STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676035	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kingsland	3727 W Ranch Rd 1431 Kingsland, TX 78639

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 10 of (10/05/25, 10/15/25, 10/18/25, 10/19/25, 10/23/25, 11/01/25, 11/06/25, 11/16/25, 12/27/25 and 12/28/25) of 15 days reviewed for RN coverage.The facility failed to ensure they had an RN coverage for the facility on 10/05/25, 10/15/25, 10/18/25, 10/19/25, 10/23/25, 11/01/25, 11/06/25, 11/16/25, 12/27/25 and 12/28/25.This failure could place residents at risk of missed nursing assessments, interventions, care and treatment. Findings included:Review of daily HR total employee hours report (lists total clocked in hours worked daily by staff across all departments) provided by the ADM for the following dates: 10/05/25, 10/15/25, 10/18/25, 10/19/25, 10/23/25, 11/01/25, 11/06/25, 11/16/25, 12/27/25 and 12/28/25 reflected zero RN hours were registered as worked. During an interview on 05/28/26 at 01:24 PM with the DON, she stated she was not the DON during the infraction dates found with no RN coverage and could not speak as to why there was no RN coverage since she started her time at the facility February of 2026. She stated the facility was required to have 8 consecutive hours every day 7 days a week of RN coverage and that being without an RN is unacceptable for her. The DON stated that having an RN in the facility gave an extra layer of professionalism and resident care. During an interview on 05/28/26 at 02:49 PM with the ADM, he stated he did not know why there were no RN hours on the reports for the infraction dates 10/05/25, 10/15/25, 10/18/25, 10/19/25, 10/23/25, 11/01/25, 11/06/25, 11/16/25, 12/27/25 or 12/28/25 since he only started as administrator March of 2026. He stated it was the expectation that they would have the minimum 8 RN hours required daily. He stated it was ultimately the responsibility of the administrator to ensure staffing coverage. He stated a potential negative outcome of not having daily RN hours would be not having the clinical oversight that you need. He stated he attempted to look for anything that indicated an RN worked on those dates but could not find documentation that indicated an RN was in the facility for the 8 hours required. The ADM stated there was not a facility policy specific to RN hours, but that they follow state and federal guidelines.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure each resident was provided and received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 kitchen reviewed for palatable food. 1. The facility failed to provide meal services in a manner to ensure palatable food served was appetizing to residents.2. The facility failed to provide palatable food served at an appetizing temperature or taste to Residents #7, #13, and #28.These failures could place residents at risk of weight loss, altered nutritional status, and diminished quality of life. Findings include:During an interview on 5/26/26 at 8:30 a.m., Resident #7 said the food at the facility was not good. She stated that she rarely eats the food in the facility because it isn't good. She stated that she had to get the backup meal, which is mainly salads. She stated that she has reported the food being a problem. During an interview on 5/26/26 at 8:35 a.m., Resident #13 said the food at the facility was not good. She stated that he rarely ate the food in the facility because it was not good. She stated that she would have to get the backup meal, which was mainly salads.During an interview on 5/26/26 at 10:05 a.m., Resident #28 said he liked living in the facility. He stated that he got the same food over and over again. He stated that there were times when the food was unappealing. He stated that he ate the food anyway, because he did not want to eat the sandwich. He stated that often the food did not taste good.An observation on 05/27/2026 12:50 PM lunch tray revealed it was served to the residents on 5-27-2026. The lunch consisted of black beans, corn, carnitas, and a tortilla. The carnitas did not look appealing and appeared to have been boiled. The Carnitas had little flavor and tasted like it was boiled. During an interview on 05/28/2026 at 11:15 AM, CK A stated that she had cooked the food that was given to her. She was shown a picture of the food that had been cooked on 5/27/2026. She stated that the food was carnitas. She stated that she had not been working the day that food was cooked. She stated that the food cooked on 5/27/2026 did not look appealing and she would not have eaten it. She stated that residents could have lost weight if they did not eat the food. During an interview on 05/28/2026 11:15 AM, with the ADM, a picture of the food that was prepared for residents on 5/27/2026 was shown to him. He stated that the food did not look good. He stated that he would not eat that food unless someone made him. He stated that they were in the process of getting a different food provider. He stated that unappealing food could lead to weight loss. On 5-28-2026 at 2:30 PM ADM stated there was no policy for food palatability.