STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 in accordance with professional standards for food service safety from 1 of 1 kitchen observed for safe food handling practices. The DM failed to ensure weekend kitchen staff deep cleaned the convection oven.Cook P failed to cover the four cooking sheets of chocolate chip cookies and to allow the plate covers (domes) to air dry before stacking them.The DM failed to ensure lunch items (pork chop with gravy, mixed vegetables and whipped sweet potatoes (regular diet) maintained safe range temperature on 2/26/26. The facility failed to ensure the handwashing sink in the kitchen was functional. These deficient practice could place residents at risk of food borne illnesses and result in a decline in the resident's health. The findings were:Review of the facility Safe Food Temperatures in the Dietary Log read as follows: Cold holding of food 41 degreesHot holding of food 135 degreesMeat, fish and raw shell eggs 145 degreesGround meat and fish injected meat 155 degreesPoultry and ground poultry 165 degrees Review of week at a glance menu for the Fall/Winter 2025-26 read: Thursday 2/26/26Lunch Sliced Pork with GravyWhipped Sweet PotatoSeasoned Spinach Honey Kissed RollMargarineFruit Cobbler Observation and Interview on 2/24/26 at 9:27 AM revealed built up black residue build up on the bottom of the convection oven. [NAME] Q stated they deep cleaned all appliances on the weekends. Interview on 2/24/26 at 9:30 AM with the DM revealed the weekend staff would deep clean all kitchen appliances. She stated the convection oven had not been cleaned for about 2 weeks and stated there was caked on burnt food on the bottom and steel trays in the convection oven. The DM stated the food being baked would be contaminated if crumbs fell on it. Observation and interview on 2/24/26 at 9:33 AM revealed 4 baking sheets of chocolate cookies sitting on the prep table along the front wall. They were not covered. Interview with [NAME] P revealed she baked the cookies in the convection oven and she brought them out not even 5 minutes ago. She stated she should have covered them right away, so they were not contaminated by debris but stated she got busy with washing the dishes. Observation on 02/24/2026 at 9:35 AM revealed the hand-washing sink in the kitchen was not working. There was no running water. Further observation revealed staff was washing their hands at sink by the stove. Observation and interview on 2/24/26 at 9:40 AM revealed about 5 stacks of plate covers (domes) stacked in front of the partition for the stove. QA P checked them/turned them over and said there was still water in between and should wait until they were dry before stacking them. She stated bacteria could grow in most areas. The DA stated there was not enough space to spread them out to allow them to air dry. Observation and interview on 02/26/2026 at12:21 PM revealed the DM taking the temperature of the lunch meal including all stated items per the week at a glance menu for 2/26/26. The DM stated she substituted seasoned spinach with mixed vegetables. The DM removed the last two trays from the 200-hall cart; 1 was a regular diet and 1 was a puree diet. The DM took temperatures with a digital thermometer. The regular diet temperatures she called out were as follows: whipped sweet potatoes 135 degrees, mixed vegetables 134 degrees, pork chop with brown gravy 133 degrees. The puree diet temperatures as the DM called out were as follows: pork chop with gravy 141 degrees, whipped sweet potatoes 130 degrees, mixed vegetables 125 degrees. Observation and interview on 02/26/2026 at (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3:57 PM revealed the hand-washing sink in the kitchen was still not working. It did not have running water. Interview on 02/27/2026 at 2:44 PM with the DM revealed the temperatures she took of the food items served for lunch earlier (2/26/26) on the sampled trays did not reach the safe temperature range of 135 degrees except the sweet potatoes served on the regular diet. The DM stated the pork should have reached 145 degrees. She stated serving the food that was not in the safe range could result in the spread of foodborne illness and the residents could get sick or complain the food was too cold. Interview on 2/27/26 at 4:42 PM with the DM revealed the hand-washing sink in the kitchen had not been working for about 2 weeks. She stated it looked like there was not any pressure and there was no running water. The DM stated the previous MS looked at it but was not able to fix it. She stated the sink she and other dietary staff used to wash their hands was normally used for rinsing dishes. The DM further stated she was aware the plate covers/domes were dry before being stacked but stated they should be dry before stacking them. The DM bacteria could grow and get the resident's sick. Interview on 2/27/26 at 7:15 PM with the MS revealed he had started working for the facility about 1 week ago. He stated he learned the hand-washing sink was not working. He stated he ordered parts for it this week and he would repair it upon receipt of the parts. Review of facility policy, Sanitation, dated November 2022, read The food service area is maintained in a clean and sanitary manner. 1. All kitchen, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions', open seams, cracks and chipped areas that may affect their use or proper cleaning.3. All equipment, food contact surfaces and utensils are cleaning and sanitized using heat or chemical sanitizing solutions.7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Review of a facility policy, Food Receiving and Storage, dated November 2022, read Foods shall be received and stored in a manner that complies for safe food handling practices. 1. Critical Control Point means a specific point, procedure, or step in food preparation and serving process at which control can be exercised to reduce, eliminate, or prevent the possibility of a food safety hazard. Some operational steps that are critical to control in facilities to prevent or prevent food safety hazards are thawing, cooking, holding, reheating foods and employee hygienic practices.2. Danger Zone means temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow the rapid growth of pathogenic microorganisms that can cause food borne illness.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review the facility failed to ensure staff disposed of garbage and refuse properly in 1 of 1 dumpster reviewed for disposal of trash. The facility failed to ensure the grounds around the dumpster were clean and free from food items. This deficient practice could place residents at risk for rodent and insect activity in the facility. The findings were:Observation and interview of the dumpster located outside about 100 yards from the facility. Interview with the DM stated all staff used the one dumpster to dispose of trash. Further observation revealed about 2 servings of sweet potatoes on the ground a few feet from the dumpster. The DM stated the food looked like sweet potatoes and stated it could attract insects and rodents. The DM stated the facility including resident rooms could become infested with insects and rodents. She stated the insects and rodents could carry diseases and infect the residents. Review of facility policy, Sanitation, dated November 2022 read 14. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters, compacters with lids (or otherwise covered).15. Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to identify a diagnosis of mental illness on the preadmission screening and resident review (PASRR) assessment for 3 of 8 residents (Resident #3, Resident #4 and Resident #23) whose records were reviewed for PASARR services.The facility failed to include Resident #3, Resident #4, and Resident #23's mental health status was coded on the PASARR screening Level I.These deficient practices could place residents with mental illness at risk for not obtaining the services needed to treat their mental health diagnoses.Review of Resident #3's face sheet, dated 2/27/26, revealed she was admitted to the facility on [DATE] with diagnoses including anxiety and schizoaffective disorder bipolar type (condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania. Bipolar type, which includes bouts of hypomania or mania and sometimes major depression.) . Review of Resident #3's quarterly MDS, dated [DATE], revealed Resident #3 had Schizophrenia. Further review revealed her BIMS score was 3 of 15 reflecting severe cognitive impairment. Review of Resident #3's Care Plan dated 2/18/26 revealed it did not include history of mental illness including depression, anxiety and schizoaffective disorder, bipolar type. Further review revealed Resident #3 had impaired cognitive function related to dementia and a communication problem. Observation and attempted interview on 2/25/26 at 4:45 PM with Resident #3 revealed she was lying in bed. She answered yes or no questions but did not answer open-ended questions. Resident #3 presented as being alert to self with confusion. Resident #3 was unable to answer any questions related to her health condition. Interview on 2/27/26 at 1:58 PM with MDS Coordinator revealed he would look at a resident's health chart for any diagnoses that would trigger mental illness. He stated when completing a PASARR 1 screening he would add any diagnoses reflecting mental illness and it would then trigger for the local authority to complete a PASRR II evaluation. The LIDDA (Local Intellectual and Development Disability Authorities) would determine if a resident qualified for services. The MDS Coordinator stated a diagnosis of Dementia would not negate an evaluation. Upon reviewing Resident #3's diagnosis of schizoaffective disorder, bipolar type and the initial PASRR 1 screening he stated the diagnosis was not added so it did not trigger for a PASARR II evaluation. He stated Resident #3's PASSAR 1 screening was completed prior to him assuming his position and stated he had not checked any of the residents PASSR screenings for accuracy. The MDS Coordinator stated if Resident #3 qualified for PASSAR services she would lose out on benefits such as money follows the resident, psychiatric services, habilitative services (healthcare programs designed to help individuals acquire, maintain, or improve skills necessary for daily living and independence), returning to the community, getting specialized medical equipment and any other benefits that PASSAR services provided. Review of a facility policy, PASRR, dated 7/29/25, read The PASRR aims to ensure that individuals with mental illness or intellectual disabilities receives appropriate care and services. It assesses whether the nursing home is the most suitable setting for the individual's needs. 