13pm. CNA E stated, on 09/13/25 early in the morning, she was helping CNA B in changing Resident #1. She stated since Resident #1 had contracted legs it was very difficult to change her. She stated in the process of separating her legs she had seen Resident#1 bleeding profusely from her right leg. CNA E said, CNA B rushed out of the room to report it to LVN A. She stated they wrapped a towel around Resident #1's leg to put some pressure on to stop the bleeding. She stated the bleeding was pretty bad and non-stopping. Since she was on duty in another hall and had other tasks to accomplish with her residents in her hall, she left Resident #1 with CNA B. When investigator asked about in services she attended, CNA B stated at the facility there were in services at least once a week. She stated she attended an in-service of reporting abuse and neglect and importance of reporting concerns related to residents in handover meetings. A phone call was made to CNA D on 10/08/25 at 1:50 pm and left a voice message to call back. No return call was received from CNA D, prior to the investigation exit. During an interview on 09/08/25 at 12:45pm the DON stated LVN A did not assess Resident #1 and perform interventions to stop the bleeding in a timely manner. She stated loss of excessive blood is a threat to Resident #1's life. She said RN C did the wound care to stop the bleeding at 7:20am immediately after she commenced her shift. The DON stated Resident #1 was under observation and her wound was assessed many times that day to ensure her safety. The DON stated LVN A and other staff were in- serviced regarding the importance of triaging nursing care and reporting issues that needed continuity of care, during handover at shift changes. The DON stated staff were observed and reviewed by the DON and ADON daily and issues if any were discussed during the daily staff meeting. During an interview on 09/08/25 at 12:30pm the ADM stated, on 09/13/25 in the afternoon the RP of Resident #1 met him at his office. He stated the RP was visibly upset and complained about the competency of LVN A . The ADM stated , the RP told him to terminate LVN A and demanded a drug test on her as she did nothing to stop Resident #1 from (continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>bleeding. The ADM stated LVN A did not do her job correctly. He said though she was busy with administering medications she should have triaged and prioritized assessing Resident #1 when CNA B reported to her about skin tears and bleeding. He stated he did a facility investigation on the incident . The ADM said, though LVN A had not done her job in a timely manner , Resident #1 was taken care of by RN C immediately after she commenced her shift and subsequent follow up throughout the day. When the investigator pointed out that although RN C attended to Resident#1 at 7:20am , Resident #1 was left unattended bleeding for about two hours until 7:20am, the ADM responded that LVN A should not have allowed that happened. He stated LVN A and other nurses received an in-service on preventing , recognizing and reporting abuse and neglect and expectations of reporting during shift changes. The ADM stated he included an employee disciplinary report in LVN A's file as well. The ADM stated they have an annual performance evaluation program for all the employees, in placeRecord review of facility in service revealed on 09/15/25 an in service conducted on the shift to shift report must be given to oncoming staff. Nurses and CNAs must be given a detailed report after every shift.' Record review of the in services revealed about 20 staff members attended the in service that was conducted on 9/15/25. Record review of facility policy staffing, sufficient and competent Nursing revised in August 2022 reflected: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents with resident care plans and the facility assessment.Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas:a. Resident Rights .m. Identification of changes in condition .Licensed nurse and nursing assistance are trained and must demonstrate competency in identifying, documenting, reporting resident changes of condition consistent with their scope of practice and responsibilities .