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the 1 of 1 kitchen reviewed. 1.The facility failed to label and date food correctly. 2.The facility failed to staff properly sanitized their hands while passing out trays during food service on 5-26-2026. 3.The facility failed to maintain a clean kitchen, 4.The facility sanitizes the thermometer while taking the temperatures of food. These failures could place residents at risk for foodborne illness. Findings included:An observation on 05/26/2026 at 6:48 AM of Refrigerator #1 revealed the following: Juice in a single serve cup was not labeled with the name or date on the tray. Jello in a clear container that was dated 5-25 with no use by date. Ketchup with an open date of 4-20 and no use by date. Cheese in a zip lock bag with no open date and no use by date. Pudding in a single serve container on a tray that was not dated. Single Serve sugar, mayo, tarter, and tater sauce that was in a bin and not labeled with any dates. An observation on 05/26/2026 at 6:53 AM of the kitchen revealed the following: The storage shelf that contained food trays had food debris on the shelf. Onion in a clear container was dated 5-20-2026 had no use by date. A bin container with serving utensils had food debris in the bottom of the container. A tray of coffee mugs had food debris on the tray. During an observation on 05/26/2026 at 7:50 AM, CNA B and RN G were passing out breakfast trays in dining room [ROOM NUMBER] on the secured 400 hall. While CNAs B and RN G they did not sanitize their hands. During an observation on 05/26/2026 at 11:45 AM with CK A, she rinsed the thermometer off with water and used it to take the temperatures of other foods. She would rinse the thermometer in water, wipe it with her glove, and then take the food's temperature. She would push the thermometer all the way into the food, leaving the top that was not cleaned in the food. She wore the same gloves throughout the temp process, and while taking the food's temperature, the gloves touched the food. During an interview on 05/27/2026 at 10:41 AM with CK A, she stated that she was supposed to change gloves when she started another task and returned to take the temperature of a different food item. She stated that each time she took the temperature of a food item, she was supposed to use an alcohol pad and clean the thermometer, then take the temperature of another food item. She stated that she was not supposed to use water to clean the thermometer. She stated that she had gotten in a hurry and did not have an alcohol pad close to her. She stated that she should not have cleaned the thermometer with water. She stated that the gloves should not have been in contact with food after performing other tasks in the kitchen. She stated that doing these things could have contaminated the food and that residents could have gotten sick. During an interview on 05/28/2026 at 11:15 AM with DA C, she stated that it was everyone's responsibility to label and date food in the kitchen. She stated that it is everyone's responsibility to clean the kitchen. She stated that if these things are not done, the residents could get sick. She stated that she had in-service training on labeling, dating, and cleaning the kitchen. She stated they get training every month. During an interview on 05/28/2026 at 11:23 AM with DA D, she stated that it was everyone's responsibility to label and date food in the kitchen. She stated that it was everyone's responsibility to clean the kitchen. She stated that if these things were not done, then residents could have gotten sick. She stated that she had had in-service training on labeling, dating, and cleaning the kitchen. She stated they received training every month. An interview on 05/28/2026 11:23 AM CK A. She stated that it was everyone's responsibility to label and date food in the kitchen. She stated that it is everyone's responsibility to clean the kitchen. She stated that if these things are not done, then residents could get sick. She stated that she has had in-service training on labeling, dating, and cleaning the kitchen. She stated they get training every month. An interview on 05/28/2026 11:23 AM the DM. She stated that when taking food temperatures, a clean thermometer should be used between food measurements. She stated that all staff were responsible (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for labeling and dating all food in the kitchen. She stated that she checks dates weekly. She stated that residents could get sick and spread gems. The DM stated that everyone should be cleaning the kitchen. She stated that she goes over this daily and weekly. Inservice not long ago on all the above. During an interview on 05/28/2026 at 4:05 PM with the DON, she stated that all staff were expected to knock on the door when