2. a) Level I screening: This initial screening determines if the individual may have a mental illness or intellectual disability. it is generally by the nursing facility prior to admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Level II Evaluation: If the Level I screening indicates potential mental illness or intellectual disability, a Level II evaluation is conducted. This comprehensive assessment is performed by a mental health professional and evaluates the individual's needs and whether nursing home placement is appropriate. The findings included: Record review of Resident #4's face sheet, dated 02/26/2026, revealed he was admitted to the facility on [DATE], original admission date 03/21/2025 diagnoses which included: major depressive disorder, single episode, severe with psychotic features, and bipolar disorder, current episode depressed, mild or moderate severity, unspecified. Record review of resident #4's Quarterly MDS assessment, dated 12/17/2025, revealed the resident's BIMS score of 14 noting resident with intact cognition. Quarterly MDS assessment revealed with diagnoses of bipolar disorder and depression (other than bipolar). Record review of Resident #4's care plan, initiated date 12/10/2025, revealed Resident #4's care plan had a focus of The resident has depression. Record review of Resident #4's PASRR screening dated 04/10/2025, noted an answer of 0 (No) in section C0100 Mental Illness in response to the question, Is there evidence or an indicator this is an individual with a Mental Illness? Observation and interview on 02/24/2026 at 10:22 a.m. revealed Resident #4 sitting up in a tall back wheelchair watching television. Resident #4 stated the staff responded to his needs when he requested and shaved him when he allowed them to. Record review of Resident #23's face sheet, dated 02/26/2026, revealed he was admitted to the facility on [DATE] with diagnoses which included: post-traumatic stress disorder, unspecified, and depression, unspecified. Record review of Resident #23's Quarterly MDS assessment, dated 02/20/2026, revealed the resident's BIMS score of 9 noting resident with moderate cognitive impairment. Quarterly MDS assessment revealed diagnoses of depression and post-traumatic stress disorder. Record review of Resident #23's care plan, initiated date 03/10/2025, revealed Resident #23's care plan had a focus of Risk for Depression. Record review of Resident #23's PASRR screening dated 08/14/2024, noted an answer of 0 (No) in section C0100 Mental Illness in response to the question, Is there evidence or an indicator this is an individual with a Mental Illness? Observation and interview on 02/24/2026 at 10:35 a.m. revealed Resident #23 lying across his bed with his rolling walker with a bench at bedside. Resident #23 stated he did not really have any concerns. During an interview on 02/26/2026 at 2:29 p.m. MDS Coordinator stated Resident #4 did have a diagnosis of major depressive disorder upon admission and this should have been added to PASRR I which would have triggered the local authority to come out for an evaluation. The MDS Coordinator (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident #23's diagnosis of PTSD should have been added to his PASRR I screen. During an interview on 02/27/2026 at 4:03 p.m. the MDS Coordinator stated by not coding the PASRR I accurately and not referring for an evaluation a resident could possibly not get the benefits from the PASRR if they qualified, such as rehabilitative services or possibly discharge assistance. During an interview on 02/27/2026 at 5:09 p.m. the Administrator stated the MDS Coordinator was responsible for ensuring PASRR was accurate. Record review of Texas Health and Human Services (THHSC)'s Detailed Item by Item Guide for Local Authorities and Nursing Facilities to Complete the PASRR Level 1 Screening Form guidelines, dated June 2023, read, Section C.1: PASRR Screening: Steps for Assessment: 1. Identify diagnoses: Review the medical record, if available, for an MI, ID, and/or DD/RC diagnoses. Medical record sources can include but are not limited to: verbal interview with the individual, family members or LAR, observation, progress notes, annual physical exam, the most recent History and Physical, hospital discharge summaries or diagnosis list. 2. If you cannot locate a diagnosis, but suspect that an individual does have an MI, ID, and/or DD/RC, then document that information in this section of the form. C0100 Mental Illness-Is there evidence or an indicator this is an individual that has Mental Illness? 0. No 1. Yes. Examples of MI diagnoses are: Schizophrenia, Mood Disorder (Bipolar Disorder, Major Depressive Disorder or other mood disorder) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident and identify the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 5 of 24 Residents (Resident #3, #20, #23, #18, and #19) whose records were reviewed for resident needs. Nursing staff failed to identify in Resident #3's care plan her mental health status, care and services she required.Nursing staff failed to identify in Resident #20's care plan his behavior of removing his colostomy bag and throwing it on the floor.The facility failed to ensure Resident #23's care plan included his being a smoker. The facility failed to ensure Resident #18's care plan reflected the cares for the resident's wound and tube feeding. The facility failed to ensure Resident #19's care plan reflected the cares for the resident's smoking. These deficient practices could place residents at risk of not receiving proper care and services. Findings included:1. Review of Resident #3's face sheet, dated 2/27/26, revealed she was admitted to the facility on [DATE] with diagnoses including anxiety, depression and schizoaffective disorder bipolar type. Review of Resident #3's quarterly MDS, dated [DATE], revealed Resident #3 was diagnosed with depression and schizophrenia. Further review revealed her BIMS score was 3 of 15 reflecting severe cognitive impairment. Review of Resident #3's Care Plan dated 2/18/26 revealed it did not include Resident #3's history of mental illness including depression, anxiety and schizoaffective disorder, bipolar type. Further review revealed Resident #3 had impaired cognitive function related to dementia and a communication problem. Observation and attempted interview on 2/25/26 at 4:45 PM with Resident #3 revealed she was lying in bed. She answered yes or no questions but did not answer open-ended questions. Resident #3 presented as being alert to self with confusion. Interview on 2/27/26 at 1:58 PM with the MDS Coordinator revealed he had worked at the nursing facility for about one year and as the MDS Coordinator since September 2025. He stated he would write the comprehensive care plan for the residents and nursing staff would add any acute issues. He stated he was not involved in writing residents' care plan who had been in the facility longer than one year. However, the MDS Coordinator stated a resident's care plan should reflect a resident's care needs and services to be provided as identified in the MDS assessment. He stated otherwise nursing staff would not know the care and services to provide the resident. He stated ultimately, the resident, would not receive the care and services as needed. Interview on 2/7/26 at 6:56 PM with the DON revealed Resident #3's care plan did not include her history of mental illness including depression, anxiety and schizoaffective disorder, bipolar type. She stated a resident's care plan should reflect the resident's care areas and services required to meet the resident's needs. The DON stated otherwise nursing staff would not know what care and services to provide the resident. 2. Review of Resident #20's quarterly MDS, dated [DATE], revealed he was admitted to the facility on [DATE], with diagnoses including Cancer, Heart Failure and Renal insufficiency, Renal Failure (the gradual loss of kidney function — reaches an advanced state), or End Stage Renal disease (the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kidneys no longer work as they should to meet your body's needs). Further review revealed the resident had an ostomy; to include colostomy and he did not exhibit behaviors towards himself or others. Observation and interview on 2/24/26 at 2:54 PM with Resident #42 revealed he was lying in bed. He engaged in conversation and shared some of his experiences while at the facility. He reported his roommate Resident #20 would remove his colostomy bag and throw it on the floor. He stated staff would not check on him regularly and Resident #20 would lie in bed while he was covered in feces. Resident #42 stated it smelled badly of feces in their room. He stated he reported it to staff. Observation and attempted interview on 2/24/26 at 3:00 PM revealed Resident #20 was lying in bed. Attempted interview revealed he shook his hand and would not engage in conversation. Review of Resident #20's Care Plan, dated 2/1/26, did not reveal Resident #20 would remove his colostomy bag and throw it on the floor. Review of Resident #20's progress notes from 1/1/26 to 2/27/26 did not reveal Resident #20 would remove his colostomy bag and throw it on the floor. Interview on 2/24/26 at 3:15 PM with LVN D revealed he had never seen Resident #20 remove his colostomy bag, but other nursing staff reported he had removed his colostomy bag several times and would throw it on the floor. Interview on 02/26/20264 at 5:20 PM with the DON revealed Resident #20 was able to make his basic needs known. The DON stated Resident #20's care plan did not identify that he would remove his colostomy bag and throw it on the floor. She stated she was not aware that he had the behavior and if true then it should be included so that staff would know how to approach the situation and how to address the concern with Resident #20. The DON stated not including this behavior would place him at risk of nursing staff not knowing how to address the behavior. Review of a facility policy, Care Plans, Comprehensive Person-Centered dated March 2022 read A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team, (IDT) in conjunction with the resident, his/her family or legal representative, develops and implements a person-centered care plan for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered from the comprehensive assessment. 7. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well- being. 3. Record review of Resident #23's face sheet, dated 02/26/2026, revealed he was admitted to the facility on [DATE] with diagnoses which included: post-traumatic stress disorder, unspecified, and depression, unspecified. Record review of Resident #23's Quarterly MDS assessment, dated 02/20/2026, revealed the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's BIMS score of 9 which indicated the resident had moderate cognitive impairment. Record review of Resident #23's Smoking assessment, dated 08/21/2025, revealed, Supervision during smoking at all times/Facility will store cigarettes and lighters/Resident is safe to hold and smoke cigarettes. Record review of Resident #23's care plan, with a revision date of 12/10/2025, revealed there was not a care plan reflecting Resident #23's smoking behavior. Observation on 02/27/2026 at 11:06 a.m. revealed Resident #23 smoking with supervision with other residents in the designated smoking area. During an interview and observation on 02/27/2026 at 11:55 a.m. the DON stated a resident smoking should be care planned because it was part of a resident's care plan. The DON further stated the care plan reflects everything that included their care and how to manage a resident's care. The DON stated there were 3 of them that were responsible for care plans which included herself, the MDS Coordinator and the ADON. The DON reviewed Resident #23's care plan and stated she did not see where smoking had been care planned. The DON stated smoking would i be care planned to make sure the residents were safe. The DON stated Resident #23 was considered a safe smoker. The DON stated by not care planning smoking the staff would not be aware of if the resident was a safe smoker or if the resident needed assistive items while smoking. During an interview on 02/27/2026 at 4:13 p.m. the MDS Coordinator stated he had not known they were doing care plans for smoking. The MDS Coordinator stated he did not know who did them before he started in November 2025. The MDS Coordinator stated he would be doing them now. The MDS Coordinator stated the care plan gave basic guidance on how they were going to care for a patient or an outline. The MDS Coordinator stated by not care planning smoking staff might not know if a resident needed a smoking apron. 