STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676069	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Texarkana	4925 Elizabeth St Texarkana, TX 75503

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice for 1 of 3 residents (Resident #2) reviewed for pain. The facility failed to ensure Resident #2 had his scheduled pain medication Hydrocodone-Acetaminophen tablet 10-325 mg by mouth three times daily from [DATE] - [DATE]. The facility failed to notify the Physician when Resident #2 was experiencing uncontrolled, excruciating pain with behavioral changes. The facility failed to ensure that Resident #2 received adequate pain medication management options. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 09:49 AM. While the IJ was removed on [DATE], the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of experiencing unnecessary pain and a decreased quality of life.Findings included: Record review of a face sheet dated [DATE] indicated Resident #2 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including physical disability related to age, hypertension (high blood pressure), schizophrenia (hallucinations, delusions, disorganized speech/behavior), major depression disorder. Record review of the Quarterly MDS assessment dated [DATE], indicated Resident #2 was able to make was able to make himself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS summary score of 14, which indicated he was cognitively intact. The MDS assessment indicated Resident 2 was taking scheduled pain medication. Record review of Resident #2's care plan initiated on [DATE] indicated Resident #2 would remain free from pain with the following interventions: Give pain medication and evaluation of pain. Record review of Resident #2's Order Summary Report dated [DATE] indicated he had an order for Hydrocodone-Acetaminophen tablet 10-325 milligrams give one tablet by mouth three times a day for pain with a start date of [DATE]. Record review of Resident #2's medication administration record for the month of [DATE] indicated, hydrocodone 10-325mg give one tablet by mouth three times a day for pain. Resident #2's medication administration record indicated: [DATE] at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G [DATE] at 07:00 AM was documented as administered by MA G, at 12:00 PM, and 5:00 PM it was documented as not administered reason indicated other/see progress note signed by MA G [DATE] at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G [DATE] at 07:00 AM was documented as administered by MA B, at 12:00 PM, and 5:00 PM it was documented as not administered reason indicated other/see progress note signed by MA B Record review of Resident #1's medication administration record for the month of February 2026 indicated that hydrocodone 10-325mg, give one tablet by mouth three times a day for pain. Resident #2's medication administration record indicated: [DATE] at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA B [DATE] at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G [DATE] at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G [DATE] (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: 676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Avir at Texarkana		STREET ADDRESS, CITY, STATE, ZIP CODE 4925 Elizabeth St Texarkana, TX 75503	

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G [DATE] at 07:00 AM, 12:00 PM it was documented as not administered reason indicated other/see progress note and at 5:00 PM it was documented as given signed by MA G Record review of Resident #2's administration notes dated [DATE]-[DATE] indicated: [DATE] at 09:25 AM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 12:24 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 5:57 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 2:23 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 5:07 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 7:16 AM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 4:50 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 12:47 PM, hydrocodone 10-325mg on order signed by MA B [DATE] at 4:50 PM, hydrocodone 10-325mg on order signed by MA B [DATE] at 08:31 AM, hydrocodone 10-325mg N/A signed by MA B [DATE] at 1:39 PM, hydrocodone 10-325mg on order signed by MA B [DATE] at 5:02 PM, hydrocodone 10-325mg on order signed by MA B [DATE] at 08:37 AM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 12:48 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 6:41 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 07:40 AM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 12:43 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 4:15 PM, hydrocodone 10-325mg waiting on arrival signed by MA G [DATE] at 08:04 AM, hydrocodone 10-325mg on order signed by MA B [DATE] at 12:32 PM, hydrocodone 10-325mg N/A signed by MA B [DATE] at 4:03 PM, hydrocodone 10-325mg on order signed by MA B [DATE] at 08:12 AM, hydrocodone 10-325mg on order signed by MA B [DATE] at 12:38 PM, hydrocodone 10-325mg on order signed by MA B Record review of Resident #2's progress notes dated [DATE]-[DATE] did not indicate Resident #2's physician, NP or the pharmacy were notified he was out of his hydrocodone. Record review of Resident #2's Triplicate Request form dated [DATE] for Hydrocodone-Acetaminophen tablet 10-325 milligrams give one tablet by mouth three times day indicated there was an unsigned and undated handwritten note which stated a new triplicate was required because they changed pharmacies. During an interview on [DATE], at 08:35 AM Resident #2 stated that he had received his medications lately. Resident #2 stated that about a month ago he had not received his pain medication for 5 days. Resident #2 said the MA had tried to help him get his pain medication every day that she was at work. Resident #2 said the nurse (unable to recall who) was not helping the situation. Resident #2 said he was never told what happened and why he could not have his pain medication. Resident #2 said all he knew was that the MA said his pain medication was not in the building. Resident #2 said he could not sleep or get any rest due to the excessive pain he felt. He said he suffered excruciating pain in his back and neck and experienced numbness in his hands and fingers. Resident #2 stated that he had a fall prior to his admission into the facility. Resident #2 stated his pain in his back and neck since the fall could be unbearable without the pain medications. Resident #2 was tearful and anxious and said he was embarrassed by how he treated the staff due to being agitated and irritable from lack of sleep due to so much pain. Resident #2 said he felt off the chart in pain greater than 10 on a scale of 1 out of 10 with 10 being the greatest pain. Resident #2 said, the MA had offered to reposition and adjusted his pillows but at that point he denied anything and I wanted my real pain medication - nothing else was going to touch my pain. Resident #2 said he was not offered any other pain medication by the nurse or MA. He said he prayed that he never had to experience that pain again. Resident #2 said he was responsible for