entering the room. She stated that she had not seen any staff not knocking on residents' doors. She stated that if she saw staff not knocking on the door, then she would correct them. She stated it was a privacy and dignity issue for the residents when staff did not knock on residents' doors. She stated that if a staff member did not knock, a resident could have been getting care. She stated that staff were expected to sanitize their hands in between passing trays to each resident. She stated that when this was not done, it was an infection control issue. She stated that she had not seen any staff not sanitizing their hands in between residents. She stated if she saw staff not doing that, she would have stopped them and reminded them to do it. She stated that she would have had staff retrained on infection control.An Interview on 05/28/2026 4:20 PM with the ADM. The ADM stated that staff were expected to regularly check for dates in the kitchen, and ensure there is no out-of-date food. She stated that all staff are expected to sanitize their hands in between each resident when passing out to residents. She stated all staff were supposed to be cleaning the kitchen. She stated that if these are not followed, residents could get sick, Record review of the facility's Food and Storage policy updated December 2021 reflected, Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded.All food preparation items should be sanitized before use. Kitchen should be cleaned regularly.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 2 of 3 Residents (Resident #2 and Resident #1) reviewed for pharmacy services.1.The facility failed to obtain a current active consent regarding the risks and benefits of the medications prior to administration of the medication from Resident #2's family representative for the use of Quetiapine Fumarate (antipsychotic) used for agitation/anxiety related to dementia, Depakote ER (extended release) antiepileptic/ antimanic, Buspirone (anti-anxiety), Paroxetine (antidepressant), and donepezil (used for dementia) and failed to have an active diagnosis of anxiety and depression to correspond with medications prescribed from November 2025 through May 2026.2.The facility failed to have a consent regarding the risks and benefits of the medications prior to administration of the medication on file for the administration of Quetiapine Fumarate and failed to have a corresponding diagnosis of insomnia or depression for Resident #1. These deficient practices could affect residents who received medications for mood disorders and could contribute to the use of unnecessary medications.The findings were:Review of Resident #2's face sheet dated 05/28/26 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia-severe-with psychotic disturbance, dementia in other diseases classified elsewhere- mild- without behavioral disturbance-psychotic disturbance- mood disturbance and anxiety, and need for assistance with personal care. There was no active diagnosis information for depression or anxiety. Review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 03 indicating severe cognitive impairment. Active diagnosis reflected non-Alzheimer's dementia. Psychiatric/ mood disorders were NOT listed as an active diagnosis, this included anxiety, depression, and psychotic disorders (other than schizophrenia). The MDS reflected Resident #2 was actively taking an antipsychotic, antianxiety, antidepressant, and anticonvulsant. Review of Resident #2's care plan last revised 05/13/26 reflected there was no focus for the use of any antipsychotic/ antidepressant/ antianxiety medications with any interventions. Review of Resident #2's physician orders reflected the following active medications: -Quetiapine Fumarate oral tablet 50MG; one table by mouth at bedtime for agitation/ anxiety with an order start date of 04/09/26. This is a recent increase from Quetiapine Fumarate oral tablet 25MG order start date 11/13/25 and ending 04/09/26. -Buspirone HCl oral tablet 10MG; give one tablet by mouth in the afternoon for anxiety with an order start date of 04/25/26. -Depakote ER (extended release) oral tablet extended release 24 hours 250 MG; give 1 tablet by mouth at bedtime related to dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with an order start date of 01/23/26. -Paroxetine HCl oral tablet 20MG; give 1 tablet by mouth at bedtime related to dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with an order start date of 01/23/26.