STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676164	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bellville	106 N Baron Bellville, TX 77418

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 14 residents (Residents #11 and #96) reviewed for assessments: 1. Resident #11's significant change MDS, dated [DATE], identified the resident had insulin. However, Resident #11 did not have insulin. 2. Resident #96's admission MDS, dated [DATE], identified the resident was always continent for urinary bladder. However, Resident #96 had an indwelling urinary catheter. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: 1. Record review of Resident #11's face sheet, dated 03/21/2025, revealed the resident was a [AGE] year old female and admitted to the facility on [DATE] with the diagnoses of moderate protein-calorie malnutrition (reduced availability of nutrients leads to changes in body composition and function), type 2 diabetes mellitus (not control blood sugar in the body), muscle weakness, anemia (not have enough red blood cells), and vertigo (dizziness). Record review of Resident #11's significant change MDS, dated [DATE], revealed the resident's BIMS was 15 out of 15, which indicated the resident's cognitive function was intact, and in the Section N (medications), the resident was receiving insulin once a week. Record review of Resident #11's physician orders, dated 03/21/2025, revealed there was no orders of insulin. Further record review of the resident's physician order indicated the resident had the order of Trulicity (Dulaglutide) pen injector 3 mg/0.5 ml one dose, subcutaneous, once a day on Friday at 6:00 am for diabetes. Record review of Drugs.com (https://www.drugs.com/medical-answers/trulicity-form-insulin-3544515), dated 03/20/2025, revealed Trulicity is not a form of insulin. It occurs hormone that stimulates insulin secretion. Interview on 03/20/2025 at 12:15 p.m. with a pharmacist surveyor stated Trulicity was not insulin. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/2025 at 12:20 p.m. with the MDS nurse stated Resident #11 did not have insulin. The resident had Trulicity shot once a week, and the MDS nurse thought it was insulin. However, it was not insulin. The MDS nurse said that Resident #11's significant change MDS, dated [DATE], should have not coded the resident was receiving insulin and inaccurate MDS assessment potentially caused incorrect care to Resident #11. 2. Record review of Resident #96's face sheet, dated 03/21/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia (do not have enough oxygen in the tissues in the body), muscle weakness, neuromuscular dysfunction of bladder (nerves that carry messages back and forth between the bladder and the spinal cord and brain do not work), hear failure (heart not pumping enough blood to the body), and kidney disease state 3 (kidneys have damage and less able to filter waste and fluid). Record review of Resident #96's admission MDS, dated [DATE], revealed the resident's BIMS score was 10 out of 15, which indicated the resident had moderate cognitive impairment, and the resident was always continent for urinary bladder. Record review Resident #96's comprehensive care plan, dated 03/19/2025, revealed Resident requires a suprapubic catheter (medical device that helps drain urine from the bladder. It enters the body through a small incision in abdomen) related to neurogenic bladder. For intervention - Keep catheter system. Observation on 03/20/2025 at 2:13 p.m. revealed Resident #96 had a suprapubic catheter, which was one of indwelling urinary catheter, and LVN-A was providing catheter care to the resident. Interview on 03/20/2025 at 12:06 p.m. with the MDS nurse stated Resident #96 had a suprapubic urinary catheter, so Resident #96's admission MDS, dated [DATE], was inaccurate. The MDS nurse said that she should have coded the resident had indwelling urinary catheter because the suprapubic urinary catheter that Resident #96 had was one of the indwelling urinary catheters. It was mistake, and inaccurate MDS assessment potentially caused incorrect care to Resident #96. Record review of the facility policy, titled Resident assessment, revised 03/2022, revealed . 8. All persons who have completed any portion of the MDS resident assessment from must sign the document attesting to the accuracy of such information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 14 residents (Resident #7) reviewed for care plans. The facility failed to ensure Resident #7's care plan reflected her oxygen status and included a care plan regarding how to take care of the resident's oxygen. This failure could place residents at risk for not receiving proper care and services due to inaccurate care plans. The findings included: Record review of Resident #7's face sheet, dated 03/21/2025, revealed the resident was an [AGE] year old female, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses of chronic kidney disease state 3 (kidneys have damage and less able to filter waste and fluid), venous insufficiency (veins have problem moving blood back to the heart), hear failure (heart not pumping enough blood to the body), muscle weakness, and hypertension (high blood pressure). Record review Resident #7's significant change MDS, dated [DATE], revealed the resident's BIMS score was 11 out of 15, which indicated the resident had moderate cognitive impairment, and the resident was receiving oxygen therapy. Record review of Resident #7's comprehensive care plan, dated 01/13/2025, revealed there was no care plan related to oxygen therapy. Record review of Resident #7's physician order, dated 02/28/2025, revealed the resident had the order of oxygen at 3 liter per minutes via nasal cannular. Apply oxygen via nasal cannula for less than 92% oxygen saturation levels every 4 hours as needed. Interview on 03/18/2025 at 4:42 p.m. with Resident #7 said the resident received oxygen via nasal cannula and sometimes she had difficulty breathing. Interview on 03/20/2025 at 1:04 p.m. with LVN-A stated Resident #7 received oxygen therapy sometimes when the resident's oxygen saturation was less than 92%. Interview on 03/20/2025 at 1:56 p.m. with the MDS nurse stated the MDS nurse should have developed Resident #7's comprehensive care plan related to oxygen therapy because the resident received it sometimes when her oxygen saturation was less than 92%. Further interview with the MDS nurse said she overlooked it, and it was her mistake. No care plan potentially caused improper care to Resident #7. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Care plan, comprehensive person-centered, revised 03/2022, revealed 7. The comprehensive, person-centered care plan: . b. describes the services that are to be furnished to attain or maintain the resident highest practicable physical, [NAME], and psychosocial well-being including: (3) which professional services are responsible for each element of care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #16) reviewed for incontinence care. When CNA-C was providing incontinent care to Resident #16 on 03/19/2025, the CNA-C did not clean the resident's suprapubic area (the area of the abdomen located below the umbilical region). This failures could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: Record review of Resident #16's face sheet, dated 03/21/2025, revealed the resident was a [AGE] year old male and admitted to the facility on [DATE] with the diagnoses of cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), hypertension (high blood pressure), hypokalemia (low potassium in the blood), muscle weakness, type 2 diabetes mellitus (not control blood sugar in the body), and muscle wasting and atrophy (wasting or thinning of muscle mass). Record review of Resident #16's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive function was intact, and the resident was always incontinent to bladder and bowel. Resident #16 was dependent (helper does all of the effort) to sit-to-stand and not applicable to chair-to-bed and toilet transfer. Record review of Resident #16's comprehensive care plan, dated 03/04/2025, revealed Incontinence of bowel and bladder related to history of stroke. For intervention - incontinent care per rounds and monitor and document for signs and symptoms of urinary tract infection. Observation on 03/19/2025 at 2:08 p.m. revealed CNA-C opened Resident #16's old and dirty brief and cleaned the resident's penis, and then cleaned the left and right groin area. CNA-C and CNA-D turned the resident to his left side without cleaning the suprapubic area. CNA-C cleaned the resident's buttock area, then put a new and clean brief on the resident. Interview on 03/19/2025 at 2:19 p.m. with CNA-C stated she did not clean Resident #16's suprapubic area, because she was nervous and forgot to clean the area. CNA-C said she should have cleaned the area when providing peri-care to Resident #16 and had peri-care training when she was hired, which was three months ago. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/2025 at 5:05 p.m. with the DON said CNA-C should have cleaned Resident #16's suprapubic area, when providing peri-care to the resident. The DON stated DON had responsibility for monitoring CNA-C by checking off the CNA's skills, but she did not conduct the skill check-off of on CNA-C yet, and that it was scheduled for May of 2025. However, CNA-C followed senior CNAs for three days before she worked on the floor and showed her skills regarding perineal care. Record review of the facility policy, titled Perineal care, revised 02/2018, revealed Clean the peri area with wipes going front to back/clean to dirty.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #26) of one resident reviewed for enteral nutrition. When RN-E administered a medication via gastrostomy tube to Resident #26, RN-E did not check residual by aspiration of gastric content of the resident. This failure could place residents with gastrostomy tube at risk for complications, aspiration, and pneumonia. Findings included: Record review of Resident #26's face sheet, dated 03/21/2025, revealed the resident was a [AGE] year old male and admitted to the facility on [DATE] with the diagnoses of moderate protein-calorie malnutrition (not enough protein and energy to meet nutritional needs), dysphagia (difficulty of swallowing), gastro-esophageal reflux disease (stomach acid repeatedly flows back up), and muscle wasting and atrophy (wasting or thinning of muscle mass). Record review of Resident #26's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 6 out of 15, which indicated the resident had severe cognitive impairment and had gastrostomy tube. Resident #26 was dependent (helper does all of the effort) for eating and substantial/maximal assistance (helper does more than half the effort) chair-to-bed transfer and toilet transfer. Record review of Resident #26's comprehensive care plan, dated 03/04/2025, revealed Dependent on tube feeding for nutrition and hydration with potential for complications and side effects. For intervention - administer tube feeding, medications and water flushes as ordered. See medical doctor orders for current feeding orders and check for gastric content/residual volume per protocol and document. Record review of Resident #26's physician order, dated 01/27/2025, revealed the resident had the order of Tube placement checked by aspiration of gastric content and visual inspection prior to feeding or medication administration. Notify supervisor and/or physician/physician extender of abnormal findings. If aspirate greater than (>) 100 cc, hold formula/water/medication and notify physician/physician extender. Observation on 03/19/2025 at 4:52 p.m. revealed RN-E conducted Resident #26's gastrostomy tube placement by visual inspection prior to medication administration after connecting the syringe to the tube, then RN-E flushed the tube with 30 cc of water before giving med via the tube and administered one medication without checking residual by aspiration of gastric content. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/2025 at 5:05 p.m. RN-E stated he did not check Resident #26's residual by aspiration of gastric content. RN-E conducted the tube placement with only visual inspection. Further interview with the RN-E said he should have checked the resident's residual by aspiration of gastric content because the physician order indicated If aspirate greater than (>) 100 cc, hold formula/water/medication and notify physician/physician extender. The RN-E said that If he did not check the residual, he did not know if the resident's residual was greater than 100 cc. RN-E was nervous and forgot checking the residual. Interview on 03/19/2025 at 5:25 p.m. with Resident #26's primary care physician stated not checking Resident #26's residual did not cause any harm because the resident did not have any history of high residual. The order was not specific but general for most residents with gastrostomy tube. Interview on 03/19/2025 at 5:29 p.m. the DON said RN-E should have checked Resident #26's residual by aspiration of gastric content prior to medication administration as ordered. Not checking Resident #26's residual prior to medication administration did not cause any harm because RN-E administered only one medication, but potentially the resident might have high residual (greater than 100cc). It was DON's responsibility to oversee and monitor nurses' skills regarding tube feeding. Record review of the facility policy, titled Administering medications through an enteral tube, revised 03/2015, revealed . 18. Confirm placement feeding tube per physician order. By aspirating stomach contents, if no residual is aspirated check for bowel sounds, bloating, vomiting, and pain. If not, changes are noted precede to administer medications/formula.20. Checked gastric residual volume to assess for tolerance of enteral feeding.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure that licensed staff were able to demonstrate the specific competencies and skill sets necessary to care for resident's needs for 2 of 2 nursing staff (CNA-C and CNA-D) reviewed for competencies. The facility did not perform CNA-C and CNA-D's annual skill check-off. This failure could place the residents at risk for receiving care by staff who do not have the training and competency needed for providing care. The findings included: Record review of CNA-C and CNA-D's employee profiles revealed CNA-C was hired to the facility on [DATE], and CNA-D was hired on 05/25/2023. CNA-C did not have skill check-off for perineal care upon hiring date, and CNA-D did not have skill check-off for perineal care in 2024. Observation on 03/19/2025 at 2:08 p.m. revealed CNA-C opened Resident #16's old and dirty brief and cleaned the resident's penis, and then cleaned the left and right groin area. CNA-C and CNA-D turned the resident to his left side without cleaning the suprapubic area. CNA-C cleaned the resident's buttock area, then put a new and clean brief on the resident. Interview on 03/19/2025 at 2:19 p.m. with CNA-C stated she did not clean Resident #16's suprapubic area, because she was nervous and forgot to clean the area. CNA-C said she should have cleaned the area when providing peri-care to Resident #16 and had peri-care training when she was hired, which was three months ago. Interview on 03/21/2025 at 2:33 p.m. the DON said she did not conduct CNA-C's perineal skill check off on 01/20/2025 (date of hire) and did not conduct CNA-D's perineal skill check off in 2024. The DON did not know what reason the previous DON did not perform the annual skill check-off because the DON was hired to the facility in August of 2025, and the facility generally performed annual skill check-off every April or May. It was DON's responsibility to oversee CNAs' skill check-off for competency. To ensure CNA-C and D's competency to meet residents' needs, when the facility hired CNA-C and D, the facility provided three days to the CNAs for following senior CNAs for three days, and the CNAs should demonstrate their skills correctly, then the facility allowed the CNAs to work on the floor. Further interview with the DON said she would have plan to do the skill check-off in May of 2025. Record review of the facility policy, titled Staffing, sufficient and competent nursing, revised 08/2022, revealed . 