self and did not have any other family members to visit or check on him. During an interview on [DATE] at 09:35 AM, the anonymous person said she was aware Resident #2 had not received the ordered Hydrocodone-Acetaminophen tablet 10-325 milligrams and had multiple missed dosages. An anonymous person said she had told the charge nurses. The anonymous person said she could not recall which nurse she told. The anonymous person said not all nurses would follow through. The anonymous person said the ADON was aware and tried to assist. The anonymous person said she thought the ADON had done her part to (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	follow up with the pharmacy by calling and faxing but nothing had changed. The anonymous person said the ADON had notified the physician to get a new triplicate ordered. The anonymous person said Resident #2 was irritable from not getting his scheduled pain medications, but she did not notice any excessive pain. The anonymous person said it was important for residents to receive their ordered medications as prescribed by the physician to prevent a decline in their health condition or have increased pain. During an interview on [DATE] at 10:00 AM, MA B said Resident #2 expressed pain to her that was uncontrolled. MA B said she noticed his frustration and immediately reported it to the charge nurse, LVN A, on [DATE] and also on several other occasions. MA B said LVN A said she called the pharmacy and the physician, but nothing changed. The next day, [DATE], there were still no pain medications for Resident #2. MA B said she had to repeatedly tell the nurses about low quantities of medications. MA B said some nurses do not want to help follow up with the pharmacy. MA B said the residents needed the medications as the doctor has ordered or the doctor needed to be notified otherwise. MA B said somebody needed to get to the bottom of why the medications do not come to the facility in larger quantities. MA B said she ordered the medications off the MAR in the electronic records systems by pushing the reorder button approximately 7 days before the medication is depleted. MA B said if the medications had not arrived soon after, she notified the charge nurse, notified the ADON, and left notes to remind anybody and everybody. MA B said residents that had not gotten medications as ordered were at risk of many things such as seizures, increased behaviors, high blood pressure, depression and uncontrolled pain depending on what medication is ordered. MA B said Resident #2 was distraught and he was so agitated. That he was past comforting at that point. MA B said she offered position changes, but he denied everything because he knew his medications and what he was supposed to get and that was what he wanted. During an interview on [DATE] at 01:40 PM, the ADON said they had been without a DON for two months. The ADON said she was aware that Resident #2 had not received the ordered Hydrocodone-Acetaminophen tablet 10-325 milligrams and had missed dosages. The ADON said she had called and faxed the pharmacy on numerous occasions during the dates of [DATE] - [DATE] and had followed up each day. The ADON said she had contacted the Nurse Practitioner to update the triplicates. The ADON said Hydrocodone-Acetaminophen tablet 10-325 milligrams was kept in the pyxis for emergency situations, but the problem was we had no idea the triplicate expired so it would not dispense the medication after a couple of times. The ADON said the facility had struggled with getting the medications in the building timely when the corporate pharmacy took over and made a location change from a major city in southern part of the state to a different city in the northern part of the state. The ADON said there had not been a system in place since the corporate pharmacy took over in January for a check and balance of medications ordered and the medications received. The ADON said there were problems with which number to dial and the pharmacy staff saying it was now housed out of a different location and no longer covered by the pharmacy they had called. The ADON said, we never knew who we were talking to or where we were supposed to be calling. The ADON said she had sent the Triplicate Request Form on [DATE]. The ADON said the triplicate had expired so then it had to be sent again. The ADON said she had not documented any of the requests, faxes, conversations or follow-ups on the needed medications for Resident #2 with the pharmacy. The ADON said she had not documented notifying the Physician or the Nurse Practitioner of Resident #2's missed medications. The ADON said, she kept thinking after she faxed or had a conversation with the pharmacy the medication would arrive, but it never had arrived. The ADON said the medication aides requested the medication through the electronic computer system from the Medication Administration Record page to reorder the medication. The ADON said she thinks the medication aides were ordering the medications too early and the pharmacy could not send the medication out yet to the facility. The ADON said the nurses would then follow - up with the pharmacy if the medication aide was unable to resolve the issue. The ADON said the nurse should attempt to call the pharmacy and find out the situation and see if they needed to contact the nurse practitioner for another order or if a local pharmacy could fill the (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medication temporarily until the medication was provided by the corporate pharmacy. The ADON said if the nurse was unsuccessful at getting the medication in the building timely, that she and the DON should be notified as well as the Administrator. The ADON said it was important for residents to be reassessed for pain to prevent the pain from getting out of control. The ADON said the physician/NP should be notified for alternate measures such as a different pain-relieving medication. During an interview on [DATE] at 02:15 PM, the Nurse Practitioner said she expected the staff to notify her if an ordered medication is not available. The Nurse Practitioner said she would always pick up the phone and contact the pharmacy immediately to verify the prescription or to find out what is needed to prevent any missed dosages. The Nurse Practitioner stated she had no knowledge that Resident #2 was without pain medication until weeks after the incident had occurred when Resident #2 mentioned this during a visit. The Nurse Practitioner stated the facility never told her that Resident #2 was out of pain medication or had a change in condition. The Nurse Practitioner stated that she could not write the Triplicate herself due to that was out of her scope of practice. However, she expected to be notified regarding the missed dosages and any changes in condition such as increased pain. The Nurse Practitioner stated that it was imperative to have accurate and timely communication with the staff to ensure coordination of care of the residents. The Nurse Practitioner stated that. The Nurse Practitioner stated ordered medications should be given appropriately to prevent a