4. Record review of Resident #18's face sheet, dated 02/27/2026, revealed the resident was an 85-years-old male and admitted to the facility on [DATE] with diagnosis of protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), pressure ulcer of buttock – stage 3 (wound that from as a direct result of pressure over a bony prominence to the buttock area), and gastrostomy status (surgical opening into the stomach for nutritional support or gastric decompression). Record review of Resident #18's quarterly MDS assessment, dated 01/28/2026, revealed the resident's BIMS score was 14 out of 15, which indicated the resident's cognitive was intact, and in Section M (Skin conditions), it was coded that Resident #18 did not have one or more unhealed pressure ulcers/injuries. Further record review of the MDS assessment revealed the resident had a mechanically altered diet which was required change in texture of food or liquids, for example, pureed food or thickened liquids in Section K (Swallowing/Nutritional Status). Record review of Resident #18's physician's order revealed the resident had the order of Wound Care: Left Ankle, right great toe, and left foot 4th interspace area - Cleanse with wound care cleanser, pat dry, apply Iodine, leave open to air. Every day shift related to UNSPECIFIED SKIN CHANGES. Started dated 02/14/2026 and Verify enteral tube placement by checking for residual gastric volume prior to medication admin and feedings every shift and Enteral Feed Order every shift Complete enteral site (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care every shift and as needed. Started 10/17/2025. Record review of Resident #18's comprehensive care plan, dated 02/24/2026, revealed there were no care plans regarding the resident's wound and tube feeding. Interview on 02/26/2026 at 4:51 p.m. MDS coordinator stated Resident #18 did not have any wounds when he was admitted to the facility on [DATE], but the resident had skin changes to his left ankle, right great toe, and left foot 4th interspace area on 02/14/2026 and received wound cares. The MDS coordinator said the facility ADON had the responsibility for developing care plans for wounds and did not know what reason the facility ADON did not develop the care plan for Resident #18's wound. Further interview with the MDS coordinator on 02/27/2026 at 8:21 a.m. said Resident #18 took all foods and medications by mouth, instead of gastrostomy tube and that was why tube feeding was not coded in MDS assessment per the guideline, but the facility nurses were providing care the resident's gastrostomy tube as ordered such as checking residual and clean the site, so the care plan should have reflected the care regarding the resident's gastrostomy tube, and not developing the care plan regarding tube feeding was the MDS coordinator's mistake. The MDS coordinator stated not developing care plan for tube feeding might affect inappropriate care to Resident #18. Interview on 02/26/2026 at 4:54 p.m. the ADON stated she was providing wound care to Resident #18 as ordered, and she thought the MDS Coordinator had the responsibility to develop Resident #18's care plans for wounds, instead of the facility ADON, and the facility ADON assumed the MDS Coordinator already developed the care plan. The facility ADON said there was some miscommunications between the ADON and MDS Coordinator regarding Resident #18's care plan for wounds, and no care plans might affect the resident could not receive correct wound care. Interview on 02/27/2026 at 3:53 p.m. the DON stated the facility ADON and MDS Coordinator should have developed the care plans regarding Resident #18's wound and tube feeding, and no care plan might affect the resident could have inappropriate cares. 5. Record review of Resident #19's face sheet, dated 02/27/2026, revealed the resident was a 65-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of anxiety disorder (symptoms of intense anxiety or panic that are directly caused by a physical health problem), cystitis (inflammation of the bladder), and psychosis (losing some contact with reality). Record review of Resident #19's quarterly MDS assessment, dated 01/17/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact, and the resident required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand and chair to bed. Record review of Resident #19's smoking assessment, dated 08/21/2025, revealed Resident #19 was smoking and Supervision during smoking at all times / Facility will store cigarettes and lighters / Resident is safe to hold and smoke cigarettes. Record review of Resident #19's comprehensive care plan, undated, revealed there was no care plan regarding Resident #19's smoking. (continued on next page)

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	676301	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/27/2026 at 8:33 a.m. the DON stated Resident #19 was smoking since she was admitted to the facility on [DATE], but there was no care plan regarding Resident #19's smoking, and developing a care plan for smoking was the DON and MDS nurse's responsibility. The DON said she did not know what reason she did not develop the care plan, and it was her mistake. The DON stated no care plan might affect the resident could receive inappropriate care regarding smoking. Record review of the facility policy, Care Plans, Comprehensive Person-Centered dated March 2022 read A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team, (IDT) in conjunction with the resident, his/her family or legal representative, develops and implements a person-centered care plan for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered from the comprehensive assessment. 7. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well- being.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who need respiratory care were provided such care, consistent with professional standards of practice for 2 of 2 residents (Residents #43 and Resident #48) and in 1 of 4 rooms (room [ROOM NUMBER]) reviewed for respiratory care.1. Resident #43's CPAP (continuous positive airway pressure) mask was not covered in a plastic bag when it was not used on 02/24/2026.2. The facility failed to ensure Resident #48 did not have a physician's order for oxygen that was observed being used on 02/24/2026 and 02/27/2026.3. The facility failed to store 2 portable oxygen cylinders in the designated oxygen storage room. This failure could place residents at risk of illness, respiratory complications and accidents.Findings included:Observation on 02/24/2026 at 2:23 PM in room [ROOM NUMBER] revealed two (2) oxygen cylinders by bed A along the wall by the dresser. The oxygen cylinders were placed on the floor; they were not secured on a stand. Observation and Interview on 02/24/2026 at 2:41 PM with LVN D revealed he stated the oxygen cylinders should not be placed on the floor in the resident's room. He stated they should be secured in a stand, so the oxygen cylinders were not knocked over. He stated it was dangerous and could cause a fire or blow up if knocked over on the floor. LVN D stated the residents could get injured. He stated there was a room in the front of the facility where they stored all oxygen cylinders that were empty or not being used. Interview on 2/27/26 at 5:20 PM with the DON revealed oxygen cylinders should not be placed on the floor in a resident's room and should be stored in the oxygen storage room located in the front of the facility. The DON stated oxygen concentrators were highly flammable and stated she had seen an oxygen cylinder pop, create an explosion when it was knocked over on the floor. She stated not securing the oxygen cylinders on a caddie or stand was dangerous and the residents could get injured. Review of facility policy, Oxygen Storage, undated, read It is the policy of center to maintain appropriate and safe storage of oxygen. Interior 3. All cylinders will be secured to the wall or be stored in appropriate transport carts or stands. 2. Record review of Resident #48's face sheet dated 02/24/2026, revealed Resident #48 was admitted to the facility on [DATE], original admission date 10/17/2025 with diagnoses that included: Chronic Obstructive Pulmonary Disease, unspecified (a progressive, incurable, yet treatable lung disease that obstructs airflow and makes breathing difficult), acute respiratory failure with hypoxia (critical condition where the lungs cannot adequately transfer oxygen to the blood), and anoxic brain damage, not elsewhere classified (severe, non-traumatic injury caused by a complete lack of oxygen to the brain). Record review of Resident #48's Quarterly MDS assessment, dated 01/14/2026, revealed the resident's BIMS score was 03 indicating severe cognitive impairment. Section O Special Treatments, Procedures, and Programs revealed C1 Oxygen Therapy was coded for Resident #48's oxygen use while a resident. Record review of Resident #48's care plan, revised on 02/24/2026, revealed Resident #48 had a focus (continued on next page)

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Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Impaired Gas Exchange and interventions/task of Administer oxygen as prescribed or per standing order. Record review of Resident #48's physician's order summary report, dated 02/26/2026, revealed there was not an order for oxygen use. Observation on 02/24/2026 at 10:35 a.m. Resident #48 was observed sitting up in the wheelchair in her room with her oxygen cannula under her chin, with the tubing attached to the oxygen concentrator that was set at 4 liters per minute. Observation on 02/24/2026 at 12:13 p.m. Resident #48 was observed sitting in her wheelchair at a dining table with the oxygen concentrator plugged in behind her with the tubing attached. The resident was holding the oxygen tubing in her hand as a staff member assisted her with placing it on her face. Observation and interview on 02/27/2026 at 9:54 a.m. Resident #48 was observed sitting in the television/common area wearing her oxygen cannula and smiling as she watched television. The oxygen concentrator was attached to a nasal cannula and was set a below 2 liters per minute at approximately 1 liter per minute with the maintenance light red. LVN C stated Resident #48 should have the oxygen concentrator set between 2 and 3 liters per minute. LVN C stated that typically the red light would come on if the back of the concentrator was too close to the wall or was blocked from air circulation. LVN C was observed taking Resident #48's nasal cannula off feeling for oxygen and then checked the oxygen concentrator setting, adjusted it to between 2 and 3 liters per minute and the red maintenance light then changed to green. LVN C proceeded to check Resident #48's orders for oxygen to confirm the setting and could not find an order. LVN C stated she was sure Resident #48 had an order but could not see it. During an interview on 02/27/2026 12:05 p.m., the DON stated Resident #48's oxygen concentrator should be set at 2 to 6 liters per minute. The DON stated Resident #48 should have had orders for her oxygen and did not know why Resident #48 did not have orders for the oxygen, however, she had been to the hospital and returned. The DON stated physician orders were necessary for the staff to know what the oxygen concentrator should be set at as far as her oxygen liters per minute. The DON stated by not having orders and not knowing the proper settings for the oxygen concentrator Resident #48 could potentially be put at risk of being short of breath, not getting adequate oxygen, and she would not be able to rest properly. During an interview on 02/27/2026 at 5:22 p.m., the Administrator stated the nurse was responsible for ensuring orders were received. The Administrator stated the orders were important for the nurses to know what the residents were to receive. During an interview on 02/27/2026 at 5:24 p.m., the RNC stated it was important to have orders so the nurses would know what they were doing and for patient safety. Record review of the facility's policy titled, Oxygen Administration, revised October 2010, read, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders, facility protocol for oxygen administration. 