2. All nursing staff must meet the specific competency requirements of their respective licensure and certificate requirement defined by state law.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 39049 Based on interviews and record reviews, the facility failed to maintain the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 25 days (10/05/2024, 10/06/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/19/2024, 10/20/2024, 10/21/2024, 10/26/2024, 10/27/2024, 11/02/2024, 11/03/2024, 11/09/2024, 11/10/2024, 11/16/2024, 11/17/2024, 11/23/2024, 11/24/2024, 11/28/2024, 11/30/2024, 12/01/2024, 12/14/2024, and 12/15/2024) of the 6-month review period, reviewed for RN coverage. The facility failed to ensure the facility maintained the required RN coverage for 25 days between October 2024 to March 2025. This failure could place residents at risk of not having their nursing and medical needs met and receiving improper care. Findings included: Review of CMS PBJ staffing reports, from October 2024 to December 2024, reflected the facility triggered for no RN hours for FY 4th Quarter 2024 (October 2024 to December 2024). Review of the facility RN schedule from January 2025 to March 2025 revealed the facility did not have the required Registered Nurses coverage of at least 8 consecutive hours a day for the following dates: 10/05/2024 no hours recorded. 10/06/2024 no hours recorded. 10/10/2024 no hours recorded. 10/11/2024 no hours recorded. 10/12/2024 no hours recorded. 10/13/2024 no hours recorded. 10/14/2024 no hours recorded. 10/19/2024 no hours recorded. 10/20/2024 no hours recorded. 10/21/2024 no hours recorded. 10/26/2024 no hours recorded. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/27/2024 no hours recorded. 11/02/2024 no hours recorded. 11/03/2024 no hours recorded. 11/09/2024 no hours recorded. 11/10/2024 no hours recorded. 11/16/2024 no hours recorded. 11/17/2024 no hours recorded. 11/23/2024 no hours recorded. 11/24/2024 no hours recorded. 11/28/2024 no hours recorded. 11/30/2024 no hours recorded. 12/01/2024 no hours recorded. 12/14/2024 no hours recorded. 12/15/2024 no hours recorded. Interview on 03/21/2025 at 2:09 p.m. with the Administrator stated the Administrator could not find RN hours for the 25 days, which meant the facility did not have RN working to those 25 days because they could not find RNs. The facility had RN since 12/15/2024. If RNs did not work at the facility, it might cause improper care to residents. Record review of the facility policy, titled Staffing, sufficient, and Competent Nursing, revised 08/2022, revealed 3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. Registered nurses many be scheduled more than eight (8) hours depending on the acuity needs of the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, 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 14 residents (Resident #5 and #97) and 1 of 1 medication room reviewed for pharmacy services. 1. There was one medication (Ketoconazole cream for fungal or yeast infection) expired on 08/2022 found on Resident #5's nightstand in the resident's room on 03/18/2025. 2. Medication aide-B administered Resident #97's Cyclosporine 0.05% eye drop for increasing tear production two drops to the resident's each eye on 03/20/2025. However, the physician order indicated Cyclosporine 0.05% one drop into both eyes. 3. In the medication room, a. There was one medication (Hydrocortisone cream for fast itch and rash relief) expired on 02/2025 found inside the medication room on 03/19/2025. b. There were total 14 Intell-Swab covid-19 rapid home test for nasal swap expired on 12/31/2024 found inside the medication room on 03/19/2025. These failures could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: 1. Record review of Resident #5's face sheet, dated 03/21/2025, revealed the resident was an [AGE] year old male, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses of cerebral infarction (disrupted blood flow to the brain due to problem with the blood vessels that supply it), type 2 diabetes mellitus (not control blood sugar in the body), muscle wasting and atrophy (wasting or thinning of muscle mass), embolism and thrombosis of deep vein of lower extremity (blood clot develops in the deep veins in legs), and hypertension (high blood pressure). Record review of Resident #5's annual MDS, dated [DATE], revealed the resident's BIMS score was 10 out of 15, which indicated he had moderate cognitive impairment and required set up assistance (helper sets up or cleans up) for eating, chair-to-bed transfer, and toilet transfer. Record review of Resident #5's physician orders, dated 03/21/2025, revealed there was no physician order regarding the medication of Ketoconazole cream for fungal or yeast infection. Record review of Resident #5's medical record from 03/20/2024 to 03/20/2025 revealed the resident did not have any fungal or yeast infection to his skin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676164	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bellville	106 N Baron Bellville, TX 77418

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/18/2025 at 10:52 a.m. revealed Resident #5 was sleeping in his wheelchair in his room. There was one medication (Ketoconazole cream for fungal or yeast infection) expired on 08/2022 found on Resident #5's nightstand in his room. Interview on 03/18/2025 at 11:18 a.m. with LVN-A stated she saw one medication (Ketoconazole cream for fungal or yeast infection) expired on 08/2022 found on Resident #5's nightstand in his room with the surveyor. LVN-A said she worked on 03/17/2025 but did not see it. The nurse did not know why this expired medication was on Resident #5's nightstand. Further interview with the LVN-A stated Resident #5's family member visited on 03/17/2025 and might've brought it. However, LVN-A said Resident #5 did not have fungal or yeast infection at this time, and making sure all expired medications were removed even though family member brought was still nurses' responsibility. Resident #5 might have allergy or not have therapeutic effects due to the expired medication. Interview on 03/20/2025 at 5:05 p.m. with the DON stated all expired medications should have been removed even though family member brought, and it was nurses' responsibility. Resident #5 might have adverse effects or not have therapeutic effects due to the expired medication. 