</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice for 1 of 2 nurses (LVN A) reviewed for nursing services. The facility failed to ensure LVN A assessed and performed necessary interventions to stop Resident #1 from bleeding from skin tears on 09/13/25. This failure could place residents with wounds at risk for bleeding related complications. Findings included: Record review of Resident #1's face sheet dated 10/08/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included shortness of breath, Alzheimer's disease, muscle weakness, chronic pain, hypertension and other abnormalities of gait and mobility. Record review of Resident #1's quarterly MDS dated [DATE] revealed that a BIMS interview could not be conducted as she rarely/never understood the interview questions. Record review of Resident #1's Care Plan dated 06/08/25 revealed Resident #1 had potential for impaired skin integrity and was at risk of bleeding. The relevant intervention was evaluating skin for integrity and impaired coagulation (Bruising, petechia (pinpoint red spots on skin from bleeding from capillaries) , bleeding from orifices) Record review of Resident #1's MAR of September 25 revealed Resident #1 was not blood thinners. Record review of physician's order reflected: Skin Tear to Right Distal Lower Leg: Cleanse with wound cleanser, dry, apply Xeroform, ABD pad, and wrap with Kerlix daily and PRN. Everyday shift. Record review of the wound assessment profile revealed substantial improvement in healing. The dimensions of the wound during the assessment on 09/15/25 was 4cm L x 0.5cms W x 0.1cm D and on 10/06/25 it was 0.9cm L x 0.4cm W x UTD A phone call made to LVN A on 10/08/25 at 11:20am and left to VM to call back. No return call was received as on 10/08/25 at 5:00pm. During an interview on 10/08/25 at 12:30pm the RP stated she visited Resident #1 almost every day. She said Resident #1 was on prednisone (An anti-inflammatory drug) for a very long time and due to that she had very vulnerable skin (as side effect of prednisone medication) with bilateral edema (swelling on both legs). The RP said Resident #1's skin was prone to skin tears very easily . The RP reported on 09/13/25 early in the morning CNAs who took care of Resident #1 noticed she was bleeding from newly developed skin tears on her left leg. The RP said CNA B who noticed the bleeding threw a towel on the wound to stop the bleeding and reported to LVN A however she did not do any interventions and let Resident #1 bleed until a nurse from the next shift came and fixed it. She said LVN A left the facility without even look at Resident #1 to see what was going on. The RP stated Resident #1's condition is stable currently and there was no further complication from the wound and bleeding. During an observation on 10/08/25 at 1:15pm she was in her room in her wheelchair and napping. She appeared calm and relaxed without any distress. The wound was covered by dressing. She could not answer any of the interview questions and responded with unrelated answers. During a phone interview on 10/08/25 at 1:33pm CNA B stated she was the night CNA who worked on the night shift on 09/12/25 and finished the next day at 7:00am. CNA B stated, on 09/13/25 at about 5:10am she and CNA E were changing Resident #1 and getting her for the day. She said, while separating Resident #1's crossed legs, a skin tear occurred on her right lower leg from rubbing her left leg on the other leg, as her skin was sensitive even to mild pressure. CNA B stated Resident #1 was bleeding from the skin tears. She said as the bleeding was not stopping, she reported immediately to LVN A who was in the same hall administering medications. CNA B reported that LVN A told her that she was busy with administering medications and would go and assess Resident #1 once she completed administering medications to the residents in the hall. CNA B said she returned to Resident #1 and wrapped a towel around the wound to minimize further damage until LVN A's visit and intervention. CNA B stated she clocked out at about 7:20am and went home thinking Resident #1's bleeding was taken care of by LVN A. She said, at around noon she received a phone call at her home from LVN A asking her how severe Resident #1's wound was and stated she got busy with administering medications and had forgotten (continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>to take care of Resident #1's bleeding. CNA B stated on 09/15/25 she attended Inservice on abuse and neglect, reporting to the oncoming nursing team and competent nursing. A phone call made to CNA E on 10/08/25 at 2:15pm and left a VM to call back. She returned the call on 10/10/25 at 3: 13pm. CNA E stated, on 09/13/25 early in the morning, she was helping CNA B in changing Resident #1. She stated since Resident #1 had contracted legs it was very difficult to change her. She stated in the process of separating her legs she had seen Resident#1 bleeding from her right leg. CNA E said, CNA B rushed out of the room to report it to LVN A. She stated they wrapped a towel around Resident #1's leg to put some pressure on to stop the bleeding. She stated the bleeding was pretty bad and non-stopping. Since she was on duty in another hall and had other tasks to accomplish with her residents in her hall, she left Resident #1 with CNA B. When investigator asked about in services she attended, CNA B stated at the facility there were in services at least once a week. She stated she attended an in-service of reporting abuse and neglect, and importance of reporting concerns related to