further decline in the resident's health and wellbeing. The Nurse Practitioner stated she expected notification of missed medications or unavailable medications so alternative actions could be made timely such as contacting a local pharmacy or prescribing another medication to prevent a negative outcome such as increased, uncontrolled pain. The Nurse Practitioner said she also had standing orders available for the staff to utilize as well. During an interview on [DATE] at 03:35 PM, the Corporate Regional Nurse stated she had not contacted the pharmacy to inquire on the facility follow-up attempts because she had not realized there were ongoing problems. The Corporate Regional Nurse stated the ADON had not reported the Resident #2 had missed dosages of pain medications because of the unavailability of medications. The Corporate Regional Nurse stated she expected the staff to have clear and effective communication and to follow the medication administration policy accurately. The Corporate Regional Nurse stated that a resident can experience a decline in health and increase of pain, seizure, blood pressure, behaviors when prescribed medications are not given as ordered. During an interview on [DATE] at 4:53 PM, the pharmacy representative stated the record of activity for Resident #2 indicated the following:[DATE] - facility requested order for 50 tablets of Hydrocodone-Acetaminophen tablet 10-325 milligrams[DATE] - facility received order for 16-day supply - last through [DATE]XXX[DATE] - Pyxis was accessed for 2 tablets Hydrocodone-Acetaminophen tablet 10-325 milligramsNo other logged activity via faxes, telephone calls or computer request made until [DATE]. During an interview on [DATE] at 07:45 AM, LVN A stated she was the charge nurse for Resident #2 on [DATE], [DATE]. LVN A stated she was aware Resident #2 did not have the Hydrocodone-Acetaminophen tablet 10-325 milligrams as ordered. LVN A stated the facility was always lacking the medications needed. LVN A stated the corporate pharmacy was always sending 2 to 3 pills instead of sending the right amounts to last the entire month. LVN A stated she had to call the pharmacy a lot but could not say for certain when she had call regarding Resident #2. LVN A stated she had no time to document all the calls she made to the pharmacy for medications. LVN A stated she made the calls when she walked down the halls providing care and doing other things. LVN A stated her cart had not run out of medications because she took care of her job and sent her medications needs in 6 - 7 days ahead of time so she did not run out of medications. But she had to follow up on the corporate pharmacy when they did not send the full months' worth of pills like they were supposed to do. LVN A said the MAs were responsible for stocking their own carts. LVN A said, there was no reason for MAs to come to her when their carts were low because they all had the same access she had and that was on them to get their stuff done on their own. LVN A said, the MAs could make calls to follow up on the medications, send faxes or whatever was (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	administering pain medications per physician orders, that when a resident complains of pain and they do not have ordered pain medications and/or PRN pain medications to immediately notify the charge nurse and nursing administration, and the medication reordering process and to reorder medication per policy. All certified medication aides will be educated prior to working their next shift. Record review of Inservice dated [DATE] initiated by the Regional Nurse Consult to DON, ADON, Weekend Supervisor or Designee over run their medication admin audit report from their electronic medical record, daily, to check for medications that were not administered per order, check to ensure the medication is available, notify the physician, and reorder, if necessary, x4 weeks. Record Review of the QAPI Committee Review -committee meeting was completed on [DATE] with the Administrator, DON and Medical Director (over the telephone). The QAPI meeting consisted of education and training on nursing staff to pain assessment management, administering pain medication, change in condition, medication order and reorder. The key focus for nurses is to assess the resident for pain, notify the physician of pain, follow physician orders and administer pain medications as ordered, notify the nursing leadership and the physician if pain medication or any medication is not available, and the medication reordering process and to reorder medication per the policy. The CMA were educated on administering pain medications, change in condition, medication order and reorder. The focus was administering pain medications per the physician orders, that when a resident complains of pain and they do not have ordered pain medications and/or prn pain medications to immediately notify the charge nurse and nursing administration, and the medication reordering process and to reorder medication per policy. The DON, ADON and weekend supervisor or designee will run their medication admin audit report from the EMR, daily to check for pain medications that were not administered per order, check to ensure the mediation is available, notify the physician, and reorder, if necessary, monitor for the next 4 weeks. Re- education will occur, as necessary. During the interviews on [DATE] at 08:30 AM - 10:30 AM, the nursing staff on the 6AM to 6PM schedule: DON, ADON, MDS Nurse, LVN A, MA B, LVN E, LVN D, MA G, RN K and the Nursing staff on the 6 PM to 6AM schedule: LVN F, RN L, LVN M, LVN H staff were able to correctly identify the steps for proper medication administration and what to do if a medication is unavailable such as (check the e-kit, notify the nursing administration, pharmacy, and MD that the medication is not available, ensure the medication is reordered and follow physician orders). assess the resident for pain, notify the physician of pain, follow physician orders and administer pain medications as ordered, notify the nursing leadership and the physician if pain medication is unavailable. The CMAs were educated on administering pain medications, change in condition, medication order and reorder. The focus was administering pain medications per the physician orders, that when a resident complains of pain and they do not have ordered pain medications and/or prn pain medications to immediately notify the charge nurse and nursing administration. During the interviews on [DATE] at 10:30 AM - 11:30 AM , the DON, ADON, RN L (Weekend Supervisor/designer) verbalized the expectation to run/monitor their medication admin audit report from their electronic medical record, daily, to check for medications that were not administered per order, check to ensure the medication is available, notify the physician, and reorder, if necessary, x4 weeks of monitoring On [DATE] at 11:35 AM, the Administrator was informed that the IJ was removed; ; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facilities need to complete in-service training and evaluate the effectiveness of the corrective systems.