2. Record review of Resident #97's face sheet, dated 03/21/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] with diagnoses of partial intestinal obstruction (bowel is partly blocked and some faces can still get through), muscle weakness, edema (swelling caused by fluid), hypothyroidism (thyroid gland does not produce enough thyroid hormone), and rheumatoid arthritis (chronic inflammatory disorder usually affecting small joints in the hands and feet). Record review of Resident #97's admission MDS, dated [DATE], revealed it was still in progress and in time because the resident was admitted to the facility on [DATE]. Record review of Resident #97's physician order, dated 03/12/2025, revealed the resident had the order of Cyclosporine 0.05% one drop, ophthalmic twice a day at 8 am and 4 pm. Place one drop into both eyes two times a day for increasing tear production. Record review of Resident #97's medication administration record, from 03/01/2025 to 03/31/2025, revealed the resident received Cyclosporine 0.05% one drop, ophthalmic twice a day at 8 am and 4 pm into both eyes for increasing tear production. Observation on 03/20/2025 at 8:57 a.m. revealed medication aide-B opened Resident #97's Cyclosporine 0. 05% eye drop and placed two drops to the resident's each eye. Interview on 03/20/2025 at 9:15 a.m. with Resident #97 said she did not want to talk to the surveyor. (continued on next page)

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Avir at Bellville	106 N Baron Bellville, TX 77418

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/20/2025 at 8:58 a.m. with medication aide-B said she placed two drops of Cyclosporine 0. 05% to Resident #97's both eyes because the resident said she would like to receive two drops to just one time a day, instead of one drop to two times a day. Further interview with medication aide-B stated she notified the charge nurse, and the charge nurse said the nurse would report it to Resident #97's primary care physician. However, the nurse did not say anything to medication aide-B, so the medication aide-B thought placing two drops to Resident #97's both eyes once a day was fine. Medication aide-B said she did not remember the nurse's name because the nurse was an agency nurse and did not work anymore since the medication aide-B reported it to the nurse. Interview on 03/20/2025 at 11:07 a.m. with LVN-A stated the nurse did not know Resident #97 would like to receive her Cyclosporine 0.05% eye drop to two drops to her each eye to just once a day, instead of one drop to each eye twice a day. Nobody reported it to LVN-A, and LVN-A said facility nurses should have contacted Resident #97's primary care physician and asked for their advice regarding the resident's preference about the eye drop. If the doctor changed the order, the nurses should update the order and follow the updated order. Interview on 03/20/2025 at 11:12 a.m. with the DON stated the DON did not know Resident #97's preference regarding the resident's Cyclosporine 0.05% eye drop. The DON had knowledge regarding the resident's preference because of the surveyor. Per the nursing schedule, only one agency nurse worked only one day since the resident was admitted to the facility, and it was 03/15/2025. However, the agency nurse did not work anymore. The DON said that the agency nurse should have notified regarding Resident #97's eye drop to the primary care physician and followed any updated order per the professional standard of nursing practice and facility policy. It was medication error also. Resident #97 might not receive adequate care and medical interventions to maintain her health. 3. a. Observation on 03/19/2025 at 2:46 p.m. revealed there was one medication (Hydrocortisone cream for fast itch and rash relief) expired on 02/2025 found inside the medication room. b. Observation on 03/19/2025 at 2:48 p.m. revealed there were total 14 Intell-Swab covid-19 rapid home test for nasal swap expired on 12/31/2024 found inside the medication room. Interview on 03/19/2025 at 2:49 p.m. with the DON stated there was one medication (Hydrocortisone cream for fast itch and rash relief) expired on 02/2025 and total 14 Intell-Swab covid-19 rapid home test for nasal swap expired on 12/31/2024 found inside the medication room. The DON said she did not know the reason why these expired medications were stored inside the medication room., The DON said all expired medications should have been removed, and it was the facility nurses' responsibility. The DON said the expired covid-19 test might have false result, and residents might have adverse effects or not have therapeutic effects due to the expired medications. Record review of the facility policy, titled Administering Medications, revised 04/2019, revealed . 4. Medications are administered in accordance with prescriber orders, including any required time frame. Record review of the facility policy, titled medication Labeling and storage, revised 02/2023, revealed . 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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Avir at Bellville	106 N Baron Bellville, TX 77418

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 8% based on 2 errors out of 25 opportunities, which involved two residents (Residents #10 and #97) of five residents reviewed for medication errors. 1. Medication aide-B administered fiber laxative calcium polycarbophil 625 mg one tablet for constipation to Resident #10 on 03/19/2025, but the physician order indicated Metamucil (psyllium husk) 0.4-gram one capsule for constipation. 2. Medication aide-B administered Resident #97's Cyclosporine 0.05% eye drop for increasing tear production two drops to the resident's each eye on 03/20/2025. However, the physician order indicated Cyclosporine 0.05% one drop into both eyes. These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications or not receiving them as prescribed, per physician orders. Findings include: Record review of Resident #10's face sheet, dated 03/21/2025, revealed the resident was a [AGE] year old female, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses of chronic kidney disease stage 3 (kidney does not filter waste and fluid well), sciatica (pain that travels along the path of buttock and down to each leg), constipation, osteoporosis (weakness of bone), heartburn, and irritable bowel syndrome with constipation (stomach and intestines pain, bloating, or constipation). Record review of Resident #10's significant change MDS, dated [DATE], revealed the resident's BIMS score was 13 out of 15, which indicated the resident's cognition was intact and required set up assistance (helper sets up or cleans up) for eating, chair-to-bed transfer, and toilet transfer. Record review of Resident #10's physician order, dated 05/01/2023, revealed the resident had the order of Metamucil (psyllium husk) capsule; 0.4 gram; amount one; oral; twice a day at 8 am and 5 pm for constipation. Observation on 03/19/2025 at 4:06 p.m. revealed Medication aide-B administered fiber laxative calcium polycarbophil 625 mg one tablet for constipation to Resident #10, instead of Metamucil (psyllium husk) capsule; 0.4 gram. Interview on 03/20/2025 at 11:24 a.m. with Medication aide-B stated she administered fiber laxative calcium polycarbophil 625 mg one tablet for constipation to Resident #10 on 03/19/2025, instead of Metamucil (psyllium husk) capsule; 0.4 gram because the facility was using not Metamucil (psyllium husk) capsule; 0.4 gram but fiber laxative calcium polycarbophil 625 mg, and she was told it was fine from nurses. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/2025 at 11:25 a.m. with the DON stated the facility was using not Metamucil (psyllium husk) capsule; 0.4 gram but fiber laxative calcium polycarbophil 625 mg for constipation because physician indicated may use generic fiber capsule. However, if the facility did not have Metamucil (psyllium husk) capsule, the facility nurses should have contacted the physician and received more and additional clarification. The DON said it was medication error. 2. Record review of Resident #97's face sheet, dated 03/21/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] with diagnoses of partial intestinal obstruction (bowel is partly blocked and some faces can still get through), muscle weakness, edema (swelling caused by fluid), hypothyroidism (thyroid gland does not produce enough thyroid hormone), and rheumatoid arthritis (chronic inflammatory disorder usually affecting small joints in the hands and feet). Record review of Resident #97's admission MDS, dated [DATE], revealed it was still in progress and in time because the resident was admitted to the facility on [DATE]. Record review of Resident #97's physician order, dated 03/12/2025, revealed the resident had the order of Cyclosporine 0.05% one drop, ophthalmic twice a day at 8 am and 4 pm. Place one drop into both eyes two times a day for increasing tear production. Record review of Resident #97's medication administration record, from 03/01/2025 to 03/31/2025, revealed the resident received Cyclosporine 0.05% one drop, ophthalmic twice a day at 8 am and 4 pm into both eyes for increasing tear production. Observation on 03/20/2025 at 8:57 a.m. revealed medication aide-B opened Resident #97's Cyclosporine 0.05% eye drop and placed two drops to the resident's each eye. Interview on 03/20/2025 at 9:15 a.m. with Resident #97 said she did not want to talk to the surveyor. Interview on 03/20/2025 at 8:58 a.m. with medication aide-B said she placed two drops of Cyclosporine 0.05% to Resident #97's both eyes because the resident said she would like to receive two drops to just one time a day, instead of one drop to two times a day. Further interview with medication aide-B stated she notified the charge nurse, and the charge nurse said the nurse would report it to Resident #97's primary care physician. However, the nurse did not say anything to medication aide-B, so the medication aide-B thought placing two drops to Resident #97's both eyes once a day was fine. Medication aide-B said she did not remember the nurse's name because the nurse was an agency nurse and did not work anymore since the medication aide-B reported it to the nurse. Interview on 03/20/2025 at 11:07 a.m. with LVN-A stated the nurse did not know Resident #97 would like to receive her Cyclosporine 0.05% eye drop to two drops to her each eye to just once a day, instead of one drop to each eye twice a day. Nobody reported it to LVN-A, and LVN-A said facility nurses should have contacted Resident #97's primary care physician and asked for their advice regarding the resident's preference about the eye drop. If the doctor changed the order, the nurses should update the order and follow the updated order. (continued on next page)

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Avir at Bellville	106 N Baron Bellville, TX 77418

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/2025 at 11:12 a.m. with the DON stated the DON did not know Resident #97's preference regarding the resident's Cyclosporine 0.05% eye drop. The DON had knowledge regarding the resident's preference because of the surveyor. Per the nursing schedule, only one agency nurse worked only one day since the resident was admitted to the facility, and it was 03/15/2025. However, the agency nurse did not work anymore. The DON said that the agency nurse should have notified regarding Resident #97's eye drop to the primary care physician and followed any updated order per the professional standard of nursing practice and facility policy. It was medication error also. Resident #97 might not receive adequate care and medical interventions to maintain her health. Record review of the facility policy, titled Administering Medications, revised 04/2019, revealed . 4. Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 14 residents (Resident #5) and 1 nursing carts (C-unit nursing cart) out of 2 nursing carts reviewed for storage. 1. Ketoconazole cream for fungal or yeast infection was found on Resident #5's nightstand in the resident's room on [DATE]. 2. The C-unit nursing cart was left open and unattended by RN -E. These failures could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings were: 1. Record review of Resident #5's face sheet, dated [DATE], revealed the resident was an [AGE] year old male, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses of cerebral infarction (disrupted blood flow to the brain due to problem with the blood vessels that supply it), type 2 diabetes mellitus (not control blood sugar in the body), muscle wasting and atrophy (wasting or thinning of muscle mass), embolism and thrombosis of deep vein of lower extremity (blood clot develops in the deep veins in legs), and hypertension (high blood pressure). Record review of Resident #5's annual MDS, dated [DATE], revealed the resident's BIMS score was 10 out of 15, which indicated he had moderate cognitive impairment and required set up assistance (helper sets up or cleans up) for eating, chair-to-bed transfer, and toilet transfer. Record review of Resident #5's physician orders, dated [DATE], revealed there was no physician order regarding the medication of Ketoconazole cream for fungal or yeast infection. Observation on [DATE] at 10:52 a.m. revealed Resident #5 was sleeping in his wheelchair in his room. Medication, Ketoconazole cream was found on Resident #5's nightstand in his room. Interview on [DATE] at 11:18 a.m. with LVN-A stated she saw one medication (Ketoconazole cream for fungal or yeast infection) expired on Resident #5's nightstand in his room with the surveyor. LVN-A said she worked on [DATE] but did not see it. The nurse did not know what reason this expired medication was on Resident #5's nightstand. Further interview with the LVN-A stated Resident #5's daughter visited on [DATE] and might bring it. However, Resident #5 did not have fungal or yeast infection at this time, and making sure all medications were stored in the locked unit even though family member brought was still nurses' responsibility. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 5:05 p.m. with the DON stated all medications should have been stored in the medication room or carts even though family member brought, and it was nurses' responsibility. Resident #5 might have adverse effects due to the unattended medication. 2. Observation on [DATE] at 4:52 p.m. revealed RN-E entered Resident #26's room without locking the C-unit nursing cart and was administering a medication via the gastrostomy tube. While the RN-E was providing a medication to Resident #26, the C-unit nursing cart was left open and unattended in the hallway. Interview on [DATE] at 5:05 p.m. with RN-E stated he did not lock the C-unit nursing cart because he forgot. RN-E stated he should have locked his cart at all times to prevent possible drug diversions. And it was RN-E's responsibility to make sure locking his cart all the time. Interview on [DATE] at 5:29 p.m. the DON said RN-E should have locked the C-unit nursing cart at all times. If the nurse did not lock the carts, some residents or any visitors might take some medications from the carts. Record review of the facility policy, titled Medication Labeling and Storage, revised ,d+[DATE], revealed The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys.

