

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Cotulla		STREET ADDRESS, CITY, STATE, ZIP CODE 369 Mars Dr Cotulla, TX 78014	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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. 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, of the 6-month review period for (25 of 184 days), reviewed for RN coverage. The facility failed to ensure the facility maintained the required RN coverage for 25 days between July 2025 to December 2025. The dates are: 7/3/2025 - 7/7/2025, 8/4/2025 - 8/8/2025, 9/8/2025 - 9/12/2025, 10/9/2025- 10/12/2025, 11/10/2025-11/12/2025 and 12/16/2025 - 12/18/2025. This failure could place residents at risk of not having their nursing and medical needs met and receiving improper care. Findings included: Record review of CMS CASPER Report (a confidential, that analyzes internal data to measure the quality of patient care) reflected the facility prompted for no RN hours for FY 4th Quarter 2025 (July 2025 to September 2025), for the following dates: 7/3/2025 - 7/7/2025, 8/4/2025 - 8/8/2025, 9/8/2025 - 9/12/2025, 10/9/2025- 10/12/2025, 11/10/2025-11/12/2025 and 12/16/2025 - 12/18/2025. Record review of the facility RN schedule from July 2025 to December 2025 revealed that the facility did not have the required Registered Nurses coverage of at least 8 consecutive hours a day for the 6-month review period for the following dates: 7/3/2025 - 7/7/2025, 8/4/2025 - 8/8/2025, 9/8/2025 - 9/12/2025, 10/9/2025- 10/12/2025, 11/10/2025-11/12/2025 and 12/16/2025 - 12/18/2025. Staff interview on 1/7/2026 at 2:09 p.m. with the Administrator, she stated the previous DON had to be released from employment, and during the hiring process, there were no RN applicants due to the location and population making it difficult to attract a sufficient number of qualified candidates. She stated that if RNs did not work at the facility, it could lead to improper care for 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) hours every 24 hours, seven (7) days a week. Registered nurses may be scheduled more than eight (8) hours depending on the acuity needs of the residents.		

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 9 residents (Resident #6, Resident #41, and Resident #52) who were reviewed for resident assessments. 1.The facility failed to document Resident #6's lack of use of scheduled pain medication on the quarterly MDS assessment. 2.The facility failed to document Resident #41's diagnosis of anxiety on the quarterly MDS assessment. 3. The facility failed to document Resident #52's use of an antidepressant on the quarterly MDS assessment. These failures could place residents at risk of improper or incorrect care or of not receiving services necessary for their physical, mental, and psychosocial well-being.The findings included: 1.Record review of Resident #6's admission sheet dated 6/30/2025 with an original admission date of 4/15/2013 documented a [AGE] year-old female resident with diagnoses including multiple sclerosis (a disease that causes breakdown of the protective covering of nerves causing numbness, weakness, trouble walking, and vision changes), dementia, peripheral vascular disease (when arteries in the limbs are narrowed, limiting blood flow), depression, and epilepsy (seizure disorder). Record review of Resident #6's quarterly MDS assessment dated [DATE] documented a BIMS could not be conducted due to the resident rarely or never being understood and recorded the use of antidepressant, anticoagulant (blood thinner), and anticonvulsant (antiseizure) medications. Further review of Resident #6's MDS in Section J &ndash; Health Conditions J0100. Pain Management revealed the assessment documented the resident had received scheduled (routine) pain medication in the last five days, despite the resident having no order for scheduled pain medication. Record review of Resident #6's order summary documented active orders for the as needed pain-relieving medications Acetaminophen with an order date of 11/14/2025 and Ibuprofen with an order date of 11/14/2025. Acetaminophen was ordered as Acetaminophen 325mg, give 2 tablet via G-Tube (a soft tube inserted through the abdomen directly into the stomach, used to provide nutrition, fluids, and medicine when a person can't eat or drink enough by mouth) every 6 hours as needed for pain. Ibuprofen was ordered as Ibuprofen 200mg, give 1 tablet via G-Tube every 8 hours as needed for pain. Further review of Resident #6's order summary revealed the resident had no order for a scheduled pain medication. Record review of Resident #6's November 2025 and December 2025 MARs revealed the resident did not receive any scheduled pain medication during the months of November and December. Record review of Resident #6's care plan with an initiation date of 1/30/2023 documented the resident was at risk for experiencing discomfort or pain r/t MS with a goal of the resident will exhibit a comfortable/relaxed appearance without facial grimacing or signs of distress. 2.Record review of Resident #41's admission sheet dated 6/16/2025 with an original admission date of 7/21/2021 documented a [AGE] year-old female resident with diagnoses including neurocognitive disorder with Lewy bodies (a disorder characterized by the presence of abnormal protein deposits called Lewy bodies in the brain, leading to cognitive decline, movement issues, and various other symptoms), depression, anxiety, hypothyroidism (a condition when the thyroid gland doesn't make enough thyroid hormone), and type 2 diabetes mellitus. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's quarterly MDS dated [DATE] documented that a BIMS could not be conducted due to the resident rarely or never being understood and recorded the use of antipsychotic, antianxiety, antiplatelet, and hypoglycemic medications. Further review of the MDS under Section I &dash; Active Diagnoses Psychiatric/Mood Disorder revealed the assessment did not include a diagnosis of anxiety in the box next to I5700 Anxiety Disorder. Record review of Resident #41's October 2025 MAR documented the resident had been receiving monitoring every shift for the following behaviors including 1=Agitation, 2=anxiety, 3=nervousness, 4=compulsiveness, 5=aggression, 6=verbal aggression, 7=hallucinations, 8=delusions, 9=repetitive verbalizations that affect function. with anxiety documented on 10/17/2025. Record review of Resident #41's psychiatric services progress note dated 3/28/2025 documented in the Reason for Visit section, the resident was seen for evaluation and management of their anxiety, depression, and dementia. Further review of the psychiatric note documented in the PMHx section a past medical history with conditions including HTN, M/S injury, hypothyroidism, Type II DM, anxiety, dementia. Under the Assessment/DSM section of the psychiatric note the diagnoses of Anxiety disorder, generalized and Depressive disorder were included in the diagnosis list. Record review of Resident #41's care plan with a problem start date of 10/19/2025 documented the resident has Behavioral Symptoms with approaches including Maintain a calm environment. and Maintain a calm, slow, understandable approach with the resident. During an interview with the MDS Nurse on 01/08/2025 at 9:26 AM, the MDS Nurse stated she was responsible for verifying MDS assessments were accurate before submission. Regarding scheduled pain medications received in the last five days, the MDS Nurse stated she included medications from the anticonvulsant drug class as scheduled pain medications on the MDS. Regarding active diagnoses, the MDS Nurse stated she only included an active diagnosis on the MDS if a resident was receiving medication or psychiatric services to manage the diagnosis, because that is how she was taught. The MDS Nurse stated it was important for the MDS to be accurate. The MDS Nurse stated she did not think there could be any danger to a resident if the MDS is inaccurate or missing items, unless they missed a behavior like suicidal ideations. 3. Record review of Resident #52's admission sheet dated 03/22/2023 with an original admission date of 01/01/2021 documented a [AGE] year-old male resident with diagnoses including hemiplegia (paralysis on one side of the body), mood disorder, dementia, anxiety disorder, major depressive disorder (depression), and schizoaffective disorder (mental health condition). Record review of Resident #52's quarterly MDS assessment dated [DATE] documented a BIMS of 15 indicating intact cognition and recorded the use of antipsychotics, antianxiety, and diuretic (promote production of urine) medications but not the use of an antidepressant. Record review of Resident #52's order summary documented active orders for an antidepressant, Trazodone, with an order date of 11/24/2025. Trazodone was ordered as Trazodone HCl oral tablet 150mg, give 1 tablet by mouth two times a day, related to schizoaffective disorder, unspecified. Record review of Resident #52's December 2025 and January 2026 MARs revealed the resident did receive an antidepressant medication, Trazodone, during the months of December and January. Record review of Resident #52's care plan with an initiation date of 12/22/2025 documented the (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was at risk for complications related to psychotropic drug use due to a DX of schizoaffective disorder, mood disorder, anxiety disorder and dementia. I am on routine antianxiety medication, routine anti antipsychotics, and routine antidepressants with a goal of the resident benefit without side effects. During an interview on 01/08/2026 at 9:46 a.m., the MDS nurse confirmed Resident #52 was currently taking an antidepressant which was Trazadone 150mg. The MDS nurse stated the MDS was not reflecting Resident #52's use of an antidepressant but that it should have. The MDS nurse stated she would have to modify the MDS in order for it to accurately reflect Resident #52's use of an antidepressant. The MDS nurse was unsure of the risk to a resident if their medications were incorrectly coded on the MDS assessment. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 noted in section N: Medications in section N0415: High-Risk Drug Classes: Use and Indication states 1. Is taking: check if the resident is taking any medications by pharmacologic classification, not how it is used, during the last 7 days. Further review shows section N0415B2. Antidepressant : Check if an antidepressant medication was taken by the resident at any time during the 7-day look-back period. Record review of an email from the Administrator on 01/08/2026 at 11:55 AM, documented the Administrator stated there was no MDS policy, they follow the RAI manual. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 noted in section J0100: Pain Management, the definition of scheduled pain medication regimen as Pain medication order that defines dose and specific time interval for pain medication administration. For example, 'once a day,' 'every 12 hours.' Further review of the RAI noted in Section I: Active Diagnoses that One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. and Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.		