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NAME OF PROVIDER OR SUPPLIER Avir at Texarkana		STREET ADDRESS, CITY, STATE, ZIP CODE 4925 Elizabeth St Texarkana, TX 75503	

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 2 of 4 residents (Resident #1 and Resident #2) reviewed for pharmacy services. The facility failed to administer Resident #1's ordered Topamax 25 mg (seizure prevention medication) by the physician from 02/10/2026 - 02/15/2026 (5 days). Resident #1 missed 15 dosages of Topamax resulting in Resident #1 being hospitalized for seizure like activity on 02/13/2026 and 02/15/2026. The facility failed to obtain Resident #1's ordered Topamax (medication used to decrease seizure activity) 25 mg from the pharmacy as instructed by the facility Nurse Practitioner on 02/13/2026. The facility failed to follow their policies on verifying and obtaining medications as ordered from their pharmacy when staff failed to follow up on the status of Resident #1's Topamax 25 mg, after it was not received on 02/10/2026. The facility failed to notify the MD/NP Resident #1 was out of Topamax from 02/10/2026-02/15/2026. The facility failed to obtain Resident #1's Topamax from an emergency source (pyxis or local pharmacy) to ensure Resident #1 received his Topamax medication as ordered for his seizures. The facility failed to ensure Resident #2 received his scheduled pain medication, hydrocodone-acetaminophen tablet 10-325 mg orally, three times a day as ordered by the physician from 1/28/26-2/5/26. Resident #2 missed 23 dosages of hydrocodone which resulted in Resident #2 experiencing uncontrolled pain. The facility failed to follow-up on Resident #2's hydrocodone when the triplicate for the hydrocodone was faxed to the pharmacy on 01/05/2026. The facility failed to notify Resident #2's MD of his uncontrolled pain and unavailable pain medication. An IJ was identified on 03/05/2026. The IJ template was provided to the facility on [DATE] at 09:49 AM. While the IJ was removed on 03/06/2026, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place other residents at risk of missed medications such as seizures and increased, uncontrolled pain levels resulting in harm or death.Findings included: 1. Record review of a face sheet dated 08/18/2025 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of epilepsy (seizures). Record review of the Annual MDS assessment dated [DATE], indicated Resident #1 was able to make was able to make himself understood and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 13, which indicated he was cognitively intact. The MDS assessment indicated Resident #1 was taking anticonvulsant medication. Record review of Resident #1's care plan initiated on 02/15/2026 indicated Resident #1 would remain free from injury related to seizure activity with the following interventions: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness; Obtain and monitor lab/diagnostic work as ordered. Report results to doctor and follow up as indicated; Post seizure treatment: turn on side with head back, hyper-extended to prevent aspiration, keep airway open. After seizures take vital signs and neurological checks; Monitor for aphasia, headache, altered level of consciousness, paralysis, weakness, pupillary changes. Record review of Resident #1's Order Summary Report dated 03/04/2026 indicated he had an order for Topamax 25 milligram tablet give one tablet by mouth three times a day related to seizure or convulsions with a start date of 12/01/2025. Record review of Resident #1's medication administration record for the month of February 2026 indicated, Topamax 25 milligram give one tablet by mouth three times a day. Resident #1's medication administration record indicated: 02/10/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other 02/11/2026 at 7:00 AM and 12:00 PM were documented as administered by MA N, 5:00 PM was documented as not administered reason indicated other/see progress note signed by MA G. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	02/12/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G. 02/13/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G. 02/14/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA B. 02/15/2026 at 07:00 AM PM not administered reason indicated other/see progress note signed by MA B, 12:00 PM was documented resident hospitalized signed by MA B. Record review of Resident #1's administration notes dated 02/10/2026-02/13/2026 indicated: 02/10/2026 at 08:44 AM, Topamax 25mg on order signed by MA B 02/10/2026 at 11:51 AM, Topamax 25mg on order signed by MA B 02/10/2026 at 5:11 PM, Topamax 25mg on order signed by MA B 02/11/2026 at 4:33 PM, Topamax 25mg waiting on arrival signed by MA G 02/12/2026 at 07:56 AM, Topamax 25mg waiting on arrival signed by MA G 02/12/2026 at 4:51 PM, Topamax 25mg waiting on arrival signed by MA G 02/13/2026 at 08:19 AM, Topamax 25mg on order signed by MA B 02/13/2026 at 4:28 PM, Topamax 25mg on order signed by MA B 02/14/2026 at 07:58 AM, Topamax 25mg on order signed by MA B 02/14/2026 at 11:08 AM, Topamax 25mg on order signed by MA B 02/14/2026 at 4:40 PM, Topamax 25mg on order signed by MA B 02/15/2026 at 8:09 AM, Topamax 25mg N/A signed by MA B Record review of Resident #1's progress notes dated 02/10/26-02/13/2026 did not indicate Resident #1's physician, NP or the pharmacy were notified he was out of his Topamax. Record review of Resident #1's progress note dated 02/13/2026 at 5:24 PM signed by LVN A indicated, Resident observed by staff shaking and not responding appropriately. Resident was unable to respond to verbal commands per baseline. Vitals signs taken and WNL (within normal limits). Resident noted to have fixed pupils at this time. [EMS provider] called for transport to [local hospital ER]. Responsible party [Name] notified of transport. Nurse Practitioner aware of change. Record review of Resident #1's discharged hospital note dated 02/13/2026 indicated, PT arrives to ED via EMS [name of ambulance] from [Facility name] due to seizure like activity witnessed by staff. EMS reports that PT was staring off on scene. PT arrives to ED room [number] with incomprehensible speech. EMS reports history of seizures. PT takes Keppra and Topamax but has not had Topamax since