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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. 46677 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed for food service. The facility failed to ensure that items stored in the reach-in refrigerator were labeled after opened or prepared. The facility failed to ensure that items stored in the chest freezer were labeled after opened. These failures could place residents who receive food prepared in the facility's only kitchen by placing them at risk for food-borne illness and food contamination. Findings included: Observation of the facility's reach-in refrigerator on 03/18/2025 at 9:17 AM revealed one 1 gallon of milk opened and unlabeled. Observation of the facility's chest freezer on 03/18/2025 at 9:19 AM revealed one box with a bag of rolls open and undated and one box with a bag of French toast open and undated. Interview with the Dietary Manager on 03/18/2025 at 9:23 AM revealed items being stored in the refrigerator and freezer were to be labeled with date they were opened. The Dietary Manager stated open items being stored in the refrigerator and freezers were to be labeled with date opened and date to be used by. The Dietary Manager stated by not labeling open items the residents would have been put at risk of food born illness. Record review of facility policy Food Receiving and Storage, dated 2022, revealed All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident #13) of 14 residents reviewed, in that: Resident #13's personal refrigerator located in her room observed on 03/18/2025, revealed an unknown food wrapped with papers inside the freezer, with no date and no label. This failure could place residents at risk of foodborne illness due to consuming foods which might be spoiled. The findings included: Record review of Resident #13's face sheet, dated 03/21/2025, reflected the resident was an [AGE] year old female and was initially admitted to the facility on [DATE] with diagnoses that included: hyperlipidemia (high level of fat), dementia (loss memory or problem solving and other thinking abilities), muscle wasting and atrophy (loss of muscle tissue and strength), and Alzheimer's disease (destroy memory and other important functions). Record review of Resident #13's quarterly MDS assessment, dated 01/31/2025, reflected the resident's BIMS score was 4 out of 15 which indicated the resident had severe cognitive impairment, and the resident required supervision or touching assistance (helper provides verbal cues or touching assistance as resident completes activity) eating and needed to have set-up assistance (helper sets up; resident completes activity) for chair-to-bed and toilet transfer. Record review of Resident #13's comprehensive care plan, dated 03/12/2025, revealed the resident had cognitive loss/dementia or alteration on though process related to impaired decision making, short-term and long-term memory loss. For intervention - Provide cues. Observation on 03/18/2025 at 10:07 a.m. revealed Resident #13 was not in her room. There was a personal refrigerator in the room, and inside the freezer there was an unknown old food wrapped with paper, with no date and no label on the paper. Interview on 03/18/2025 at 11:14 a.m. LVN-A stated Resident #13's refrigerator in her room had an unknown old food wrapped with papers, with no date and no label on the paper. The facility night nurses were supposed to check it every day. Interview on 03/21/2025 at 10:31 a.m. the DON stated facility night nurses were responsible for overseeing Resident #13's personal refrigerator and responsible for monitoring it daily by making label and date. The DON stated the resident might eat the food and have food born illness. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Foods brought by family/visitors, revised 03/2022, revealed . 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored un a manner that it is clearly distinguishable from facility prepared food - Perishable foods are stored in resealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item, and the use by date. 6. The nursing staff will discard perishable food soon or before the use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 resident (Residents #16) of 5 residents reviewed for infection control practices. When CNA-C was providing perineal care to Resident #16, the CNA-C touched new and clean brief with old and dirty gloves after cleaning the resident's buttock area. This deficient practice placed residents at risk for cross contamination and infections. The findings included: Record review of Resident #16's face sheet, dated 03/21/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnoses of cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), hypertension (high blood pressure), hypokalemia (low potassium in the blood), muscle weakness, type 2 diabetes mellitus (not control blood sugar in the body), and muscle wasting and atrophy (wasting or thinning of muscle mass). Record review of Resident #16's quarterly MDS assessment, dated 12/16/24, revealed the resident's BIMS was 15 out of 15, indicated the resident's cognitive function was intact, and the resident was always incontinent to bladder and bowel. Resident #16 was dependent (helper does all of the effort) to sit-to-stand and not applicable to chair-to-bed and toilet transfer. Record review of Resident #16's comprehensive care plan, dated 03/04/2025, revealed Incontinence of bowel and bladder related to history of stroke. For intervention - incontinent care per rounds and monitor and document for signs and symptoms of urinary tract infection. Observation on 03/19/2025 at 2:08 p.m. revealed CNA-C opened Resident #16's old and dirty brief and cleaned the resident's penis, and then cleaned the left and right groin area. CNA-C and CNA-D turned the resident to his left side, and CNA-C cleaned the resident's buttock area, then put a new and clean brief with an old and dirty glove. Interview on 03/19/2025 at 2:19 p.m. with CNA-C revealed she touched a new and clean brief with an old and dirty glove after cleaning Resident #16's buttock area. CNA-C said she should have changed her old and dirty gloves after sanitizing her hands and then should have put the new and clean brief to the resident to prevent possible infection. She forgot because she was nervous even though she received infection control training from the facility. Interview on 03/20/2025 at 5:05 p.m. with DON said CNA-C should have changed her old and dirty gloves after sanitizing hands and then should have put the new and clean brief to the resident to prevent possible infection when CNA-C was providing perineal care to Resident #16.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39049 Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 3 air filters (B-hall air filter) reviewed for environmental concerns. The air filter located B-hall, observed on 03/19/2025, was very dirty with gray colored thickened dust. It was last changed on 04/02/2024. This failure could place residents at risk of a diminished quality of life and respiratory status due to exposure to an environment that is unpleasant, unsanitary, and unsafe. The findings included: Observation on 03/18/2025 at 3:16 p.m. revealed there was an air filter on B-hall. The air filter was very dirty with gray colored thickened dust. Further observation revealed the air filter was dated 04/02/2024. Interview on 03/19/2025 at 3:26 p.m., Maintenance stated the air filter located B-hall was observed to be very dirty with gray colored thickened dust, and was last changed on 04/02/2024. Maintenance said he was responsible for changing air filters and was supposed to change them every month. He stated he forgot changing the air filter. Interview on 03/19/2025 at 3:35 p.m. with the DON said Maintenance should have changed the air filter every month. Potentially dirty air filter might cause some respiratory problems. Interview on 03/19/2025 at 4:00 pm with Administrator said Maintenance should have changed the air filter every month per the facility's maintenance checklist. Record review of the facility policy's, titled Maintenance checklist, dated 11/2023, revealed Monthly tasks - . 17. Air filters replace throughout facility.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46677 Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 9 (RN E, Dietary Aide F, Housekeeper G, CNA H, Activity Manager I, LVN J, LVN K, LVN L, DON) of 20 employees reviewed for training requirements. The facility failed to implement and maintain a training program that ensured Dietary Aide F and DON received required trainings upon hire. The facility failed to implement and maintain a training program that ensured required trainings were provided to Housekeeper G, CNA H, Activity Manager I, LVN J, LVN K, and LVN L annually. The facility failed to implement and maintain a training program that ensured required trainings were provided to RN E annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings include: Record review of the personnel records for RN E revealed a hire date of 04/24/2023. Further review of a training log from the previous 12 months for RN E, provided by the Administrator revealed no evidence of QAPI training, Infection control training or behavior health training being provided annually. Record review of the personnel records for the Dietary Aide F revealed a hire date of 03/05/2025. Further review of a training log from the previous 12 months for Dietary Aide F, provided by the Administrator revealed no evidence of resident rights training, fall prevention training, restraint training, or emergency preparedness training being provided upon hire. Record review of the personnel records for the Housekeeper G revealed a hire date of 06/15/2022. Further review of a training log from the previous 12 months for Housekeeper G, provided by the Administrator revealed no evidence of communication training, QAPI training, ethics training, emergency preparedness training being provided annually. Record review of the personnel records for the CNA H revealed a hire date of 07/13/2023. Further review of a training log from the previous 12 months for CNA H, provided by the Administrator revealed no evidence of QAPI training being provided annually. Record review of the personnel records for the Activity Manager I revealed a hire date of 06/01/2022. Further review of a training log from the previous 12 months for Activity Manager, provided by the Administrator revealed no evidence of behavior health training being provided annually. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the personnel records for LVN J revealed a hire date of 11/04/2022. Further review of a training log from the previous 12 months for LVN J, provided by the Administrator revealed no evidence of QAPI training, ethics training being provided annually. Record review of the personnel records for LVN K revealed a hire date of 06/01/2022. Further review of a training log from the previous 12 months forLVN K, provided by the Administrator revealed no evidence of communication training, ethics training, or emergency preparedness training being provided annually. Record review of the personnel records for LVN L revealed a hire date of 06/01/2022. Further review of a training log from the previous 12 months for LVN L, provided by the Administrator revealed no evidence of QAPI training, or behavior health training being provided annually. Record review of the personnel records for DON revealed a hire date of 04/22/2024. Further review of a training log from the previous 12 months for DON, provided by the Administrator revealed no evidence of QAPI training being provided upon hire. Interview with the Administrator, on 03/21/2025 at 4:25 PM revealed annual trainings were available to employees via CEU360 and assigned by corporate. The Administrator stated new employees received training in house from the BOM prior to working the floor. The administrator stated shortly before Dietary Aide F started the company had chosen not to use CEU360 and Dietary Aide F did not receive required trainings prior to working in the kitchen. The Administrator stated current employees received emails informing them of assigned trainings that are due to be completed. The Administrator stated it is the responsibility of the BOM and Administrator to ensure that staff receive new employee training and annual trainings. The Administrator stated the lack of training could have affected the resident's quality of life and care. Interview with the BOM, on 03/21/2025 at 4:35 PM revealed new staff received on-boarding prior to working the floor via online training system. BOM stated during the time the company was being bought out Dietary Aide F started but the company no longer used the online training system. BOM stated Dietary Aide F started to work in the kitchen while BOM was awaiting guidance on how to train new staff. BOM stated it was the responsibility of the BOM and DON to ensure annual trainings were completed by staff annually. BOM stated it was important for staff to complete trainings to ensure resident were well taken care of. Interview with DON on 03/21/2025 at 4:43 PM revealed it was the responsibility of the BOM to ensure staff received their annual trainings. DON stated it was important to train the staff to ensure the residents received good quality care. Record review of facility policy In-Service Training, All Staff dated 2001 revealed 6. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. {Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) 7. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training completed.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 46677 Based on interview and record review, the facility failed to provide mandatory effective training on communications training for 2 of 20 employees (Housekeeper G and LVN K) reviewed for training, in that: The facility failed to ensure effective communication training was provided to Housekeeper G and LVN K annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for the Housekeeper G revealed a hire date of 06/15/2022. Further review of a training log from the previous 12 months for Housekeeper G, provided by the Administrator revealed no evidence of communication training being provided annually. Record review of the personnel records for LVN K revealed a hire date of 06/01/2022. Further review of a training log from the previous 12 months for LNV K, provided by the Administrator revealed no evidence of communication training being provided annually. Interview with the Administrator, on 03/21/2025 at 4:25 PM revealed communication trainings were available to employees via CEU360 and assigned by corporate. The Administrator stated new employees received training in house from the BOM prior to working the floor. The Administrator stated current employees received emails informing them of assigned trainings that are due to be completed. The Administrator stated it is the responsibility of the BOM and Administrator to ensure that staff receive new employee training and annual trainings. The Administrator stated the lack of training could have affected the resident's quality of life and care. Interview with the BOM, on 03/21/2025 at 4:35 PM revealed new staff received on-boarding prior to working the floor via online training system. BOM stated it was the responsibility of the BOM and DON to ensure communication trainings were completed by staff annually. BOM stated it was important for staff to complete trainings to ensure resident were well taken care of. Interview with DON on 03/21/2025 at 4:43 PM revealed it was the responsibility of the BOM to ensure staff received their communication trainings. DON stated it was important to train the staff to ensure the residents received good quality care. Record review of facility policy In-Service Training, All Staff dated 2001 revealed 6. Required training topics include the following: a. Effective communication with residents and family (direct care staff); (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. {Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) 7. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training completed.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Deficiency Text Not Available

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 46677 Based on interview and record review the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of it's QAPI program for 6 (RN E, Housekeeper G, CNA H, LVN J, LVN L and DON) of 20 employees reviewed for training requirements. The facility failed to ensure required trainings were provided to RN E, Housekeeper G, CNA H, LVN J, LVN L annually. The facility failed to ensure required trainings were provided to the DON upon hire. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings include: Record review of the personnel records for RN E revealed a hire date of 04/24/2023. Further review of a training log from the previous 12 months for RN E, provided by the Administrator revealed no evidence of QAPI training being provided annually. Record review of the personnel records for the Housekeeper G revealed a hire date of 06/15/2022. Further review of a training log from the previous 12 months for Housekeeper G, provided by the Administrator revealed no evidence of QAPI training being provided annually. Record review of the personnel records for the CNA H revealed a hire date of 07/13/2023. Further review of a training log from the previous 12 months for CNA H, provided by the Administrator revealed no evidence of QAPI training being provided annually. Record review of the personnel records for LVN J revealed a hire date of 11/04/2022. Further review of a training log from the previous 12 months for LVN J, provided by the Administrator revealed no evidence of QAPI training being provided annually. Record review of the personnel records for LVN L revealed a hire date of 06/01/2022. Further review of a training log from the previous 12 months for LVN L, provided by the Administrator revealed no evidence of QAPI training being provided annually. Record review of the personnel records for DON revealed a hire date of 04/22/2024. Further review of a training log from the previous 12 months for DON, provided by the Administrator revealed no evidence of QAPI training being provided upon hire. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator, on 03/21/2025 at 4:25 PM revealed annual trainings were available to employees via CEU360 and assigned by corporate. The Administrator stated new employees received training in house from the BOM prior to working the floor. The Administrator stated current employees received emails informing them of assigned trainings that are due to be completed. The Administrator stated it is the responsibility of the BOM and Administrator to ensure that staff receive new employee training and annual trainings. The Administrator stated the lack of training could have affected the resident's quality of life and care. Interview with the BOM, on 03/21/2025 at 4:35 PM revealed new staff received on-boarding prior to working the floor via online training system. BOM stated it was the responsibility of the BOM and DON to ensure annual trainings were completed by staff annually. BOM stated it was important for staff to complete trainings to ensure resident were well taken care of. Interview with DON on 03/21/2025 at 4:43 PM revealed it was the responsibility of the BOM to ensure staff received their annual trainings. DON stated it was important to train the staff to ensure the residents received good quality care. Record review of facility policy In-Service Training, All Staff dated 2001 revealed 6. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. {Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) 7. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training completed.