1. Record review of Resident #43's face sheet, dated 02/27/2026, revealed the resident was a [AGE] year-old female and admitted to the facility on [DATE] with diagnoses of atherosclerotic heart (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disease of native coronary artery (buildup of plaque inside the artery walls), sleep apnea (breathing stops and restarts many times while sleeping), and diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #43's quarterly MDS assessment, dated 12/18/2025, revealed the resident's BIMS score was 12 out of 15 which indicated the resident had moderate cognitive impairment and had non-invasive mechanical ventilator, which was CPAP (continuous positive airway pressure). Record review of Resident #43s comprehensive care plan, dated 12/10/2025, revealed the resident had the care plan of CPAP (continuous positive airway pressure) therapy for sleep apnea. For intervention – educate resident on the importance of CPAP (continuous positive airway pressure) therapy. Observation on 02/24/2026 at 10:51 a.m. revealed Resident #43 was on the bed, watching television in her room. Resident #43's CPAP (continuous positive airway pressure) mask was uncovered and connected to a machine that was on the nightstand. Interview on 02/24/2026 at 10:52 a.m. Resident #43 stated she was using her CPAP (continuous positive airway pressure) every night when she was sleeping. Interview on 02/24/2026 at 11:28 a.m. LVN-C stated Resident #43's CPAP (continuous positive airway pressure) mask was on the nightstand without a plastic bag. Further interview, LVN-C said the resident's CPAP (continuous positive airway pressure) mask should have been covered with a plastic bag when it was not used to prevent possible infection. Interview on 02/26/2026 at 4:03 p.m. the DON stated there was no specific facility policy for how to store the mask, but Resident #43's CPAP (continuous positive airway pressure) mask should have been covered in a plastic bag when it was not used to prevent possible infections.

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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** 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 (B-hall nursing cart and A-hall nursing cart) out of 3 medication carts and 2 (Resident #61 and #30) out of 3 residents reviewed for pharmacy services. 1. There were three bottles of sterile water that expired 02/09/2026 and one spray bottle of safe simple-odor eliminate clear lubricant for ostomy pouch that expired 09/02/2025 found inside the B-hall nursing cart on 02/25/2026. 2. There was one bottle of Geri care Iron supplement liquid ferrous sulfate 220 mg/5ml that expired on 07/2025 and one bottle of calcium carbonate 500 mg that expired on 01/2026 found inside the A-hall nursing cart on 02/25/2026. 3. The facility nurses opened Resident #61's insulin pen (Glargine-Lantus) on 01/23/2026 and used the insulin on 02/25/2026. However, the label of the insulin indicated Discard 28 days after opening, and 28th day was 02/20/2026. 4. The facility nurses did not check Resident #30's blood sugars and did not give the resident's insulin Lispro per the sliding scale on 02/17/2026, 02/18/2026, 02/19/2026, and 02/20/2026. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: 1. Observation on 02/25/2026 at 3:12 p.m. revealed there were three 250 ml bottles of sterile water inside the B-hall nursing cart, and the bottles expired on 02/09/2026. Further observation revealed there was one spray bottle of safe simple-odor eliminate clear lubricant for ostomy pouch inside the B-hall nursing cart, and it expired 09/02/2025. Interview on 02/25/2026 at 3:36 p.m. LVN-M stated there were three bottles of sterile water that expired 02/09/2026 and one spray bottle of safe simple-odor eliminate clear lubricant for ostomy pouch that expired 09/02/2025 found inside the B-hall nursing cart, and nurses might use sterile water for cleaning wounds and spray for eliminating odor from colostomy care. Further interview, LVN-M said she did not know what reason they were stored in the nursing cart, and any expired medications should have been removed from the cart per the facility policy. Interview on 02/25/2026 at 3:30 p.m. the DON said any expired medications should have been removed from the cart per the facility policy because using expired medication might cause not reaching therapeutic effects. 2. Observation on 02/25/2026 at 3:43 p.m. revealed there was one bottle of Geri care Iron supplement liquid ferrous sulfate 220 mg/5ml inside the A-hall nursing cart, and the bottle expired on 07/2025. Further observation revealed there was one bottle of calcium carbonate 500 mg found inside the A-hall nursing cart, and it expired on 01/2026. Interview on 02/25/2026 at 3:55 p.m. LVN-N stated there was one bottle of Geri care Iron supplement liquid ferrous sulfate 220 mg/5ml that expired on 07/2025 and one bottle of calcium carbonate 500 mg that expired on 01/2026 found inside the A-hall nursing cart on 02/25/2026. Further interview, LVN-N said she did not use the medications and did not know what reason they were stored in the nursing cart, and any expired medications should have been removed from the cart per the facility policy. Interview on 02/25/2026 at 3:46 p.m. with the DON said any expired medications should have been removed from the cart per the facility policy because using expired medication might not reach therapeutic effects. 3. Record review of Resident #61's face sheet, dated 02/27/2026, revealed the resident was 69-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of metabolic encephalopathy (problem in the brain due to chemical imbalance in the blood), diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and dementia (loss of memory and thinking ability). Record review of Resident #61's quarterly MDS assessment, dated 01/16/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and received insulin injections every day. Record review of Resident #61's physician's order, dated 08/12/2025, revealed the resident had the order of Basaglar (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Glargine-Lantus) Inject 10 unit subcutaneously in the morning related to DIABETES MELLITUS. Observation on 02/25/2026 at 3:43 p.m. revealed Resident #61's insulin pen of Insulin Glargine-Lantus inside the A-hall nursing cart, and the pen had open date of 01/23/2026. Further observation revealed the pen had the label of Discard 28 days after opening. Interview on 02/25/2026 at 3:55 p.m. LVN-N stated Resident #61's insulin pen of Insulin Glargine-Lantus was inside the A-hall nursing cart, and the pen had an open date of 01/23/2026, and the pen had the label of Discard 28 days after opening. Further interview, LVN-N stated she used it on 02/25/2026, but she should have discarded it on 02/20/2026 because 2/20/2026 was the 28th day after opening the insulin pen, and it was her mistake. LVN-N stated expired insulin might not have therapeutic effects. Interview on 02/26/2025 at 3:56 p.m. the DON stated the facility nurses should have discarded Resident #61's insulin pen of Insulin Glargine-Lantus on 02/20/2026 because 2/20/2026 was the 28th day after opening the insulin pen as the label, and using expired insulin might not have therapeutic effects. 4. Record review of Resident #30's face sheet, dated 02/27/2026, revealed the resident was a 79-years-old female and admitted to the facility on [DATE] with diagnosis of fracture of left lower leg, type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and dementia (loss of memory and thinking ability). Record review of Resident #30's admission MDS assessment, dated 01/29/2026, revealed the resident's BIMS was 11 out of 15 which indicated the resident had moderate cognitive impairment and was Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to chair to bed and toilet transfer. Record review of Resident #30's physician order, dated 02/12/2026, revealed the resident had the order of Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 25 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS and Insulin Lispro (1 Unit Dial) 100 UNIT/ML Solution pen injectorInject as per sliding scale: if 150 - 199 = 2units Give 2 units; 200 - 249 = 4 units Give 4 units; 250 - 299 = 6 units Give 6 units; 300 - 349 = 8 units Give 8 units; 350 - 400 = 10 units If above 400 give 10 units and notified MD, subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS. Started 02/21/2026. Record review of Resident #30's medication administration record from 02/01/2026 to 02/28/2026 revealed the resident received her long acting insulin of Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine)-Inject 25 unit subcutaneously at 9:00 PM every night since 02/12/2026 as ordered. Further record review of the resident's medication administration record revealed the resident received her short acting insulin (Lispro) as per sliding scale from 02/12/2026 to 02/16/2026, but there was no documented evidence the resident received her short acting insulin on 02/17/2026, 02/18/2026, 02/19/2026, and 02/20/2026. The resident resumed receiving the short acting insulin since 02/21/2026. Interview on 02/25/2026 at 1:14 p.m. the DON stated Resident #30's primary care physician started the resident's long acting and short acting insulin on 02/12/2026, and the facility nurses administered the long and short acting insulin to the resident as ordered. However, on 02/17/2026, the facility pharmacy staff deleted Resident #30's short acting insulin order from the system by accident, and the DON realized Resident #30's short acting insulin order disappeared from the system by accident on 02/21/2026 so she put the order on the system immediately, so the facility nurses resumed giving the short acting insulin to Resident #30 on 02/21/2026 as ordered. The DON said as a result, Resident #30 did not receive short acting insulin for 4 days, which were 02/17/2026, 02/18/2026, 02/19/2026, and 02/20/2026, and the resident did not have any negative effect such as signs or symptoms related to high blood sugars or low blood sugars for those days. The DON said the facility nurses should have asked regarding Resident #30's short acting insulin when it was disappeared on the system, but if the order was disappeared on the system by accident, the facility nurses could not see the order on the electronic medication administration record, and this was why facility nurses did not ask regarding Resident #30's short acting insulin to the DON. The DON said not (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	giving insulin might cause the resident to have high blood sugars, but Resident #30 did not have any negative effect because the resident received long-acting insulin every day as ordered, and the facility did not have policy regarding specifically insulin, but nurses should follow physician orders. Interview on 02/26/2026 at 1:50 p.m. Resident #30's Nurse Practitioner said he started long-acting and short-acting insulin for Resident #30 on 02/12/2026 because the resident's blood sugars were a little bit high (average 200 mg/dL), and the facility DON reported the resident did not receive short-acting insulin for 4 days (02/17/2026, 02/18/2026, 02/19/2026, and 02/20/2026) because the order disappeared by accident due to the pharmacy and it was resumed on 02/21/2026. The Nurse Practitioner stated based on his assessment the resident did not have any negative effect regarding missing the short-acting insulin for 4 days because the resident received long-acting insulin every day as ordered and did not have any signs or symptoms regarding low and high blood sugars; and the resident's blood sugars were controlled with the long-acting insulin for those days on the resident's baselines, so missing short-acting insulin for 4-days did not cause any harm to the resident. Record review of the facility policy, titled Medication Storage and Labeling, dated 06/2023, revealed Multi-dose vials which have not been opened or accessed should be discarded according to the manufacturer's expiration date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 4 (Resident #71, #7, #5, and #56) of 24 residents reviewed for infection control practices. 