-Donepezil HCl oral tablet 5MG; give 2 tablets by mouth at bedtime related to dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with a start date of 01/21/26. Review of resident #2's MAR reflected medications being provided as prescribed from order start date (listed above) through review end date of 05/28/26 (medications reviewed from November 2025 through May 2026). Review of Resident #2's consents on 05/28/26 reflected: -Consent signed on 11/18/25 by NP H (prescriber) for Seroquel (Quetiapine Fumarate) 25MG at bedtime, NP H indicated Pt doesn't have the psychiatric condition required for medication. She has dementia with no behavioral problems. It was signed by NP H without further signatures by Resident #2 or family. There were no other consents for the use of Seroquel (Quetiapine Fumarate) 25MG or (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seroquel (Quetiapine Fumarate) 50MG prescribed and provided to Resident #2. -A consent was observed effective 12/05/25 for Buspirone being used to treat anxiety; the proposed course of the medication for which the consent was obtained was 3 months. There was no other consent that was active for the current prescribed order of Buspirone HCl oral tablet 10MG still being administered effective after the prior 3-month consent ended. -A consent was observed effective 02/17/26 for Paroxetine being used to treat depression; the proposed course of the medication for which the consent was obtained was 1 month - There was no other consent that was active for the current prescribed order of Paroxetine HCl oral tablet 20MG still being administered effective after the prior 1-month consent ended. -A consent was observed effective 02/17/26 for Depakote being used to treat marked other with no listed condition to be treated listed. The proposed course of the medication for which the consent was obtained was 1 month- There was no other consent that was active for the current prescribed order of Depakote ER (extended release) oral tablet extended release 24 hours 250 MG still being administered effective after the prior 1-month consent ended. -There was no consent at all for the use of Donepezil HCl oral tablet 5MG. During an interview on 05/28/26 at 01:24 PM with the DON, she stated that she did not find any of the consents needed for Resident #2's medications (listed above) either in the chart or in the consent binder. She stated she only saw the consent for the 11/18/25 by NP H (prescriber) for Seroquel (Quetiapine Fumarate) 25MG that indicated Pt doesn't have the psychiatric condition required for medication and she did not know why the consent stated that and why the medication was still provided after not having a valid consent. She stated she only arrived at the facility in February 2026, so she had no knowledge of it. She stated she placed a call to NP H to ask about it and that NP H did not recall or have information that could help her. The DON stated the purpose of the consents for these medications is to make sure the family is involved in the decision-making process, it's a holistic approach so everyone is on the same page. The DON stated, if the resident was on a lot of different psychoactive medications that would not be good; there is the potential for polypharmacy if family is not aware of the medications being given. The DON stated she had not observed the combination of medications being administered having an overly sedative effect on Resident #2, or other concerns. She stated medications should have consents on file as required. During an interview on 05/28/26 at 02:48 PM with the ADM, he stated it was his expectation that nursing staff be compliant with pharmacological expectations and that they do the best for the resident. He stated he expected to have consents on file as required and that the purpose of the consents was so that the family or RP was in the know or aware of what was being used, could ask questions, and refuse the medication if they did not want to give consent. The ADM stated failing to gather a consent for psychotropic medication quality of life can suffer if they do not have a consent or medical necessity. During an interview on 05/28/26 at 03:27 PM with NP H, she stated that she had been treating Resident #2 since November 2025. She stated that she did not recall why the consent for Seroquel (Quetiapine Fumarate) indicated that Resident #2 did not have behavior problems and why the medication was still administered. She stated she would help with orders and sign off on them to help the facility because nobody else was available. She stated she was not able to sign off on those medications because the medications having a history of being used as chemical restraints and that it would normally be psychiatric services, however, she felt the doses and the medications were appropriate for Resident #2 based on anxiety and other behaviors initially on admission. NP H stated that the purpose of the consents was, so the family was aware of what was being ordered. She stated psychotropic medications required consents and the family had to consent in order for the resident to receive it. She stated if the consent was only obtained for 1 month as indicated on the consent, it should have been revisited to see how the resident was responding and a new consent obtained, if the medication was still needed. She stated a negative outcome of not getting the consents would be residents could have reactions to medications administered that were not consented