the 11th (02/11/2026) per the facility. The discharge note indicated Resident #1 reason for visit was seizures and his diagnosis was seizures. The discharge note indicated Resident #1 was given Keppra 1000 milligrams IV. The discharge note indicated Resident #1 had instructions to continue current medications as prescribed, seizure precautions and to return to the emergency room as needed. Record review of Resident #1's progress note dated 02/14/2026 at 3:03 AM signed by LVN C, indicated, Resident returned to the facility via [ambulance name] from [local hospital ER]. Discharge instructions given to resident to continue current medications and seizure precautions at this time, resident was given levetiracetam (Keppra) (a seizure medication) at 7:37 PM. Resident #1 showed no signs and symptoms of distress and was talking. Record review of Resident #1's progress note dated 02/15/2026 at 10:43 AM signed by LVN A indicated, Resident #1 in bed not responding to verbal stimuli, sternal rub performed and resident opened eyes but unable to respond per baseline, pupils not reacting to light unable to follow commands per usual. Notified Nurse Practitioner [Name] of condition. [EMS name] called for transport to ER for further eval (evaluation). Responsible Party made aware. Record review of a pharmacy invoice dated 02/15/2026 indicated 42 tablets of Topamax 25 mg were ordered by Nurse Practitioner and received by the facility on 02/16/2026 at 3:59 AM. During an interview on 03/04/2026 at 10:00 AM, MA B said she had to repeatedly tell the nurses (unknown who) about low quantities of medications. MA B said some nurses did not want to help follow up with the pharmacy. MA B said the residents needed the medications as the doctor has ordered or the doctor needed to be notified otherwise. MA B said somebody needed to get to the bottom of why the medications do not come to the facility in larger quantities. MA B said she ordered the medications off the MAR in the electronic records systems by pushing the reorder button approximately 7 days before the medication was depleted. MA B said when she tried to reorder Resident #1 Topamax from the MAR the button had already been pushed to reorder so she was not able to reorder again. MA B said if the medications did (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not arrive after ordering, she notified the charge nurse, the ADON and left notes to remind anybody and everybody. MA B said residents that had not gotten medications as ordered were at risk of many things such as seizures, increased behaviors, high blood pressure, depression and uncontrolled pain depending on what medication was missed. During an interview on 03/04/2026 at 09:35 AM, an anonymous person said some things at the facility were not working the way they should. The anonymous person said some of the staff (not identified) did not want to do what was needed to ensure the residents were taken care of right. The anonymous person said the medications were ordered in the system but for whatever reason the medications would not arrive to the facility timely or in the correct quantity. The problems started when the corporate pharmacy changed the facility to a different location and it had been a fight ever since to get what they needed. The anonymous person said she was aware Resident #1 had not received the ordered Topamax and had missed multiple dosages. An anonymous person said she had told the charge nurses (unable to identify who) several times that Resident #1 was out of Topamax. The anonymous person said not all nurses would follow up with the pharmacy regarding Resident #1 Topamax. The anonymous person said she did not call the pharmacy since they were not allowed and it was the responsibility of the nurse. The anonymous person said she had told the ADON on numerous occasions, and she thought the ADON had followed up on it by contacting the pharmacy and the doctor. The anonymous staff member said it was important for residents to receive their ordered medications as prescribed to prevent a decline in their health condition. During an interview on 03/03/2026 at 04:30 PM, the ADON said she was notified by MA G that Resident #1 was out of his Topamax but unable to recall what day she was notified. The ADON said she had called the pharmacy multiple times from 02/10/2026-02/15/2026 regarding Resident #1's Topamax medication. She said she had even faxed over Resident #1's Topamax order to the pharmacy. The ADON said she had followed up every day since 02/10/2026 repeatedly to ensure they medication was in the facility. The ADON said she had contacted the Nurse Practitioner prior to Resident #1 being sent out to the hospital for seizure activity, on 02/13/2026, and told the Nurse Practitioner there was no Topamax available. The ADON said she was unsure of the date she had notified the Nurse Practitioner. The ADON said she had informed the Nurse Practitioner Resident #1 had missed multiple dosages of the Topamax. The ADON said she could not recall how many dosages she had told the Nurse Practitioner that Resident #1 had missed. The ADON said the Nurse Practitioner just told her she needed to get the medication in the facility. The ADON said Topamax was not kept in the pyxis for emergency situations because she had tried to get it from there before. The ADON said the facility had struggled with getting the medications in the building timely when the corporate pharmacy took over and their pharmacy location changed. The ADON said there had not been a system in place for ordering and receiving medications since the corporate pharmacy took over in January 2026 The ADON said there were problems with which number to dial and the pharmacy staff saying it was now housed out of a different location and no longer covered by the pharmacy they had called. The ADON said, we never knew who we were talking to or where we were supposed to be calling. The ADON said she had not documented any of the requests, faxes, conversations or follow-ups on the needed medications for Resident #1 with the pharmacy. The ADON said she had not documented notifying the Physician or the Nurse Practitioner of Resident #1's missed medications. The ADON said, she kept thinking after she faxed or had a conversation with the pharmacy the medication would arrive, but it never did. The ADON said whenever a medication needed to be reordered, the medication aides reordered the medication through the electronic computer system from the Medication Administration Record page. The ADON said she thought the medication aides were ordering the medications too early and the reason why the pharmacy had not sent the medication to the facility. The ADON said if the medication aide was unable to resolve any issues with medications not being delivered then it was the responsibility of the nurse to follow up. The ADON said she expected the nurses to call the pharmacy and find out what the issue was regarding medications not being sent since they were able to contact the MD or NP for any new order needed. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADON said if the pharmacy was not delivering the medication, then the nurse should have contacted MD or NP so the medication could have been ordered from a local pharmacy until the medication was able to be provided by the facility pharmacy. The ADON said if the nurse was unsuccessful at getting the medication in the building timely, that she and the DON should be notified. During an interview on 03/03/2026 at 10:30 AM, LVN B said she expected the MA to report to her directly if a medication was not available as ordered for a resident. LVN B said if a resident was out of medication, she would first follow up at the pharmacy by calling to see what was needed. During an interview on 03/03/2026 at 2:00 PM, LVN E said she would contact the Nurse Practitioner if needed. LVN E said if the resident was going to be without the ordered medication after those steps had been followed, she would then reach out to the ADON/DON. LVN E said she had not experienced any issues other than a phone call to the pharmacy or a required fax that she could recall. LVN E said it was important for all residents to receive their medications as the physician had ordered to prevent a decline in their health. LVN E said she could not recall that the MAs had reported to her directly regarding Resident#1's Topamax was not available. LVN E said she thought they had reported to the ADON but she could not be for certain. Attempted telephone call on 03/03/2026 at 10:40 AM to LVN C - left a voice message and requested a call back. During an interview on 03/03/2026 at 02:15 PM, the DON said this was her first day of employment with the facility and was not aware of any issues with medications not being delivered from the pharmacy. The DON said she did not have access to the residents' EMRs and was not able to run any reports. During an interview on 03/03/2026 at 5:35 PM, the Physician stated he expected the facility to contact him if a medication was not administered as ordered. The Physician stated he was not notified and was not aware that Resident #1 had not received the Topamax 25 milligrams one tablet by mouth three times daily as ordered and had missed doses for 5 days. The Physician said he was not aware the resident had been transported to the hospital twice for seizure like activity and irresponsiveness after not receiving the ordered Topamax as prescribed. The Physician said he was not aware Resident #1 was no longer in the facility. The Physician stated that it was important for Resident #1 to have received the Topamax as ordered to prevent seizure activity. The Physician stated that Topamax should not be stopped abruptly because it would or could cause a seizure. The Physician stated if the facility had contacted him about the Topamax not being available, he would have reached out to a local pharmacy for assistance to ensure Resident #1's medication needs were met timely and effectively. The Physician stated that the corporation had experienced some growing pains that had made it difficult for staff at times to get through to the proper location, but no residents should go without medications, and he or the Nurse Practitioner should had been contacted immediately to resolve the matter. During an interview on 03/04/2026 at 09:00 AM, the Corporate Regional Nurse said during an acute review call (meeting to discuss an issue) on 02/16/2026 it was identified that Resident #1's medication was missed due to being unavailable. The Corporate Regional Nurse said Resident #1's Topamax medication had originally been requested to be refilled on 01/25/2026. The Corporate Regional Nurse said the nursing staff, Nurse Practitioner and the ADON had made several follow up phone calls to the pharmacy between 01/25/2026 - 02/15/2026 but the medication had not arrived. The Corporate Regional Nurse stated the Nurse Practitioner, on 02/16/26, was educated to call a local pharmacy to fill any medications that were unavailable after completing a MAR to medication cart audit. The Corporate Regional Nurse said there were no other residents identified with medication needs during the audit. The Corporate Regional Nurse said it was not the facility's fault that the medications were not available for Resident #1 because the facility had notified the Nurse Practitioner (which was an extension of the Physician) and followed up with the pharmacy numerous times. The Corporate Regional Nurse said she had escalated the pharmacy issue up to the corporate offices as well. During an interview on 03/04/2026 at 02:15 PM, the Nurse Practitioner said she expected the staff to notify her if an ordered medications that were not available before the residents missed any medications. The Nurse Practitioner said if she was notified of a resident being out of medications, she would call (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the pharmacy immediately to verify the prescriptions or to find out what was needed to prevent any residents from having missed medications. The Nurse Practitioner stated she had no knowledge that Resident #1 was without medication prior to 02/15/2026. She stated that on 02/13/2026 she was notified by the facility that Resident #1 had seizure activity that was witnessed by staff. The Nurse Practitioner stated she instructed the staff to send Resident #1 out by EMS at that time due to Resident #1 being unresponsive to verbal and touch stimuli. The Nurse Practitioner stated she was not