1. When the facility ADON was providing wound care to Resident #71 on EBP (Enhanced Barrier Precaution), the ADON did not wear a gown, and the facility did not attach the sign of EBP on the door of the resident. 2. When CNA-L was providing urinary indwelling catheter care to Resident #7 on EBP (Enhanced Barrier Precaution), the CNA-L did not wear a gown. 3. When CNA-O was providing incontinent care to Resident #5 on 02/26/2026, the CNA-O touched new and clean brief with old and dirty gloves. 4. When CNA-J was providing incontinent care to Resident #56 on 02/26/2026, the CNA-J touched new and clean brief with old and dirty gloves. This deficient practice could place residents at risk for cross contamination and infections. The findings included: 1. Record review of Resident #71's face sheet, dated 02/27/2026, revealed the resident was an [AGE] year-old-male and admitted to the facility on [DATE] with diagnoses of encounter for surgical aftercare following surgery on the digestive system (postoperative care related to digestive system surgery), hypertension (high blood pressure), and lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that is usually drained through the body's lymphatic system). Record review of Resident #71's admission MDS assessment, dated 02/24/2026, revealed the resident's BIMS score was 14 out of 15 which indicated the resident's cognitive was intact and required Substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to sit to stand, chair to bed, and toilet transfer. Further record review of the MDS assessment revealed the resident had one or more unhealed pressure ulcers/injuries. Record review of Resident #71's comprehensive care plan, dated 02/17/2026, revealed the resident had the care plan of Provide wound care per treatment order and Risk for Infection - Administer antibiotic therapy as prescribed and Evaluate surgical incision and temperature. Record review of Resident #71's physician order, dated 02/26/2026, revealed the resident had the order of WOUND CARE: Cleanse RIGHT GREAT TOE with wound cleanser, pat dry, paint with betadine and leave open to air daily. Everyday shift, and WOUND CARE: Cleanse RIGHT LOWER LEG with wound cleanser, pat dry, apply xeroform, apply abdominal pad and wrap with kerlix and ace bandage. Every Tuesday, Thursday, and Saturday. Observation on 02/26/2026 at 10:32 a.m. revealed the facility ADON washed her hands with water, put on new gloves, and provided wound care to Resident #71 without putting on a gown. Further observation revealed there was no sign on the door regarding EBP (Enhanced Barrier Precaution). Interview on 02/26/2026 at 11:29 a.m. with the facility ADON said Resident #71 was supposed to have EBP because of his wounds per the facility policy, but the facility did not attach the EBP sign on the door of the resident's room, and she forgot to wear a gown while she was providing wound care to the resident. ADON stated she should have put on a gown when providing wound care to the resident to prevent possible infection even though there was no sign on the door, and it was her mistake. Interview on 02/26/2026 at 3:47 p.m. with the DON stated Resident #71 was supposed to have EBP because of his wounds per the facility policy, but the DON did not attach the EBP sign on the door of the resident's room. The DON said Resident #71 was new, so she missed it, and attaching EBP sign on the door was the DON's responsibility, and ADON should have put on a gown when providing wound care to the resident to prevent possible infection. 2. Record review of Resident #7's face sheet, dated on 02/27/2026, revealed the resident was a [AGE] year-old-male, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of cerebral infarction (brain tissue death due to the blood vessel blockage), neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), and urinary tract infection (an infection in any (continued on next page)

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	676301	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	part of kidneys, bladder, and urethra). Record review of Resident #7's quarterly MDS assessment, dated 01/15/2026, revealed the resident's BIMS score was 10 out of 15 which indicated the resident had moderate cognitive impairment and Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to chair to bed transfer, and had indwelling urinary catheter. Record review of Resident #7's comprehensive care plan, dated 10/31/2025, the resident had the care plan of [Resident #7] has a urinary tract infection related to use of indwelling urinary catheter. For intervention - EBP: Staff must use gown and gloves during high-contact resident care activities that could possibly to result in transfer of Multi Dru Resistant Organisms (MDRO) to hands and clothing of staff. Record review of Resident #7's physician order, dated 09/08/2025, revealed the resident had the order of EBP: Staff must use gown and gloves during high contact resident care activities that could possibly to result in transfer of Multi Dru Resistant Organisms (MDRO) to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds or indwelling medical devices). every shift for EBP Precautions. Observation on 02/26/2026 at 3:09 p.m. revealed CNA-L washed her hands with water and provided indwelling urinary catheter care to Resident #7 without putting on a gown, and on the door, there was EBP sign, use gown and gloves during high contact resident care activities such as catheter care. Interview on 02/26/2026 at 3:14 p.m. with CNA-L stated she did not put on a gown when providing urinary indwelling catheter care to Resident #7. CNA-L said she was nervous so forgot to wear a gown, and she should have put on a gown while providing catheter care to the resident because the resident had EBP to prevent possible infection. Interview on 02/26/2026 at 3:47 p.m. with the DON said per the facility policy, CNA-L should have put on a gown while providing catheter care to Resident #7 because the resident had EBP to prevent possible infection. Record review of the facility policy, titled Enhanced Barrier Precaution, revised 02/2025, revealed . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include - device care or use (central lines, urinary catheter, feeding tube, and tracheostomy) and wound care (any skin opening requiring a dressing). 3. Record review of Resident #5's face sheet, dated 02/27/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses of epilepsy (a brain disorder that causes people to have recurring seizures), restlessness and agitation (sudden, distressing state of intense restlessness), and schizoaffective (exhibiting symptoms of both schizophrenia and a mood disorder such as bipolar disorder). Record review of Resident #5's admission MDS assessment, dated 02/16/2026 reflected that she was assessed to have a BIMS score was 3 out of 15 indicating she had severe cognitive impairment. Resident #5 was assessed to always incontinence to bowel and bladder. Record review of Resident #5's comprehensive care plan, dated 02/24/2026, reflected the resident had the care plan of The resident has bowel and bladder incontinence. For intervention - Clean peri-area with each incontinence episode. Observation on 02/26/2026 at 2:04 p.m. revealed CNA-O opened Resident #5's old and dirty brief, cleaned the resident's right and left groin areas, and cleaned the resident's genital area (middle area) without opening the resident's labia area, then cleaning the resident's buttock areas. Further observation revealed CNA-O removed old and dirty brief and put the new and clean brief under the resident without changing the old and dirty gloves and then closed the new and clean brief. Interview on 02/26/2026 at 2:12 p.m. with CNA-O stated when she cleaned Resident #5's genital area, she should have changed her gloves to new and clean gloves when putting new and clean brief under the resident to prevent possible cross contamination. Interview on 02/26/2026 at 3:54 p.m. with the DON said CNA-O should have changed her gloves to new and clean gloves when putting new and clean brief under the resident to prevent possible infection. 4. Record review of Resident #56's face sheet, dated 02/27/2026, revealed the resident was a 38-years-old male and admitted to the facility on [DATE] with diagnosis of encounter for other orthopedic aftercare (intensive physical rehabilitation), fracture of part of neck of right femur (fracture to right (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thigh bone), and infection following a procedure deep incisional surgical site (infection to surgical site). Record review of Resident #56's admission MDS assessment, dated 02/13/2026, revealed the resident's BIMS score was 0 out of 15 which indicated the resident had severe cognitive impairment, required substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to chair to bed and toilet transfer, and always incontinent to bowel and bladder. Record review of Resident #56's comprehensive care plan, dated 02/16/2026, revealed the resident had the care plan of self-care deficit for bathing, dressing, and feeding. For intervention - provide assistance with activities of daily livings. Observation on 02/26/2026 at 1:25 p.m. revealed when CNA-J opened Resident #56's old and dirty brief, the resident was uncircumcised. CNA-J cleaned the resident's right and left groin area, then cleaned the resident's penis area without pulling back the foreskin of the resident's penis with multiple pass of one wipe, then turned the resident to side and cleaned the resident's buttock area. Further observation revealed CNA-J put new and clean brief under the resident without changing her gloves to new and clean gloves, then closed the new and clean brief. Interview on 02/26/2026 at 1:32 p.m. with CNA-J stated when she was providing incontinent care to Resident #56, she put new and clean brief under the resident without changing her gloves to new and clean gloves because she was very nervous. Further interview with CNA-J said she should have should have changed her gloves to new and clean gloves when putting a new and clean brief to the resident, and should have used a new wipe with each stroke to prevent infection. Interview on 02/26/2026 at 3:52 p.m. with the DON said CNA-J should have changed her gloves to new and clean gloves when putting a new and clean brief to the resident, and should have used a new wipe with each stroke to prevent infection. Record review of the facility policy, titled Perineal Care, revised 02/2018, revealed Female - cleanse the peri area with wipes going front to back to dirty and separate the labia and use a new wipe with each stroke. Male - if the resident is uncircumcised gently pull back the foreskin and wipe the head of the penis beginning at the urethral opening working outward and away from the penis head.4. discard soiled gloves, sanitize hands. Re-glove prior to touching clean lines or adult brief.