to. During an interview on 05/29/26 at 12:36 PM with FM A, she stated Resident #2 did have behaviors on admission and described Resident #2 as being anxious, trying to run away, and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other behaviors that warranted psychotropic medications. She stated she knew Seroquel to have been used for anxiety but was not aware of the other medications or giving consent to them recently. She stated it was alarming to hear Resident #2 was on multiple medications without family giving consent. She stated, in her visits, she had not seen any concerns with the resident being heavily sedated, increased falls, or other concerns due to the medications she is on. She stated during visits, Resident #2 was alert, up and talking and not in any distress. During an interview on 05/29/26 at 1:26 PM with FM B, he stated that he had not provided consent for the use of any psychotropic medications. He stated he visited Resident #2 and had not observed any issues with heavy sedation, sleeping all day, increased falls etc. He stated when he arrived for visits she was in bed but alert, or in the day room at the table and was awake with no concerns noted. He stated the facility did alert him if there were any falls, but he had not received any calls where the resident had a fall with a major injury or required hospitalization.2. Review of Resident #1's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] and discharged on 5/26/2026. She was admitted for rehab services following a fall and surgical repair of a fracture to her left hip. Diagnoses information included: Displaced fracture of the base of neck of left femur with routine healing, epistaxis (nose bleeds), Cachexia (complex metabolic condition leading to muscle and or fat loss), Restless leg syndrome, lack of coordination, history of fall with injury to head, idiopathic gout (painful inflammatory arthritis caused by excess uric acid in the blood), Dementia unspecified severity without behavior disturbances, hearing loss, hypertension (high blood pressure), Paroxysmal Atrial Fibrillation (heart arrythmia), Chronic heart failure, acute kidney failure, history of falling.Review of Resident #1's physician orders revealed orders for Trazodone HCl oral tablet (50 MG, give 1 tablet by mouth at bedtime for insomnia) and Quetiapine Fumarate oral tablet (25 MG, give 1 tablet by mouth at bedtime for depression). Orders were scheduled to start on 3/31/2026 and were both signed for approval by the MD. Resident #1 does not have a diagnosis of insomnia or depression listed. In a telephone interview on 5/28/2026 at 4:40 PM with the MD, he stated that he did quite a bit of psych medication for dementia behaviors. He stated the process for orders is he gives the orders verbally or he will enter the orders himself, and depending if they are on hospice care, then the orders have to come through hospice. He stated that the consent is based on nursing home policy and the facility is responsible for obtaining signed consent. He stated that consent is only needed for certain psych medications. He agreed that medications like Seroquel, trazadone and Depakote needed consent. When other medications such as Buspar, Fluoxetine he stated, A lot of these medications you are listing are prescribed by psych services and they would get consent. When asked about prescribing Resident #1 Trazadone for Insomnia and Quetiapine for depression, he stated, I would never treat depression with Seroquel. Seroquel is a medication also known as Quetiapine in generic form. He stated that if the order for Quetiapine stated it was for depression, then the order was entered wrong. He stated that he does review the verbal orders placed in point click care after they have been entered and checks them for accuracy before signing. He stated he may have missed the error in the order. He did not explain why the medication was prescribed without a matching diagnosis. He stated that he needed to go back to work and ended the interview incomplete.Review of the facility's Resident Rights policy revised 02/2021 reflected:Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to-Be free from chemical restraints not required to treat the residents' symptoms. -Be informed of and participate in his or her care planning and treatment