notified that Resident #1 had returned to the facility on [DATE]. The Nurse Practitioner stated she was notified on 02/15/2026 that Resident #1 had another episode of seizure activity followed by unresponsive to verbal and touch stimuli and she instructed the staff to send Resident #1 to the hospital again for further evaluation. The Nurse Practitioner stated that one of the staff mentioned Resident #1 had missed 5 days of the ordered Topamax on 02/15/2026. The Nurse Practitioner stated she contacted the pharmacy immediately that day and placed the prescribed order. The Nurse Practitioner stated she followed up the next day with the facility and confirmed the Topamax medication had been delivered for Resident #1. The Nurse Practitioner stated Resident #1 had not returned to the facility, but the medication was available upon his return. The Nurse Practitioner stated she expected the facility to notify her when a resident had returned to the facility from a hospital. The Nurse Practitioner stated that it was imperative to have accurate and timely communication with the staff to ensure coordination of care of the residents. The Nurse Practitioner stated that Topamax should not be stopped abruptly because it could cause seizures. The Nurse Practitioner stated ordered medications should be given appropriately to prevent a further decline in the resident's health and wellbeing. The Nurse Practitioner stated she expected notification of missed medications or unavailable medications so alternative actions could be made timely such as contacting a local pharmacy or prescribing another medication to prevent a negative outcome. During an interview on 03/04/2026 at 4:53 PM, the pharmacy representative stated the record of activity for Resident #1 indicated the following:1/25/2026 - An order request for Resident #1's Topamax was received from the facility1/26/2026 - The facility received 42 tablets of Topamax 25mg at 12:08 AM for Resident #1 with instructions to take one tablet by mouth three times a day. The medication sent was a 14-day supply to last Resident #1 until 2/9/2026.No other logged activity via faxes, telephone calls or computer request made until 2/15/2026 .2/15/2026 - An order was received from the facility's Nurse Practitioner at 10:45 AM for Resident #1's Topamax .2/16/2026 - The facility received 42 tablets of Resident #1's Topamax 25mg at 3:59 AM. Attempted telephone call on 03/04/2026 at 08:45 PM to LVN D - left a voice message and requested a call back. Attempted telephone call on 03/04/2026 at 08:56 PM to LVN C - left a voice message and requested a call back. During an interview on 03/05/2026 at 07:45 AM, LVN A stated she was the charge nurse for Resident #1 on 02/13/2026 -02/15/2026. LVN A stated she was aware Resident #1 did not have the Topamax as ordered. LVN A stated the facility was always lacking the medications needed. LVN A stated the corporate pharmacy was always sending 2 to 3 pills instead of sending the right amounts to last the entire month. LVN A stated she had to call the pharmacy a lot. LVN A stated she had no time to document all the calls she made to the pharmacy for medications. LVN A stated she made the calls when she walked down the halls providing care and doing other things. LVN A stated her cart had not run out of medications because she took care of her job and sent her medications needs in 6 - 7 days ahead of time so she did not run out of medications. But she had to follow up on the corporate pharmacy when they did not send the full months' worth of pills like they were supposed to do. LVN A said the MAs were responsible for stocking their own carts. LVN A said, there was no reason for MAs to come to her when their carts were low because they all had the same access she had and that was on them to get their stuff done on their own. LVN A said, the MAs could make calls to follow up on the medications, send faxes or whatever was needed. LVN A said, when she had time, she could help them. LVN A said, she was sure that she had helped them get medication out of the pyxis when they needed them but that was a long process to do and sometimes, they got to wait until I can get over to (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	it. LVN A said it was important for Resident #1 to receive the Topamax to prevent seizures. LVN A said , that is why something has got to be done about the corporate pharmacy because there is not enough time to be backtracking all the time. LVN A said she could not recall if she had notified the Nurse Practitioner that Resident #1 had not had the Topamax when he was sent out of the facility on 12/13/2026 or on 12/15/2026LVN A said the ADON was in the facility when Resident #1 was sent out by EMS to the hospital so she would have known Resident #1 was out of medication. LVN A said, she guessed the MA told her and the ADON but that was not the problem - the problem was the corporate pharmacy. LVN A said it was important to notify the physician and or the Nurse Practitioner of resident needs or changes accurately and timely because of continuity of care. 2. Record review of a face sheet dated 03/04/2026 indicated Resident #2 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including physical disability related to age, hypertension (high blood pressure), schizophrenia (hallucinations, delusions, disorganized speech/behavior), major depression disorder. Record review of the Quarterly MDS assessment dated [DATE], indicated Resident #2 was able to make was able to make himself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS summary score of 14, which indicated he was cognitively intact. The MDS assessment indicated Resident #2 was taking scheduled pain medication. Record review of Resident #2's care plan initiated on 05/28/2025 indicated Resident #2 would remain free from pain with the following interventions: Give pain medication and evaluation of pain. Record review of Resident #2's Order Summary Report dated 03/04/2026 indicated he had an order for Hydrocodone-Acetaminophen tablet 10-325 milligrams give one tablet by mouth three times a day for pain with a start date of 05/17/2025. Record review of Resident #2's medication administration record for the month of January 2026 indicated, hydrocodone 