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 46677 Based on interview and record review, the facility failed to include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program for 1 of 20 employees (RN E) reviewed for training, in that: The facility failed to ensure standards, policies, and procedures for an infection prevention and control program training was provided RN E annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for RN E revealed a hire date of 04/24/2023. Further review of a training log from the previous 12 months for RN E, provided by the Administrator revealed no evidence of Infection control training being provided annually. Interview with the Administrator, on 03/21/2025 at 4:25 PM revealed annual Infection prevention trainings were available to employees via CEU360 and assigned by corporate. The Administrator stated new employees received training in house from the BOM prior to working the floor. The Administrator stated current employees received emails informing them of assigned trainings that are due to be completed. The Administrator stated it is the responsibility of the BOM and Administrator to ensure that staff receive new employee training and annual infection control trainings. The Administrator stated the lack of training could have affected the resident's quality of life and care. Interview with the BOM, on 03/21/2025 at 4:35 PM revealed new staff received on-boarding prior to working the floor via online training system. BOM stated it was the responsibility of the BOM and DON to ensure annual infection control trainings were completed by staff annually. BOM stated it was important for staff to complete trainings to ensure resident were well taken care of. Interview with DON on 03/21/2025 at 4:43 PM revealed it was the responsibility of the BOM to ensure staff received their annual infection control trainings. DON stated it was important to train the staff to ensure the residents received good quality care. Record review of facility policy In-Service Training, All Staff dated 2001 revealed 6. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. {Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) 7. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training completed.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 46677 Based on interview and record review, the facility failed to provide mandatory effective training on ethics training for 3 of 20 employees (Housekeeper G, LVN J, and LVN K) reviewed for training, in that: The facility failed to ensure ethics training was provided to Housekeeper G, LVN J, and LVN K annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for the Housekeeper G revealed a hire date of 06/15/2022. Further review of a training log from the last 12 months for Housekeeper G, provided by the Administrator revealed no evidence of ethics training being provided annually. Record review of the personnel records for LVN J revealed a hire date of 11/04/2022. Further review of a training log from the last 12 months for LVN J, provided by the Administrator revealed no evidence of ethics training being provided annually. Record review of the personnel records for LVN K revealed a hire date of 06/01/2022. Further review of a training log from the last 12 months for LVN K, provided by the Administrator revealed no evidence of ethics training being provided annually. Interview with the Administrator, on 03/21/2025 at 4:25 PM revealed annual ethics trainings were available to employees via CEU360 and assigned by corporate. The Administrator stated new employees received training in house from the BOM prior to working the floor. The Administrator stated current employees received emails informing them of assigned trainings that are due to be completed. The Administrator stated it is the responsibility of the BOM and Administrator to ensure that staff receive new employee training and annual ethics trainings. The Administrator stated the lack of training could have affected the resident's quality of life and care. Interview with the BOM, on 03/21/2025 at 4:35 PM revealed new staff received on-boarding prior to working the floor via online training system. BOM stated it was the responsibility of the BOM and DON to ensure annual ethics trainings were completed by staff annually. BOM stated it was important for staff to complete trainings to ensure resident were well taken care of. Interview with DON on 03/21/2025 at 4:43 PM revealed it was the responsibility of the BOM to ensure staff received their annual ethics trainings. DON stated it was important to train the staff to ensure the residents received good quality care. Record review of facility policy In-Service Training, All Staff dated 2001 revealed 6. Required training topics include the following: (continued on next page)

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	676164	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bellville	106 N Baron Bellville, TX 77418

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. {Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) 7. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training 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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46677 Based on interview and record review, the facility failed to provide mandatory effective in-service training for nurse aides on dementia for 1 of 5 nurse aides (CNA H) reviewed for training, in that: The facility failed to ensure dementia training was provided CNA H annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of personnel records for CNA H revealed a hire date of 07/13/2023. Further review of a training log from the previous 12 months for CNA H, provided by the Administrator revealed no evidence of Dementia training being provided annually. Interview with the Administrator, on 03/21/2025 at 4:25 PM revealed annual trainings were available to employees via CEU360 and assigned by corporate. The Administrator stated new employees received training in house from the BOM prior to working the floor. The Administrator stated current employees received emails informing them of assigned dementia trainings that are due to be completed. The Administrator stated it is the responsibility of the BOM and Administrator to ensure that staff receive new employee training and annual dementia trainings. The Administrator stated the lack of training could have affected the resident's quality of life and care. Interview with the BOM, on 03/21/2025 at 4:35 PM revealed new staff received on-boarding prior to working the floor via online training system. BOM stated it was the responsibility of the BOM and DON to ensure annual dementia trainings were completed by staff annually. BOM stated it was important for staff to complete trainings to ensure resident were well taken care of. Interview with DON on 03/21/2025 at 4:43 PM revealed it was the responsibility of the BOM to ensure staff received their annual dementia trainings. DON stated it was important to train the staff to ensure the residents received good quality care. Record review of facility policy In-Service Training, All Staff dated 2001 revealed 6. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. {Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) 7. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training 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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 46677 Based on interview and record review, the facility failed to provide behavioral health training consistent with the requirements at S483.40 and as determined by the facility assessment at S483.71 for 3 of 20 employees (Activity Manager, RN E, LVN L) reviewed for training, in that: The facility failed to ensure behavioral health training was provided to Activity Manager, RN E, LVN L annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of personnel records for the Activity Manager revealed a hire date of 06/01/2022. Further review of a training log from the past 12 months for Activity Manager, provided by the Administrator revealed no evidence of behavior health training being provided annually. Record review of personnel records for the RN E revealed a hire date of 04/24/2023. Further review of a training log from the last 12 months for RN E, provided by the Administrator revealed no evidence of behavior health training being provided annually. Record review of personnel records for LVN L revealed a hire date of 06/01/2022. Further review of a training log from the last 12 months for LVN L, provided by the Administrator revealed no evidence of behavior health training being provided annually. Interview with the Administrator, on 03/21/2025 at 4:25 PM revealed annual behavioral health trainings were available to employees via CEU360 and assigned by corporate. The Administrator stated new employees received training in house from the BOM prior to working the floor. The Administrator stated current employees received emails informing them of assigned trainings that are due to be completed. The Administrator stated it is the responsibility of the BOM and Administrator to ensure that staff receive new employee training and annual behavioral health trainings. The Administrator stated the lack of training could have affected the resident's quality of life and care. Interview with the BOM, on 03/21/2025 at 4:35 PM revealed new staff received on-boarding prior to working the floor via online training system. BOM stated it was the responsibility of the BOM and DON to ensure annual behavioral health trainings were completed by staff annually. BOM stated it was important for staff to complete trainings to ensure resident were well taken care of. Interview with DON on 03/21/2025 at 4:43 PM revealed it was the responsibility of the BOM to ensure staff received their annual behavioral health trainings. DON stated it was important to train the staff to ensure the residents received good quality care. Record review of facility policy In-Service Training, All Staff dated 2001 revealed (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures. {Compliance and ethics training is conducted annually when this organization is operating five or more facilities.) 7. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training completed.