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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 each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 24 resident (Resident #50 reviewed for resident rights.The facility failed to ensure the HK knocked on Resident #50's door when entering their room on 5-26-2026. These failures could place residents at risk of poor self-esteem, and not a home-like environment. Findings include:Record review of Resident #50's face sheet revealed that Resident #50 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses that included: Acute and Chronic Respiratory Failure (oxygenate the blood), Type 2 Diabetes (body cannot properly use or make enough insulin), Psychotic Disturbance, and Mood Disturbance (mental health disruptions that cause a person to lose touch with reality)Record review of Resident #50's admission MDS assessment, dated 03/18/2026, revealed that Resident #50 had a BIMS score of 11 (moderate cognitive impairment).Record review of Resident #50's care plan dated 05/21/2026 did not reflect anything about Resident #50 not wanting staff knocking on the door. During an interview and observation on 06/26/26 at 8:36 AM with Resident #50, the HK entered the room with laundry without knocking on the door. Resident #50 stated that staff knock most of the time, but occasionally staff don't knock. Resident #50 stated that it bothered her when staff do not knock on the door. During an interview on 05/28/2026 at 3:32 PM with RN G, she stated that staff were expected to knock on residents' doors before entering the room or announce their arrival. She stated that that was a resident's rights issue. She stated HK could have walked into the room while Resident #50 was receiving care. She stated that she had not seen any staff not knocking on residents' doors. She stated that if she saw staff not knocking on residents' doors, she would have reminded them to do so.During an interview on 05/28/2026 at 4:05 PM with the DON, she stated that all staff should knock on the door when entering the room. She stated that she had not seen any staff not knocking on residents' doors. She stated that if she saw staff not knocking on the door, then she would correct them. She stated it was a privacy and dignity issue for the residents when staff did not knock on residents' doors. She stated that if staff did not knock, a resident could have been receiving care.During an interview on 05/28/2026 4:20 PM with the ADM. He stated that it was his expectations for staff to knock on residents' doors He stated that staff were trained on knocking on doors before going in. Record review of the facility's Resident Rights policy updated on February 2021 reflected:Residents are to be treated with respect, kindness, and dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676035	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kingsland	3727 W Ranch Rd 1431 Kingsland, TX 78639

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident's drug regimen must be free from unnecessary drugs without indications for its use for 2 of 3 Residents (Resident #2 and Resident #1) reviewed for the right to be free from chemical restraints.1.The facility failed to obtain a current active consent from Resident #2's family representative for the use of Quetiapine Fumarate (antipsychotic) used for agitation/anxiety related to dementia, Depakote ER (extended release) antiepileptic/ antimanic, Buspirone (anti-anxiety), Paroxetine (antidepressant), and donepezil (used for dementia) and failed to have an active diagnosis of anxiety and depression to correspond with medications prescribed from November 2025 through May 2026.2.The facility failed to have a consent on file for the administration of Quetiapine Fumarate and failed to have a corresponding diagnosis of insomnia or depression for Resident #1. These deficient practices could affect residents who received medications for mood disorders and could contribute to the use of unnecessary medications.The findings were:Review of Resident #2's face sheet dated 05/28/26 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia-severe-with psychotic disturbance, dementia in other diseases classified elsewhere- mild- without behavioral disturbance-psychotic disturbance- mood disturbance and anxiety, and need for assistance with personal care. There was no active diagnosis information for depression or anxiety. Review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 03 indicating severe cognitive impairment. Active diagnosis reflected non-Alzheimer's dementia. Psychiatric/ mood disorders were NOT listed as an active diagnosis, this included anxiety, depression, and psychotic disorders (other than schizophrenia). The MDS reflected Resident #2 was actively taking an antipsychotic, antianxiety, antidepressant, and anticonvulsant. Review of Resident #2's care plan last revised 05/13/26 reflected there was no focus for the use of any antipsychotic/ antidepressant/ antianxiety medications with any interventions. Review of Resident #2's physician orders reflected the following active medications: -Quetiapine Fumarate oral tablet 50MG; one table by mouth at bedtime for agitation/ anxiety with an order start date of 04/09/26. This is a recent increase from Quetiapine Fumarate oral tablet 25MG order start date 11/13/25 and ending 04/09/26. -Buspirone HCl oral tablet 10MG; give one tablet by mouth in the afternoon for anxiety with an order start date of 04/25/26. -Depakote ER (extended release) oral tablet extended release 24 hours 250 MG; give 1 tablet by mouth at bedtime related to dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with an order start date of 01/23/26. -Paroxetine HCl oral tablet 20MG; give 1 tablet by mouth at bedtime related to dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with an order start date of 01/23/26.