STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676120	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Sherman	1000 Sara Swammy Dr Sherman, TX 75090

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for six of six residents (Resident #1, #2, #3, #4, #5, #6) observed during medication pass. 1. The Facility failed to ensure MA A followed the facility's policy on administering medications for Resident #1, Resident #2 and Resident #3 by prefilling the resident's morning medication prior to the administration time on 02/18/26. 2. The Facility failed to ensure MA B followed the facility policy on administering controlled medications for Resident #4, Resident #5, and Resident #6 by prefilling the resident's medication prior to the administration time on 02/18/26. This failure could affect residents who received medications by placing them at risk for medication errors and/or receiving another resident's medication.Findings Included: 1. An observation, record review and interview on 02/18/26 at 8:15 a.m. revealed 400 MA A on hall preparing to administer medications to Resident #1. MA A pulled a plastic medication cup from the top drawer of the medication cart which contained several pills and had Resident #1's name written on the cup. When asked to compare the pills in the medication cup, MA A stated she would have to go to the hall 300/400 medication cart and pull the resident's blister packs. MA A went down to the nurse's station and pulled the blister packs for Resident #1 from the Hall 200 medication cart and compared the pills in the medication cup with the electronic medication administration record and the blister packs which revealed the following medications which had been previously pulled: Amiodarone 200 mg 1 capsule-twice a day- 9 a.m.-9 p.m.Zofran 4 mg 1 tablet-every 4 hours- 12 a.m.-4 a.m.-8 a.m.-12 p.m.-4 p.m.-8 p.m.Flomax 0.4 mg 1 capsule- once a day 5 a.m.Glipizide 10 mg 1 tablet- twice a day-9 a.m.-9 p.m.Metoprolol 25 mg 1 tablet-once a day-9 a.m.Vitamin C 500 mg 1 tablet- twice a day-7 a.m.-7 p.m.Zinc 50 mg 1 tablet-once a day -7 a.m.Multi-Vitamin 1 tablet- once a day- 7 a.m.Aspirin 81 mg 1 tablet- once a day-7 a.m. MA A then returned to Resident #1's room and administered the medication. An observation, record review and interview on 02/18/26 at 8:30 a.m. revealed MA A taking two medication carts to hall 300 to administer Resident #2's medication. Again, she opened the top drawer of the hall 200 medication cart revealing multiple medication cups filled with medication that had various Resident names on the outside of the cups. MA A pulled the cup of pills that had Resident #2's name written on it. MA A then pulled the blister packs from the hall 300/400 medication cart and compared the medications in the cup with the blister packs and the electronic medication administration record and realized she had missed pulling Cranberry 500 mg. tablets. MA A then opened the Medication cart for hall 300/400 and retrieved a 500 mg bottle of cranberry tablets and added 1 tablet in with the following medications which had been previously pulled: Amiodarone 200 mg 1 tablet-twice a day 9 a.m.-9 p.m.Plavix 75 mg 1 tablet- once a day-9 a.m.Eliquis 5 mg 1 tablet-twice a day 9 a.m.-9 p.m.Potassium Chloride 20 meq 1 tablet- once a day 9 a.m.Vitamin C 500 mg 1 tablet-twice a day 9 a.m.-9 p.m.Muli-vitamin 1 tablet. Once a day- 9 a.m.Cranberry 500 mg 1 tablet- once a day- 7 a.m. (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MA A then entered Resident #2's room and administered the medications. MA A then returned the medication cart for hall 300/400 to the nurse's station and proceeded to Hall 200 with the hall 200 medication cart. An observation, interview and record review on 02/18/26 at 8:45 a.m. revealed MA A pulled a medication cup filled with pills with Resident #3's name written on it, from the top drawer of the medication cart. MA A stated his medications were due at 7 a.m., but when she came to give them to him he asked her to come back later. MA A then pulled the blister packs from the medication cart and compared the medications in the cup with the blister packs and the electronic medication administration record which revealed the following medications that had been previously pulled: Ativan 0.5 mg 1 tablet (controlled substance)- once a day 7 a.m.Hydrocodone/acetaminophen 10-325 mg 1 tablet (controlled substance) three times a day- 7 a.m-1 p.m.-7 p.m.Carbidopa-Levodopa Oral Tablet 25-100 mg 1 tablet - three times a day- 7 a.m-1 p.m.-7 p.m.Wellbutrin XL 150 mg 1 tablet-once a day-7 a.m.Lasix 40 mg 1 tablet -twice a day-7 a.m.-7 p.m.Primidone 50 mg 1 tablet-twice a day-7 a.m.