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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. Based on interview and record review the facility failed to ensure the facility implemented and maintained an effective training program for all existing staff for 4 of 8 staff (MA G, MA I, CNA J and CNA K) whose records were reviewed for training. The facility failed to ensure MA G, MA I, CNA J and CNA K completed the required yearly competency skill set training. This deficient practice could place residents at risk of being cared by unqualified nursing staff. The findings were:Review of personnel files for MA G, MA I, CNA J and CNA K all of who were hired on 3/1/25 revealed they had not completed their yearly competency skill set training. Further review revealed their competency check off lists did not include the trainer's name and the completion date for training was left blank. Review of facility, CNA Orientation/Competency Checklist included the following training:System AccessFacility EmailTeamsShare Point-Policies and ProceduresLMS ReliasMeetingsRoundsIntake ProceduresOral Intake MeasurementsPercentage of Solid Food MeasurementPercentage of LiquidCalorie Counts/Tray MonitorDistribute-Set up and Collect TraysAssist/Feed Meals to ResidentsProvide Between Meals NourishmentsHandout SnacksPass Drinking WaterFeed the swallowing impairedCorrect Documentation/Charting ProceduresBedmaking ProceduresOccupiedUnoccupiedMaking Specialized BedInfection ControlHandwashing TechniqueHandling of LinenIsolation TechniquesBlood and Body Fluid PrecautionsAdmission/Discharge Packets Measuring WeightMeasuring HeightRecording/Caring for Belongings and Valuablesadmission ProcessDischarge ProcessADL AssistPersonal Hygiene, Bathing, Showering and Bed BathTransfer Techniques: Mechanical Lift, 1 & 2 Person AssistDressingOral Hygiene: Brushing Teeth & Cleaning DenturesToileting AssistMobility Assist: [NAME] & WheelchairObservation DocumentationProperly Reporting any Changes in Resident Status to NurseCorrectly Document All Flowsheets, Charts and KiosksGeneral DutiesProvide For Resident PrivacyWork as a Team MemberCorrect Change Procedures for SuppliesProper Telephone EtiquetteCommunicate with Other Departments EffectivelyInteract with Families and Staff Professionally Interview on 2/27/26 at 4:15 PM with the HR staff revealed that MA G and MA I were also CNA's and were required to complete the same competency training as the CNA's. The HR staff reviewed the competency for MA G, MA I, CNA J and CNS J and stated it did not look like they completed their yearly competency skill set training. She stated she believed the staff completed the training but stated the competency check off lists did not include the trainers name or the date the training was completed. The HR staff stated both the DON and ADON would train the staff . She stated the trainers had to sign and date the check off lists otherwise she could not prove staff MA G, MA I, CNA J and CNA K completed their yearly competency skill set training. The HR staff was asked for a facility policy for competency training, and it was not provided by the end of survey on 2/27/26 at 8:30 PM. Interview on 2/27/26 at 6:56 PM with the DON revealed they had competency training for multiple nursing staff one day during the month of February 2026 but could not remember who all she and the ADON trained. The DON stated she could not attest to whether or not MA G, MA I, CNA J and CNA K completed the competency skill set training.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 (Resident #3) out of 24 residents reviewed for dignity. When LVN-M administered a medication to Resident #3 via the resident's gastrostomy tube on 02/26/2026, the nurse did not provide privacy, and as a result, the resident's roommate saw everything regarding how the nurse gave a medication via gastrostomy tube. These failures could place the residents at risk of not having their right to privacy and to a dignified existence maintained. Findings included: Record review of Resident #3's face sheet, dated 02/27/2026, revealed the resident was an 87-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of dementia (a group of symptoms affecting memory, thinking, and social abilities), gastrostomy tube status (tube inserted through the belly that brings nutrition or medications directly to the stomach), and cerebral infarction (brain tissue death due to the blood vessel blockage). Record review of Resident #3's quarterly MDS assessment, dated 02/18/2026, revealed the resident's BIMS score was 3 out of 15 which indicated the resident had severe cognitive impairment, and the resident had a feeding tube. Record review of Resident #3's comprehensive care plan, dated 11/19/2025, revealed I [Resident #3] require tube feeding related to dysphasia (difficulty in swallowing) and have memory loss related to dementia. For intervention - Team members will listen and respond with empathy. Observation on 02/26/2026 at 11:29 a.m. revealed when LVN-M entered Resident #3's room and started administering one medication via the resident's gastrostomy tube, the resident's roommate was sitting on the wheelchair and watching TV in the room. LVN-M did not pull the curtain for privacy and did not close the blinds of the window beside the resident's bed, and as a result Resident #3's roommate saw everything regarding how the nurse gave the medication to the resident via gastrostomy tube. Interview on 02/26/2026 at 11:30 a.m. with Resident #3 revealed the resident was unable to interview. Interview on 02/26/2026 at 11:31 a.m. with LVN-M stated she should have used the curtain for privacy because Resident #3's roommate was in the room and closed the window blind to prevent possible privacy problems. LVN-M said she forgot to provide privacy to Resident #3 because she was very nervous, and it was her mistake. Interview on 02/26/2026 at 3:49 p.m. with DON stated LVN-M should have used the curtain for privacy because Resident #3's roommate was in the room when the nurse administered medication to the resident via gastrostomy tube and closed the window blind to prevent possible privacy problems, such as somebody in the courtyard could see Resident #3. DON said it was violation to Resident #3's right to privacy. Record review of the facility policy, titled Resident Right, revised 02/2021, revealed Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to privacy and confidentiality.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the resident has the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 1 (Resident #5) out of 24 residents reviewed for resident rights. The facility failed to obtain informed consent for the use of Risperdal (an antipsychotic medication) for Resident #5. These failures could place residents who receive psychotropic medications at risk of receiving medications without consent, knowledge of possible side effects of the medications, or other treatment options.Findings included: Record review of Resident #5's face sheet, dated 02/27/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of epilepsy (a brain disorder that causes people to have recurring seizures), restlessness and agitation (sudden, distressing state of intense restlessness), and schizoaffective (exhibiting symptoms of both schizophrenia and a mood disorder such as bipolar disorder). Record review of Resident #5's admission MDS assessment, dated 02/16/2026 reflected that she was assessed to have a BIMS score was 3 out of 15 indicating she had severe cognitive impairment. Resident #5 was assessed to not have verbal and other behavioral symptoms. However, Resident #5 was assessed to have psychiatric / mood disorder: schizoaffective and restlessness and agitation, and Resident #5 was further assessed to be on an antipsychotic medication. Record review of Resident #5's comprehensive care plan, dated 02/24/2026, reflected the resident had the care plan of The resident uses psychotropic medications. For intervention - Administer PSYCHOTROPIC medications as ordered by a physician. Monitor for side effects and effectiveness every shift. Record review of Resident #5's physician's orders, dated 02/09/2026, reflected the resident had the order of risperiDONE Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth every 24 hours as needed for as needed related to RESTLESSNESS AND AGITATION. Record review of Resident #5's medication administration record from 02/01/2026 to 02/28/2026 revealed the resident received her risperidone 0.5 mg one tablet by mouth on 02/12/2026 at 7:20 PM for restlessness and agitation. Interview on 02/27/2026 at 9:51 a.m. with the DON stated there was no consent in Resident #5's medical record regarding the resident's Risperidone, and the facility should have obtained the consent from the resident's responsible party before starting the psychotropic medication. The DON said she did not know why the facility nurses did not obtain the consent. The DON stated it was a charge nurse's responsibility to get the consent, and not obtaining the consent before starting the medication might affect the resident who could receive the medication to which the resident's responsible party did not agree. Record review