-Donepezil HCl oral tablet 5MG; give 2 tablets by mouth at bedtime related to dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with a start date of 01/21/26. Review of resident #2's MAR reflected medications being provided as prescribed from order start date (listed above) through review end date of 05/28/26 (medications reviewed from November 2025 through May 2026). Review of Resident #2's consents on 05/28/26 reflected: -Consent signed on 11/18/25 by NP H (prescriber) for Seroquel (Quetiapine Fumarate) 25MG at bedtime, NP H indicated Pt doesn't have the psychiatric condition required for medication. She has dementia with no behavioral problems. It was signed by NP H without further signatures by Resident #2 or family. There were no other consents for the use of Seroquel (Quetiapine Fumarate) 25MG or Seroquel (Quetiapine Fumarate) 50MG prescribed and provided to Resident #2. -A consent was observed effective 12/05/25 for Buspirone being used to treat anxiety; the proposed course of the medication for which the consent was obtained was 3 months. There was no other consent that was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	active for the current prescribed order of Buspirone HCl oral tablet 10MG still being administered effective after the prior 3-month consent ended. -A consent was observed effective 02/17/26 for Paroxetine being used to treat depression; the proposed course of the medication for which the consent was obtained was 1 month - There was no other consent that was active for the current prescribed order of Paroxetine HCl oral tablet 20MG still being administered effective after the prior 1-month consent ended. -A consent was observed effective 02/17/26 for Depakote being used to treat marked other with no listed condition to be treated listed. The proposed course of the medication for which the consent was obtained was 1 month- There was no other consent that was active for the current prescribed order of Depakote ER (extended release) oral tablet extended release 24 hours 250 MG still being administered effective after the prior 1-month consent ended. -There was no consent at all for the use of Donepezil HCl oral tablet 5MG. During an interview on 05/28/26 at 01:24 PM with the DON, she stated that she did not find any of the consents needed for Resident #2's medications (listed above) either in the chart or in the consent binder. She stated she only saw the consent for the 11/18/25 by NP H (prescriber) for Seroquel (Quetiapine Fumarate) 25MG that indicated Pt doesn't have the psychiatric condition required for medication and she did not know why the consent stated that and why the medication was still provided after not having a valid consent. She stated she only arrived at the facility in February 2026, so she had no knowledge of it. She stated she placed a call to NP H to ask about it and that NP H did not recall or have information that could help her. The DON stated the purpose of the consents for these medications is to make sure the family is involved in the decision-making process, it's a holistic approach so everyone is on the same page. The DON stated, if the resident was on a lot of different psychoactive medications that would not be good; there is the potential for polypharmacy if family is not aware of the medications being given. The DON stated she had not observed the combination of medications being administered having an overly sedative effect on Resident #2, or other concerns. She stated medications should have consents on file as required. During an interview on 05/28/26 at 02:48 PM with the ADM, he stated it was his expectation that nursing staff be compliant with pharmacological expectations and that they do the best for the resident. He stated he expected to have consents on file as required and that the purpose of the consents was so that the family or RP was in the know or aware of what was being used, could ask questions, and refuse the medication if they did not want to give consent. The ADM stated failing to gather a consent for psychotropic medication quality of life can suffer if they do not have a consent or medical necessity. During an interview on 05/28/26 at 03:27 PM with NP H, she stated that she had been treating Resident #2 since November 2025. She stated that she did not recall why the consent for Seroquel (Quetiapine Fumarate) indicated that Resident #2 did not have behavior problems and why the medication was still administered. She stated she would help with orders and sign off on them to help the facility because nobody else was available. She stated she was not able to sign off on those medications because the medications having a history of being used as chemical restraints and that it would normally be psychiatric services, however, she felt the doses and the