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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. Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. The facility failed to date items after receiving/opening them located in the kitchen pantry. 2. The facility failed to take temperatures for both breakfast and lunch meals on 01/05/2026. This deficient practice could place residents at risk for food borne illness. The findings include: Observation on 01/06/2026 at 10:00 a.m., of the kitchen pantry revealed 1 box of food thickener with no date, 1 bag of lime gelatin, opened, in a Ziploc bag, which was sealed, with no date, 1 container of chicken flavored base with no date, and 1 container of beef flavored base with no date. Record review of the Food Temperature Chart document, dated 01/04/2026 to 01/10/2026, reflected under breakfast and lunch for Monday, 01/05/2026, no temperatures for any of the entrees served. During an interview on 01/06/2026 at 10:16 a.m., the Dietary manager stated food temperatures should be taken as soon as food items were put on the steam table, for every meal, and every day. The dietary manager stated the cook and dietary manager were responsible for dating products as they got food deliveries. The dietary manager stated the risk to the residents for not dating food products or taking temperatures of food could be food items building bacteria and risk of expiration. The Dietary manager stated they were not aware of any food borne illness outbreaks within the facility. During an interview on 01/07/2026 at 10:48 a.m., the DON stated they were not aware of any food borne illness outbreaks since being employed at the facility. During an interview on 01/08/2026 at 11:47 a.m., the [NAME] stated they were supposed to take the temperature of all foods before every meal. The [NAME] stated the purpose was to check to see if the temperature is appropriate to serve to residents. The [NAME] stated they would have to get back with what the risk could be to residents if they are not checking the food temperatures of food items. Record review of the facility's policy, Food Storage, dated 2023, reflected: 8. All containers or storage bags must be legible and accurately labeled and dated. Record review of the facility's policy, Food Temperatures, dated 2023, reflected: The temperatures of all food items will be taken and properly recorded prior to service of each meal		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 2 medication carts (Med Cart 2) reviewed for pharmacy services. The facility failed to ensure the controlled substance reconciliation log was signed for accuracy of medication quantities during hand off of the cart key for Med Cart 2 during lunch. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain and anxiety, and a decreased quality of life. The findings included: During an observation of Med Cart 2 on 1/07/2026 at 3:06 PM, a sample of controlled medications was inventoried for accuracy with LVN A. The sample inventory showed no discrepancies between medication quantities documented on the individual controlled substance logs and the number of pills remaining in the blister packs, however record review of the comprehensive controlled medication reconciliation log used for cart audit revealed the log had not been signed when LVN B gave control of her key to Med Cart 2 to LVN A before lunch. During an interview with LVN A on 1/07/2026 at 3:06 PM, LVN A stated it was important to count the controlled medications for inventory accuracy and document on the controlled medication reconciliation log to make sure the count is correct when taking supervision of a medication cart. LVN A stated if they did not count and document the counting of the controlled medications, a pill could be missing, and they would not know when the loss occurred. LVN A stated if a resident was missing a pill, they might not get the benefit of their medication. During an interview with the DON on 01/07/2026 at 4:24 PM, the DON stated staff responsible for medication carts had never counted the controlled medications when handing off their key to another staff member before lunch. The DON stated moving forward, her expectation was for staff to count and document the count of controlled medications when they hand off their key to another staff member before lunch or anytime they relinquish their key. The DON stated if staff did not reconcile the controlled medications in their carts before handing over their key to another staff member, something could go missing and they would not know where or when a medication was lost. During an interview with LVN B on 01/08/2026 at 8:10 AM, LVN B stated when they hand over their medication cart key to another staff member before lunch it was important that they count and document the controlled medications in their cart, because medications could go missing. LVN B stated moving forward, they will sign the new log developed for documenting the count of controlled substance when handing off their key to another staff member before lunch. Record review of the facility policy titled Controlled Substances with a revision date of November 2022, noted Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimized the time between loss/diversion and detection/follow-up. The policy further stated, The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.		