residents in handover meetings. A phone call was made to CNA D on 10/08/25 at 1:50 pm and left a voice message to call back. No return call was received from CNA D, prior to the investigation exit. A phone call made to RN C on 10/08/25 at 2:05pm and left a VM to call back and she returned the call on 10/10/25 at 11:06am. RN C stated on 09/13/25 she worked in the day shift. She said, at about 7:20am CNA D reported to her that Resident #1 was bleeding in her bed. RN C stated she rushed to Resident #1's room to take care of her bleeding. RN C stated on arrival she noticed Resident #1 was bleeding heavily from 3 skin tears on her right lower leg from knee to ankle and the bed sheet was visibly wet with blood. RN C stated she had to change 3 bandages that were saturated with blood and eventually managed to contain the bleeding. RN C stated Resident #1 lost copious amount of blood from the bleeding. She said, neither she nor CNA D received any handover in the morning from the previous shift regarding Resident #1. RN C stated CNA D found out about the bleeding when she entered Resident #1's room for the routine check at the beginning of the shift. RN C stated Resident #1 was a fragile person and had a very sensitive vulnerable skin that could be easily torn with minor stresses on the skin. She stated Resident #1 was on her observation the whole day and her vitals were within normal range. RN C stated she contacted MD and received an order for wound care. She stated attended an Inservice related to the incident a few days after the incident and could not remember exactly what day it was. During an interview on 10/08/25 at 2:30pm the WN stated she was not working on the day the incident occurred however she had done the wound care when she was back at work on Monday. She said the wound doctor who visited on that day had assessed Resident #1 and made no changes to the existing treatment plan as he found the wound was not significant enough to have a change in the treatment plan. During an interview on 09/08/25 at 12:45pm the DON stated LVN A did not assess Resident #1 and perform interventions to stop the bleeding in a timely manner. She stated loss of excessive blood is a threat to Resident #1's life. She said RN C did the wound care to stop the bleeding at 7:20am immediately after she commenced her shift. The DON stated Resident #1 was under observation and her wound was assessed many times that day to ensure her safety. The DON stated LVN A and other staff were in- serviced regarding the importance of triaging nursing care and reporting issues that needed continuity of care, during handover at shift changes. The DON stated staff were observed and reviewed by the DON and ADON daily and issues if any were discussed during the daily staff meeting. During an interview on 09/08/25 at 12:30pm the ADM stated, on 09/13/25 in the afternoon the RP of Resident #1 met him at his office. He stated the RP was visibly upset and complained about the competency of LVN A . The ADM stated, the RP told him to terminate LVN A and demanded a drug test on her as she did nothing to stop Resident #1 from bleeding. The ADM stated LVN A did not do her job correctly. He said though she was busy with administering medications she should have triaged and prioritized assessing Resident #1 when CNA B reported to her about skin tears and bleeding. He stated he did a facility investigation on the incident. The ADM said, though LVN A had not done her job in a timely manner, Resident #1 was taken care of by RN C immediately after she commenced her shift and subsequent (continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>follow up throughout the day. When the investigator pointed out that although RN C attended to Resident#1 at 7:20am, Resident #1 was left unattended bleeding for about two hours until 7:20am, the ADM responded that LVN A should not have allowed that happened. He stated LVN A and other nurses received an in-service on preventing, recognizing and reporting abuse and neglect and expectations of reporting during shift changes. The ADM stated he included an employee disciplinary report in LVN A's file as well. The ADM stated they have an annual performance evaluation program for all the employees, in place Record review of facility in service revealed on 09/15/25 an in service conducted on the shift to shift report must be given to oncoming staff. Nurses and CNAs must be given a detailed report after every shift'. Record review of the in services revealed about 20 staff members attended the in service that was conducted on 9/15/25. Record review of facility policy staffing, sufficient and competent Nursing revised in August 2022 reflected: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents with resident care plans and the facility assessment. 1. Competency is a measurable pattern of knowledge and skills abilities , behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully . 2. All nursing staff must meet specific competency requirements of their respective licensure ad certification requirements defined by state law. 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) following areas: .Resident rights, person centered care, communication, Basic nursing skills, medication management, infection control , Skin, and wound care.Licensed nurse and nursing assistance are trained and must demonstrate competency in identifying, documenting, reporting resident changes of condition consistent with their scope of practice and responsibilities .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed make sure that drugs are stored properly and only authorized persons have access for 2 of 3 medication carts (MC #1, and TC #2) reviewed for drug storage and labeling. The facility failed to ensure MC #1, and TC #2 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: During an observation on 11/10/2025 at 8:03a.m., revealed MC #1, was near the nurses' station, and unlocked. There were no nurses around MC #1. MC #1 contained residents' prescription drugs, over the counter medications, and narcotics in a locked box in the medication cart. During an observation on 11/10/2025 at 8:10a.m., revealed TC #2, was near the nurses' station and unlocked. No staff were in sight of TC #2. TC #2 had residents' prescription creams in the top drawer. During an interview with LVN A on 11/10/2025 at 10:53a.m., revealed that he had been trained on medication storage. He said the policy for the medication carts was the medication cart must always be locked when not around it. He said whoever is on the medication cart was responsible for ensuring the cart was locked, when not using the medication cart. He said if the medication cart was left unlocked and unattended someone or a resident could get into the cart. He said all staff monitored to ensure the medication carts were locked. He said staff monitored the medication carts by observations. He said he had to go into the medication room to get some medications and did not lock the cart. He said he should have locked the medication cart when he walked away. During an interview with TN on 11/10/2025 at 11:02a.m., revealed she had been trained on medication storage. She said the policy for the medication carts was the medication cart was to be locked any time staff were away from it. She said the nurses and other staff walking by were responsible for ensuring the medication carts were locked. She said the medication carts were to be locked at all times when not in use. She said if a medication cart was left unlocked and unattended a resident could get into the medication cart and take medications they are not supposed to have. She said nurses and all administrative staff monitored to ensure staff were locking the medication carts. She said the nurses and administrative staff monitored by observations. She said she did not know why the treatment cart was unlocked. She said she had not been to the cart by the time the surveyor saw it was unlocked. She said she did not know who used the cart last or who left the cart unlocked. During an interview with the DON on 11/10/2025 at 2:38p.m., revealed she had been trained on medication storage. She said the policy for the medication cart was that it needed to be locked and only nurses and medication aides were to have access to it. She also said if the cart is not within the nurses' eyesight it should be locked. She said if the medication was left unlocked and unattended someone who was not authorized to be in the medication cart could take something out. She said leadership monitors to ensure staff are locking the medication carts. She said when leadership sees a medication cart unlocked when they go by the cart leadership will tell the nurse or medication aid to lock the medication cart. She said she did not know why the medication cart and the treatment cart were unlocked. During an interview with the ADM on 11/10/2025 at 2:44p.m., revealed that he had not been formally trained on medication storage. He said from experience he knew the medication storage policy was the medication cart had to be locked. He said the medication cart should be locked when the nurse or treatment nurse and medication aide was not actively using the cart. He said if the medication cart was left unlocked or unattended someone could take something from the cart that someone should not have. He said that the administrative team and peer to peer monitored to ensure the carts are locked. He said the administrative staff monitor through observation. Said that he did not have a good explanation as to why the medication cart and treatment cart were unlocked. Record review of Medication Labeling and Storage Policy dated 2/2023, revealed (continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 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.</p>		