medications were appropriate for Resident #2 based on anxiety and other behaviors initially on admission. NP H stated that the purpose of the consents was, so the family was aware of what was being ordered. She stated psychotropic medications required consents and the family had to consent in order for the resident to receive it. She stated if the consent was only obtained for 1 month as indicated on the consent, it should have been revisited to see how the resident was responding and a new consent obtained, if the medication was still needed. She stated a negative outcome of not getting the consents would be residents could have reactions to medications administered that were not consented to. During an interview on 05/29/26 at 12:36 PM with FM A, she stated Resident #2 did have behaviors on admission and described Resident #2 as being anxious, trying to run away, and other behaviors that warranted psychotropic medications. She stated she knew Seroquel to have been used for anxiety but was not aware of the other medications or giving consent to them recently. She stated it was alarming to hear Resident #2 was on multiple medications without family giving consent. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated, in her visits, she had not seen any concerns with the resident being heavily sedated, increased falls, or other concerns due to the medications she is on. She stated during visits, Resident #2 was alert, up and talking and not in any distress. During an interview on 05/29/26 at 1:26 PM with FM B, he stated that he had not provided consent for the use of any psychotropic medications. He stated he visited Resident #2 and had not observed any issues with heavy sedation, sleeping all day, increased falls etc. He stated when he arrived for visits she was in bed but alert, or in the day room at the table and was awake with no concerns noted. He stated the facility did alert him if there were any falls, but he had not received any calls where the resident had a fall with a major injury or required hospitalization.2. Review of Resident #1's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] and discharged on 5/26/2026. She was admitted for rehab services following a fall and surgical repair of a fracture to her left hip. Diagnoses information included: Displaced fracture of the base of neck of left femur with routine healing, epistaxis (nose bleeds), Cachexia (complex metabolic condition leading to muscle and or fat loss), Restless leg syndrome, lack of coordination, history of fall with injury to head, idiopathic gout (painful inflammatory arthritis caused by excess uric acid in the blood), Dementia unspecified severity without behavior disturbances, hearing loss, hypertension (high blood pressure), Paroxysmal Atrial Fibrillation (heart arrythmia), Chronic heart failure, acute kidney failure, history of falling.Review of Resident #1's physician orders revealed orders for Trazodone HCl oral tablet (50 MG, give 1 tablet by mouth at bedtime for insomnia) and Quetiapine Fumarate oral tablet (25 MG, give 1 tablet by mouth at bedtime for depression). Orders were scheduled to start on 3/31/2026 and were both signed for approval by the MD. Resident #1 does not have a diagnosis of insomnia or depression listed. In a telephone interview on 5/28/2026 at 4:40 PM with the MD, he stated that he did quite a bit of psych medication for dementia behaviors. He stated the process for orders is he gives the orders verbally or he will enter the orders himself, and depending if they are on hospice care, then the orders have to come through hospice. He stated that the consent is based on nursing home policy and the facility is responsible for obtaining signed consent. He stated that consent is only needed for certain psych medications. He agreed that medications like Seroquel, trazadone and Depakote needed consent. When other medications such as Buspar, Fluoxetine he stated, A lot of these medications you are listing are prescribed by psych services and they would get consent. When asked about prescribing Resident #1 Trazadone for Insomnia and Quetiapine for depression, he stated, I would never treat depression with Seroquel. Seroquel is a medication also known as Quetiapine in generic form. He stated that if the order for Quetiapine stated it was for depression, then the order was entered wrong. He stated that he does review the verbal orders placed in point click care after they have been entered and checks them for accuracy before signing. He stated he may have missed the error in the order. He did not explain why the medication was prescribed without a matching diagnosis. He stated that he needed to go back to work and ended the interview incomplete.Review of the facility's Resident Rights policy revised 02/2021 reflected:Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to-Be free from chemical restraints not required to treat the residents' symptoms. -Be informed of and participate in his or her care planning and treatment