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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** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary storage handling, and consumption of residents' food items for 1 (refrigerators in resident room [ROOM NUMBER]-A) of 4 residents' refrigerators reviewed in that: The personal refrigerator in resident's room [ROOM NUMBER]-A contained unlabeled, undated food items. This deficient practice could place residents at risk of foodborne illness due to consuming foods which could be spoiled. The findings were: Observation on 01/06/2026, at 10:44 a.m. revealed that the personal refrigerator in resident room [ROOM NUMBER]-A contained two bottles of mayonnaise and one bottle of mustard, which had been previously opened, with expiration dates not legible, which were unlabeled and undated. During an interview on 01/06/2026 at 10:44 a.m. the resident in room [ROOM NUMBER]-A stated staff had not been labeling their food items located in their personal fridges, but that staff had been checking for the fridge's temperature. The resident in room [ROOM NUMBER]-A stated the food items were brought in by himself and family. Observation on 01/07/2026, at 7:53 a.m. revealed that the personal refrigerator in resident room [ROOM NUMBER]-A contained two bottles of mayonnaise and one bottle of mustard, which had been previously opened, with expiration dates hard to obtain, which were unlabeled and undated. During an interview on 01/07/2026, at 10:33 a.m., CNA C stated housekeeping usually checks resident's fridges, but those items should be labeled and dated. CNA C confirmed that the refrigerator in resident room [ROOM NUMBER]-A contained two bottles of mayonnaise and one bottle of mustard which were unlabeled and undated. CNA C stated if items in residents' fridges are not labeled staff would not know whose items were whose. During an interview on 01/07/2026, at 10:39 a.m., LVN D stated nurses and CNAs were responsible for checking residents' personal fridges nightly for at least expirations dates and if the item is open then staff should date the item. LVN D stated staff check the fridges for their temperature as well. LVN D stated items should be dated in residents' personal fridges. LVN D confirmed that the refrigerator in resident room [ROOM NUMBER]-A contained two bottles of mayonnaise and one bottle of mustard which were unlabeled and undated. LVN D stated if items in residents' fridges are not labeled there could be a risk for residents to get sick if the item is expired. During an interview on 01/07/2026, at 10:48 a.m., the DON stated the housekeeping checks residents' personal fridges for temperatures and in case anything needs to be thrown away. The DON stated staff would not know whose items were whose in residents' fridges if they were not labeled. The DON stated if items in residents' fridges are not labeled there could be a risk for residents to have an upset stomach if they were unsure how long the item had been opened. During an interview on 01/07/2026, at 11:06 a.m., HSKP stated they check residents' personal fridges for temperatures but was unsure if they were supposed to be checking for labels or dates. HSKP stated if an item in a resident's personal fridge has been out for a while and there weren't sure if the item was still good, they would just throw it out. Record review of the facility policy, Food Brought in by Family/Visitors, revised March 2022, revealed, Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and 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** Based on observation, interview, 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 of 5 residents (Resident #6) reviewed for infection control. The facility failed to ensure LVN B wore a PPE gown while administering medication to Resident #6 via PEG tube (a flexible feeding tube inserted through the abdominal wall into the stomach that allows for the delivery of nutrition, fluids, and medications directly into the stomach). This failure could place residents at risk for cross contamination and infection. The findings included: Record review of Resident #6's admission sheet dated 6/30/2025 with an original admission date of 4/15/2013 documented a [AGE] year-old female resident with diagnoses including multiple sclerosis (a disease that causes breakdown of the protective covering of nerves causing numbness, weakness, trouble walking, and vision changes), dementia, peripheral vascular disease (when arteries in the limbs are narrowed, limiting blood flow), depression, and epilepsy (seizure disorder). Record review of Resident #6's quarterly MDS assessment dated [DATE] documented a BIMS could not be conducted due to the resident rarely or never being understood and recorded the use of a feeding tube in Section K - Swallowing/Nutritional Status K0520 Nutritional Approaches. Record review of Resident #6's order summary documented an active order for ENHANCED BARRIER PRECAUTIONS G Tube with an order date of 11/30/2025 and no end date. Record review of Resident #6's care plan with an initiation date of 6/06/2024 documented the resident required Enhanced Barrier Precautions r/t use of my G tube for all my nutritional, hydration, and medication needs. with interventions including Follow Facility policy. During an observation of g-tube medication administration on 01/08/2026 at 7:05 AM, LVN B was observed wearing gloves while administering medications through Resident #6's g-tube. LVN B did not wear a protective gown while administering the medications. A sign regarding information for EBP was observed posted on Resident #6's door. During an interview with LVN B on 01/08/2026 at 8:10 AM, LVN B stated Resident #6 did not have a specific order to wear a gown, and that she only wore gloves when she administered medications through the resident's g-tube. LVN B stated it was important to wear EBP to protect both staff and residents from contamination during care. During an interview with the DON on 01/08/2026 at 9:08 AM, the DON stated her understanding regarding EBP was that it was important because you do not want to spread infection between staff and residents. The DON stated her expectation was for staff to wear gowns and gloves any time they provided care which indicated the use of EBP. The DON stated she had already begun instructing her staff on proper EBP usage. During an interview with the ADON on 01/08/2026 at 9:55 AM, the ADON stated she had been the facility IP since 2022. The ADON stated her expectation was that staff should be wearing EBP during care, whenever a resident is under isolation, or any time it is indicated including care provided with a g-tube. The ADON stated with any use of the g-tube she expected her staff to wear gowns and gloves, and that the wearing of these items was important to prevent transmission of infections between staff and residents. The ADON stated she had been working with the DON to reeducate staff on proper EBP procedures. Review of facility policy Enhanced Barrier Precautions with a revision date of February 2025 noted Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. and Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.).		