STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676100	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at San Angelo	5455 Knickerbocker Rd San Angelo, TX 76904

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Resident #1) of 4 residents reviewed for pressure ulcers. The facility failed to obtain treatment orders for wound care upon admission for Resident #1. This failure could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain.Findings included:Record review of Resident #1's face sheet undated revealed [AGE] year-old male admitted [DATE] from another nursing facility. Diagnoses included encounter for orthopedic aftercare following surgical amputation (the need for aftercare and follow up of a patient who has undergone surgical amputation), type 2 diabetes mellitus (metabolic condition where the body develops insulin resistance, causing high blood sugar levels because the cells fail to respond to insulin properly). Unspecified protein calorie malnutrition (the lack of sufficient energy or protein to meet the body's metabolic demands). Record review on 2/12/2026 of Resident #1's discharge orders from 1/28/2026 from discharging facility revealed wounds were present upon discharge and treatment orders were in place prior to admitting to the facility for wounds on left below knee amputation surgical site, unstageable pressure ulcer to right heel, venous ulcer to right calf, and arterial ulcer to right great toe.Record review of Resident #1's comprehensive MDS dated [DATE] revealed it was not completed due to Resident #1 only being in facility for 8 days.Record review of Resident #1's Care Plan dated 1/30/2026 revealed a problem of wound management. The goal was wounds will be free from infection. Intervention included providing wound care per treatment order.Record review of Resident #1's order summary dated January 2026 revealed no orders for wound care had been entered into the electronic health record. Record review of Resident #1's order summary dated February 2026 revealed orders for treatment were entered into the electronic health record on 2/5/2026.Record review of Resident #1's wound assessment completed on 2/5/2026 by Wound Care NP revealed the following wounds: Left below knee amputation surgical site, Unstageable pressure ulcer to right heel, venous ulcer to right posterior (the back or rear side) calf, arterial ulcer to right great toe. Wound assessment stated these wounds were present on admission. Wound care Nurse Practitioner wrote orders for these wounds upon assessment completed on 2/5/2026.Record review of hospital History and Physical dated 2/12/2026 revealed wounds did not have infections, and no new wounds were noted. History and Physical revealed Resident #1 had poor blood flow to the lower right foot and leg. Interview with ADON on 2/12/2026 at 3:00PM revealed facility does not utilize a treatment nurse. ADON stated the charge nurses do their own treatments on their patients. ADON stated orders should be obtained and entered upon admission. ADON stated it was the charge nurse's responsibility to ensure orders are entered correctly upon admission. ADON stated Resident #1's wounds did not worsen while at facility.Interview with DON on 2/13/2026 at 10:30AM revealed nurses have an (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission checklist to go by when admitting a resident. DON stated Resident #1 should have had wound care orders upon admission. DON stated the orders from previous facility should have been carried over and any changes communicated with MD. DON stated wound care was being completed for Resident #1 the orders just did not get transcribed into the electronic health record. DON stated the risk of not having orders transcribed into the electronic health record could be nurses not knowing the correct wound care and delayed healing. DON stated his wounds did not worsen while at the facility. Interview on 2/13/2026 at 10:00AM with NP revealed Resident #1 had a history of non-healing wounds in the past that led to amputation of left leg. NP stated Resident #1 had poor circulation in the right leg and wounds may not heal. NP stated admission orders should have been carried over from discharging facility on admission. NP stated the risk of this not being done could be infection and poor wound healing. Interview on 2/13/2026 at 2:00PM with wound care NP revealed that resident admitted to the facility with surgical wound to left below knee amputation site, unstageable pressure ulcer to right heel, venous ulcer to right posterior calf, and arterial ulcer to right great toe. NP stated she wrote treatment orders on 2/5/2026 after she assessed Resident #1's wounds. NP stated she could tell wound care was being completed because the dressings were not soiled like they would have if treatments were not being completed. NP stated the nurses should not wait for her to assess wounds to obtain orders and should obtain them from the MD on admission or carry over previous orders from discharging facility. NP stated the wounds did not show any signs of infection at the time of assessment on 2/5/2026. NP stated the risk of not obtaining orders on admission could be infection, and delay in healing. Interview on 2/16/2026 at 11:00PM with Regional Nurse Consultant revealed treatment orders should have been entered into the electronic health record on the day of admission. RNC stated orders should have been carried over from discharging facility and MD notified to see if changes needed to be made. RNC stated the admitting nurse was responsible for this and the DON should oversee and ensure that it was completed. RNC stated the risk of not obtaining orders on admission could be infection, delayed healing, or improper wound care.Review of facilities policy titled Wound Care with no date revealed:The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.Preparation:Verify that there is a physician's order for this procedure.Review the residents' care plan to assess any special needs of the treatment.Documentation:The following information should be recorded in the residents' medical record:The date wound care was givenThe initials of the individual performing the wound care.Any change in the resident's condition.Any problems or complaints made by the resident related to the procedure.If the resident refused the treatment and the reason why.The signature and title of the person recording the data.