of the facility policy, titled Resident Right, revised 02/2021, revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be informed of, and participate in, his or her care planning and treatment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 2 of 8 residents (Resident #15 and Resident #65) who were observed for call light placement. The facility failed to ensure the call light was within reach for Resident #15 and Resident #65. This deficient practice could place residents at risk of not being able to call for help as needed.The findings included: Record review of Resident #15's face sheet, dated 02/25/2026, revealed she was admitted to the facility on [DATE] with original admission date 10/21/2025 with diagnoses which included: mild intellectual disabilities, chronic pain syndrome, chest pain, cerebral palsy (group of conditions that affect movement and posture), and other lack of coordination. Record review of Resident #15's Quarterly MDS assessment, dated 01/13/2026, revealed the resident's BIMS score was 7, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #15 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to lying, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Record review of Resident #15's care plan, target date of 03/16/2026, revealed Resident #15's care plan did not address the use of a call light.Record review of Resident #65's face sheet, dated 02/25/2026, revealed she was admitted to the facility on [DATE] with original admission date 09/19/2025 with diagnoses which included: Alzheimer's disease (a progressive, irreversible brain disorder that damages neurons causes memory loss, cognitive decline, and behavioral changes), generalized anxiety, polyneuropathy (the widespread damage of multiple peripheral nerves, causing symmetric numbness, tingling, burning pain, and muscle weakness, typically starting in the feet and hands), unspecified, and pain in unspecified joint.Record review of Resident #65's Quarterly MDS assessment, dated 01/01/2026, revealed the resident's BIMS score was 5, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #65 required substantial/maximal assistance (helper does more than half the effort) for putting on/taking off footwear, shower/bathe self and required supervision or touching assistance (helper provides verbal cues and /or touching/steadying and /or contact guard assistance as resident completes activity) with toileting hygiene, upper body dressing, lower body dressing, personal hygiene, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Record review of Resident #65's care plan, initiated date 10/06/2025, revealed, Focus: Fall with injury. Intervention: Remind me to use call device (call light) for assistance as needed. Observation and interview on 02/24/2026 at 10:40 a.m. revealed Resident #15 lying in bed with the bed in the lowest position, head of bed elevated and call light hanging from the dresser next to the foot of Resident #15's bed. Resident #15 stated she did not think her call light worked as she looked around her bed unable to find her call light.Observation and interview on 02/24/2026 at 10:40 a.m. revealed Resident #65 lying in her bed with bed in the lowest position, head of bed elevated and call light on the dresser near the foot of her bed. Resident #65 stated she had her call light then felt around the bed and stated she could not reach the call light or find it. Resident #65's call light was observed on top of Resident #65's dresser hanging on the opposite side of the bed. Resident #65 pointed at her cellphone and stated she did not think her phone would call the facility. Observation on 02/24/2026 at 11:01 a.m. revealed Resident #15 was heard calling for assistance and calling for the nurse. Resident #15 was heard yelling; she had pain in her leg. Three staff members were to be at the end of the hallway unable to hear resident. Observation on 02/24/2026 at 11:04 a.m. revealed Resident #15 continued to yell out periodically for the nurse. Observation on 02/24/2026 at 11:05 a.m. revealed LVN entered the room and knocked on the door. LVN adjusted the bed and offered Resident #15's pain medication. LVN left Resident #15's room to get her medication from the medication cart. LVN left the room not noticing the call light on the dresser (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when she exited the room. During an interview and observation on 02/24/2026 at 11:10 a.m. CNA A stated they had showered Resident #15 that morning. When asked about Resident #15's call light she walked over and got the call light and placed it on Resident #15's lap. CNA A also assisted Resident #65 with her call light placing it on her stomach. CNA A stated the call light should be placed near the resident. CNA A further stated she was just helping on the hall but was working on the other hall. During an interview on 02/24/2026 at 11:15 a.m. CNA B stated they had showered both Resident #15 and Resident #65. CNA B stated they assisted hospice with shower of Resident #65 and she was placed back in bed. CNA B further stated she had assisted Resident #15 from the wheelchair to her bed. CNA B stated they forgot to give the residents their call light. CNA B stated residents did use their call lights. CNA B stated the call lights were used by residents to ask for medication, to be changed and it was how they communicated. During an interview on 02/27/2026 at 12:13 p.m. the DON stated the call light should always be within reach of the resident. The DON stated call lights were how the residents communicate with the staff. The DON stated everybody should make sure call lights were in reach, but CNAs have more interactions, and everyone should be looking out for it. The DON stated the residents would not be able to address a need, ask for help or communicate with the staff if they did not have their call lights. During an interview on 02/27/2026 at 4:54 p.m. the Administrator stated nursing was responsible for call lights and that they were important so the resident could ask for help when they needed it. The Administrator stated that by not having the call light residents would not be able to get assistance. Record review of facility's Call System, Residents policy, updated January 2025, read Policy Statement: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN (as needed) orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication for 1 (Resident #5) of 24 residents reviewed for chemical restraint, in that: The facility failed to ensure Resident #5 was prescribed Risperidone for restlessness and agitation, no longer than 14 days PRN (as needed). This failure could place residents at risk of receiving unnecessary psychotropic medications. The findings were: Record review of Resident #5's face sheet, dated 02/27/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of epilepsy (a brain disorder that causes people to have recurring seizures), restlessness and agitation (sudden, distressing state of intense restlessness), and schizoaffective (exhibiting symptoms of both schizophrenia and a mood disorder such as bipolar disorder). Record review of Resident #5's admission MDS assessment, dated 02/16/2026 reflected that she was assessed to have a BIMS score was 3 out of 15 indicating she had severe cognitive impairment. Resident #5 was assessed to not have verbal and other behavioral symptoms. However, Resident #5 was assessed to have psychiatric / mood disorder: schizoaffective and restlessness and agitation, and Resident #5 was further assessed to be on an antipsychotic medication. Record review of Resident #5's comprehensive care plan, dated 02/24/2026, reflected the resident had the care plan of The resident uses psychotropic medications. For intervention - Administer PSYCHOTROPIC medications as ordered by a physician. Monitor for side effects and effectiveness every shift. Record review of Resident #5's physician's orders, start dated 02/09/2026, reflected the resident had the order of risperiDONE Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth every 24 hours as needed for as needed related to RESTLESSNESS AND AGITATION. Further record review of the resident's physician order revealed there was no stop date of risperidone. Record review of Resident #5's medication administration record from 02/01/2026 to 02/28/2026 revealed Resident #5 had received Risperidone 0.5 MG on 02/12/2026 at 7:20 PM as ordered. Interview with the DON on 02/27/2026 at 9:51 a.m., it was confirmed Resident #5 had an order for risperiDONE Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth every 24 hours as needed for RESTLESSNESS AND AGITATION, and the order should have only been for 14 days. The DON stated she did not know why the order was written over 14 days, as overuse could place Resident # 5 at risk for respiratory depression. The DON said she was responsible for overseeing antipsychotic medications daily and currently monitored it at random, and it might affect that Resident #5 could receive unnecessary medications without re-evaluations. Record review of the facility's policy titled, Psychotropic Medication Use Policy, dated 2001, revised July 2022, revealed, .PRN orders for psychotropic medication are limited to 14 days.