-7 p.m.Flomax 0.4 mg 1 capsule-once a day 7 a.m. MA A entered Resident #3's room and administered the medications. In an interview with MA A on 02/18/26 at 8:55 a.m. she stated she knew she was not supposed to pre-fill medications but was supposed to follow the rights of medication administration, which was to compare the right resident, right medication, right dosage, right time and right method. She stated because the facility had put in different times for the resident's routine medication she had been having difficulty getting to all of the residents within the prescribed time when she had to go from cart to cart, hall to hall, so she took a short cut by prefilling the resident's medications and putting them in one cart. She stated after today, that would never happen again. She stated she had asked the nurses on several occasions to correct the administration times, but due to all of the staff changes it had not been corrected. She stated she knew it was a risk to pre-fill medication because meds could get spilled in the cart, or she could accidentally pick up the wrong resident's medication. She stated she had learned her lesson and would never do that again. 2. An observation, record review and interview on 02/18/26 at 09:05 a.m. with MA B revealed her at the medication cart for Hall 100. MA B stated she was about halfway through with the morning medication pass. MA B opened the top drawer of the medication cart which revealed 3 medication cups with pills in them. The medication cups had Resident #4, Resident #5 and Resident #6's names written on the outside of the cups. MA B stated the cups contained the residents'-controlled medications which were scheduled to be given with their routine morning medications. MA B unlocked the narcotic lock box to pull the blister packs and compared the medications with the electronic medication administration record and the pills in the medication cups, which revealed: Resident # 4Tramadol 50 mg 1 tablet -twice a day at 9 a.m. and 9 p.m. Resident #5Tramadol 50 mg 1 tablet-three times a day at 9 a.m. 3 p.m. and 9 p.m. Resident #6Hydrocodone/acetaminophen 10-325 mg 1 tablet-twice a day 9 a.m. and 9 p.m. In an interview with MA B on 02/18/26 at 09:10 a.m. she stated she had pulled all of the narcotics at once to save time. She stated she knew she was supposed to pull the medications one at a time and sign out when the medication was pulled which should match the time the medication was administered. She stated she had pulled all the narcotics around 8:45 a.m. for the residents' 9:00 a.m. medication pass. She stated the risk of pre-filling medications and leaving them in the top of the medication cart was the medications could get mixed up, spilled, or the wrong medication could be given to the wrong resident. She stated she just took a short cut which she should not have done. In an interview with the ADON on 02/18/26 at 9:20 a.m. she stated the staff are not allowed to pre-fill medications for multiple residents. She stated they are supposed to prepare the medication at the time of administration. She stated pre-filling multiple residents' medication and placing them in the medication cart posed the risk of the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications being spilled, mixed up with other resident's medications or the staff accidently grabbing the wrong resident's medication. She stated narcotics and controlled medication were to be signed out and administered at the time they were signed out. She stated the staff are supposed to inform the resident what they were about to be given to determine if they were going to take the medication or decline. She stated by pre-filling if the resident were to decline, then the medication would have to be wasted. She stated they do random checks on the medication carts and observations with the staff and will definitely be doing more checks and audits. In an interview with the DON on 02/18/26 at 9:44 a.m. she stated it was not the policy or procedure of the facility to pre-fill medication for the residents. She stated the staff was to compare the medication with the electronic medication administration records at the time of the administration to ensure they are giving the right dose, the right medication, the right resident, the right route and the right time. She stated some of the medications require parameters to be checked prior to administering and that might get overlooked if someone had pre-filled medications and the staff could accidently grab the wrong medication and administer someone else's medication to the wrong resident. She stated they had liberal medication pass times and stated it appeared the staff had not been following the medication pass times on several of the medications. She stated they would be reviewing all of the medication administration times to ensure consistency, patient preferences and what medications needed to be administered at a specific time. She stated they would be doing in-service on the facility's procedures for medication administration. She stated she would also be completing one on one monitoring with the staff. Record review of the facility's policy titled, Administering Medications, dated April 2019, reflected, Medications are administered in a safe and timely manner, and as prescribed.The individual administering the medications verifies the residents identify before giving the resident his/her medications.The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.For resident not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.