10-325mg give one tablet by mouth three times a day for pain. Resident #2's medication administration record indicated: 01/28/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G 01/29/2026 at 07:00 AM was documented as administered by MA G, at 12:00 PM, and 5:00 PM it was documented as not administered reason indicated other/see progress note signed by MA G 01/30/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G 01/31/2026 at 07:00 AM was documented as administered by MA B, at 12:00 PM, and 5:00 PM it was documented as not administered reason indicated other/see progress note signed by MA B Record review of Resident #1's medication administration record for the month of February 2026 indicated that hydrocodone 10-325mg give one tablet by mouth three times a day for pain. Resident #2's medication administration record indicated: 02/01/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA B 02/02/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G 02/03/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G 02/04/2026 at 07:00 AM, 12:00 PM, and 5:00 PM not administered reason indicated other/see progress note signed by MA G 02/05/2026 at 07:00 AM, 12:00 PM it was documented as not administered reason indicated other/see progress note and at 5:00 PM it was documented as given signed by MA G Record review of Resident #2's administration notes dated 01/28/2026-02/05/26 indicated: 01/28/2026 at 09:25 AM, hydrocodone 10-325mg waiting on arrival signed by MA G 01/28/2026 at 12:24 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 01/28/2026 at 5:57 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 01/29/2026 at 2:23 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 01/29/2026 at 5:07 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 01/30/2026 at 7:16 AM, hydrocodone 10-325mg waiting on arrival signed by MA G 01/30/2026 at 4:50 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 01/31/2026 at 12:47 PM, hydrocodone 10-325mg on order signed by MA B 01/31/2026 at 4:50 PM, hydrocodone 10-325mg on order signed by MA B 02/01/2026 at 08:31 AM, hydrocodone 10-325mg N/A signed by MA B 02/01/2026 at 1:39 PM, hydrocodone 10-325mg on order signed by MA B 02/01/2026 at 5:02 PM, hydrocodone 10-325mg on order signed by MA B 02/02/2026 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Avir at Texarkana		STREET ADDRESS, CITY, STATE, ZIP CODE 4925 Elizabeth St Texarkana, TX 75503	

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 08:37 AM, hydrocodone 10-325mg waiting on arrival signed by MA G 02/02/2026 at 12:48 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 02/02/2026 at 6:41 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 02/03/2026 at 07:40 AM, hydrocodone 10-325mg waiting on arrival signed by MA G 02/03/2026 at 12:43 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 02/03/2026 at 4:15 PM, hydrocodone 10-325mg waiting on arrival signed by MA G 02/04/2026 at 08:04 AM, hydrocodone 10-325mg on order signed by MA B 02/04/2026 at 12:32 PM, hydrocodone 10-325mg N/A signed by MA B 02/04/2026 at 4:03 PM, hydrocodone 10-325mg on order signed by MA B 02/05/2026 at 08:12 AM, hydrocodone 10-325mg on order signed by MA B 02/05/2026 at 12:38 PM, hydrocodone 10-325mg on order signed by MA B Record review of Resident #2's progress notes dated 01/28/2026-02/05/2026 did not indicate Resident #2's physician, NP or the pharmacy were notified he was out of his hydrocodone. Record review of Resident #2's Triplicate Request form dated 01/05/2026 for Hydrocodone-Acetaminophen tablet 10-325 milligrams give one tablet by mouth three times day indicated there was an unsigned and undated handwritten note which stated a new triplicate was required because they changed pharmacies. During an interview on 03/04/2026, at 08:35 AM Resident #2 stated that he had received his medications lately. Resident #2 stated that about a month ago he had not received his pain medication for 5 days. Resident #2 said the MA had tried to help him get his pain medication every day that she was at work. Resident #2 said the nurse (unable to recall who) was not helping the situation. Resident #2 said he was never told what happened and why he could not have his pain medication. Resident #2 said all he knew was that the MA said his pain medication was not in the building. Resident #2 said he could not sleep or get any rest due to the excessive pain he felt. He said he suffered excruciating pain in his back and neck and experienced numbness in his hands and fingers. Resident #2 stated that he had a fall prior to his admission into the facility. Resident #2 stated his pain in his back and neck since the fall could be unbearable without the pain medications. Resident #2 was tearful and anxious and said he was embarrassed by how he treated the staff due to being agitated and irritable from lack of sleep. Resident #2 said he felt off the chart in pain greater than 10 on a scale of 1 out of 10 with 10 being the greatest pain. Resident #2 said, the MA had offered to reposition and adjusted his pillows but at that point he denied anything and I wanted my real pain medication - nothing else was going to touch my pain. He said he prayed that he never had to experience that pain again. During an interview on 03/04/2026 at 09:35 AM. The anonymous person said she was aware Resident #2 had not received the ordered Hydrocodone-Acetaminophen tablet 10-325 milligrams and had multiple missed dosages. An anonymous person said she had told the charge nurses. The anonymous person said she could not recall which nurse she told. The anonymous person said not all nurses would follow through. The anonymous person said the ADON was aware and tried to assist. The anonymous person said she thought the ADON had done her part to follow up with the pharmacy by calling and faxing but nothing had changed. The anonymous person said it was important for residents to receive their ordered medications as prescribed by the physician to prevent a decline in their health condition or have increased pain. During an interview on 03/04/2026 at 10:00 AM, MA B said Resident #2 expressed pain to her that was uncontrolled. MA B said she noticed his frustration and immediately reported it to the charge nurse, LVN A on 2/15/2[TRUNCATED]