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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** Based on observation, interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 10 Residents (Resident #3 and Resident 42 whose records were reviewed for assessments. Nursing staff failed to code Resident #3 had an anxiety disorder on her MDS assessment. Nursing staff failed to code Resident #42 had an anxiety disorder on his MDS assessment. This deficient practice could place residents at risk of not identifying care areas and result in residents not receiving needed care and services. The findings were:1. Review of Resident #3's face sheet, dated 2/27/26, revealed she was admitted to the facility on [DATE] with diagnoses including anxiety and schizoaffective disorder bipolar type (Schizoaffective disorder is a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania. Bipolar type includes bouts of hypomania or mania and sometimes major depression.). Review of Resident #3's quarterly MDS, dated [DATE], revealed Resident #3 did not have an anxiety disorder. Further review revealed her BIMS score was 3 of 15 reflecting severe cognitive impairment. Review of Resident #3's Care Plan dated 2/18/26 revealed it did not include history of mental illness including depression, anxiety and schizoaffective disorder, bipolar type. Further review revealed Resident #3 had impaired cognitive function related to dementia and a communication problem. Observation and attempted interview on 2/25/26 at 4:45 PM with Resident #3 revealed she was lying in bed. She answered yes or no questions but did not answer open-ended questions. Resident #3 presented as being alert to self with confusion. Resident #3 was unable to provide any specific answers to her health condition. 2. Review of Resident #42's face sheet, dated 2/26/26, revealed he was admitted to the facility on [DATE] with diagnosis to include anxiety. Review of Resident #42's quarterly MDS, dated [DATE], reflected that Resident #42 did not have anxiety disorder. Further review revealed Resident #42's BIMS score was 15 of 15 reflecting he did not have cognitive impairment. Review of Resident #42's Care Plan dated 12/10/25 revealed The resident uses anti-anxiety medications (Buspirone). Interventions included administer anti-anxiety medication as ordered per physician. Observation and interview on 2/24/26 at 2:54 PM with Resident #42 revealed he was lying in bed. He engaged in conversation and shared his experiences while at the facility. Resident #42 was fixated on discussing his dissatisfaction with services and the food. He did not answer any other questions related to his health condition. Interview on 2/27/26 at 1:58 PM with MDS Coordinator revealed an MDS assessment should accurately reflect a resident's status otherwise the care areas might not be transferred onto the Care Plan and nursing staff would not know the resident's care areas. He stated ultimately, the resident, would not receive the care and services as needed. Interview on 2/7/26 at 6:56 PM with the DON revealed Resident #3's MDS assessment, dated 2/19/26, and Resident #42's MDS assessment, dated 1/2/26, did not reflect each resident had a diagnosis of anxiety disorder. She stated an MDS assessment should accurately reflect a resident's status to ensure they received the care and services the resident needed. Review of a facility policy, Comprehensive Assessment, dated February 2025, read 1. A comprehensive assessment is conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. Review of the RAI, dated October 2025 read Facilities must ensure that the documentation reflects the resident's status during the look-back period which directly impacts resident care, quality measures and reimbursement.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's care planning for 1 of 2 Residents (Resident #42) reviewed for PASARR services. The MDS Coordinator failed to include Resident #42 had chosen to continue with habilitative services on his Care Plan. This deficient practice could place residents at risk of not receiving services identified by the local authority. The findings were: Review of Resident #42's face sheet, dated 2/26/26, revealed he was admitted to the facility on [DATE] with diagnoses including anxiety, depression, schizoaffective disorder, bipolar type (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania) and mood disorder due to known physiological condition with depressive features (represents a significant clinical challenge within the realm of organic mental disorders. Defined as a mood disturbance that directly stems from a recognized physiological condition.) Review of Resident #42's quarterly MDS, dated [DATE], revealed Resident #42 had depression and Schizophrenia. Further review revealed Resident #42's BIMS score was 15 of 15 reflecting he did not have cognitive impairment. Review of Resident #42's Care Plan dated 12/10/25 revealed The resident uses psychotropic medications (Risperidone), and the resident has a mood problem. Interventions included administer medications as ordered per physician. Further review revealed there was no indication that Resident #42 was PASARR positive (Identification of individuals with MI or IID) or that he was receiving habilitative services (healthcare programs designed to help individuals acquire, maintain, or improve skills necessary for daily living and independence). Review of a quarterly meeting dated 12/5/25, between the local authority and the resident and facility staff, revealed Resident #42's service plan was updated and Resident #42 chose to continue habilitative services. Observation and interview on 2/24/26 at 2:54 PM with Resident #42 revealed he was lying in bed. He engaged in conversation and shared his experiences while at the facility. Resident #42 was fixated on discussing his dissatisfaction with other services and the food. Attempts were made to inquire about PASRR services; however, he did not answer any questions pertaining to PASRR. Interview on 02/26/2026 at 2:08 PM with the MDS Coordinator revealed Resident #42's Care Plan did not include a focused area related to PASRR habilitative services identified in the PASARR service plan for coordination of care. He stated the impact on Resident #42 could result in Resident #42 not receiving the services he was entitled to and required to receive through PASARR. Further interview with the MDS Coordinator revealed he had worked at the nursing facility for about one year and as an MDS Coordinator since September 2025 which included coordinating the residents care plan meetings with the local authority. He stated a resident's Care Plan should reflect a resident's care needs and services identified by the local authority. Review of facility policy, PASRR, dated 7/29/25, read The PASRR aims to ensure that individuals with mental illness or intellectual disabilities receives appropriate care and services. It assesses whether the nursing home is the most suitable setting for the individual's needs.2. a) Level I screening: This initial screening determines if the individual may have a mental illness or intellectual disability. it is generally by the nursing facility prior to admission.b) Level II Evaluation: If the Level I screening indicates potential mental illness or intellectual disability, a Level II evaluation is conducted. This comprehensive assessment is performed by a mental health professional and evaluates the individual's needs and whether nursing home placement is appropriate.4. Care planning: Based on the findings of the Level II evaluation, a care plan is developed that may include specialized services or living arrangements tailored to the individual's needs. Collaboration with mental health professionals and Local Authority to ensure continuity of care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care within 48 hours of a resident's admission, including initial goals based on admission orders, physician orders, dietary orders, and social services for 2 of 2 residents (Resident #4 and Resident #70) reviewed for baseline care plans. The facility failed to ensure a baseline care plan was completed within 48 hours from admission for Resident #4 and Resident #70. This deficient practice could place newly admitted residents at risk for not receiving care and services as needed. The findings were:Review of Resident #70's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with diagnoses including unspecified atrial fibrillation (irregular heartbeat, or arrhythmia. Can lead to blood clots, stroke, heart failure and other heart-related complications), essential hypertension (high blood pressure) and hyperlipidemia (high cholesterol). Review of 5-day MDS Care Plan, dated [DATE], revealed Resident #70's ethnicity revealed another Hispanic, Latino/a, Spanish origin, her BIMS score was 9 of 15 reflective of moderate cognitive impairment, her ability to hear was adequate and she required partial to moderate assistance for most ADL's. Review of Resident #70's electronic health chart revealed a baseline Care Plan had not been completed at all. Observation and interview on [DATE] at 11:22 AM revealed Resident #70 was lying in bed with the bed in the low position. There was a water jug on top of the bedside table. Further observation revealed Resident #70 was Spanish speaking and the surveyor had to repeat questions because Resident #70 did not appear to hear the surveyor clearly. The surveyor noted Resident #70's upper and lower teeth were decaying, they were a dark brown color. Resident #70 stated she was doing ok. Interview on [DATE] at 12:00 PM with LVN D revealed Resident #70 was a new admission but did not know too much about her. He stated she was Spanish speaking and believed she required minimal assistance with ADL's. LVN D stated Resident #70 ate in her room. Observation and interview on [DATE] at 3:45 PM revealed Resident #70 was sitting on her bed. She presented as being anxious and stated she did not understand why she was in this place. Resident #70 spoke Spanish. She stated a family member died and was not allowed to return home until she cleaned it. She stated she was from another country where all her remaining family lived. Resident #70 stated she did not want to call them because they were all elderly as well and had their own problems. Resident #70 stated staff wanted her to walk like she was normal and stated just standing up from the bed took all her energy. She stated she did not have the leg strength. Resident #70 stated staff also wanted her to eat in the dining room, but she preferred to eat in her room. Observation and interview on [DATE] at 4:55 PM with the DON revealed there were at least four (4) staff who spoke Spanish including herself. She stated Resident #70 understood basic English, but staff was able to communicate with her to determine her basic needs. The DON stated she oriented Resident #70 to the facility community. She stated she noted Resident #70 had decaying teeth and asked Resident #70 if she had any pain. The DON stated Resident #70 denied any pain. She stated (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they would add her for dental services as a new admission, but she had not talked to the SW about a dental referral for Resident #70. The DON stated either she or the ADON completed baseline care plans and stated they had not completed Resident #70's baseline care plan. She stated it was important because it identified Resident #70's basic needs and it provided staff with guidance related to the care and services Resident #70 needed. She stated without a baseline care plan, they might not provide the care and services Resident #70 needed. Review of facility policy, Care Plans - Baseline, dated [DATE] read A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care. Record review of Resident #4's face sheet, dated [DATE], revealed Resident #4 was admitted to the facility on [DATE], original admission date [DATE] with diagnoses which included: other spondylosis with radiculopathy, lumbar region, bipolar disorder, current episode depressed, mild or moderate severity, unspecified, senile degeneration of brain, not elsewhere classified, chronic pain syndrome, dysphagia, oropharyngeal phase, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, polyneuropathy, unspecified. Record review of Resident #4's Quarterly MDS assessment, dated [DATE], revealed Resident #4's BIMS score was 14 indicating intact cognition. Record review of Resident #4's electronic medical record revealed Resident #4 did not have a baseline care plan completed at all. Observation and interview on [DATE] at 10:22 a.m. revealed Resident #4 sitting in a tall back wheelchair watching his television with some hair stubble to his face. Resident #4 stated the staff take care of him and they shave him when he let them. During an interview on [DATE] at 4:16 p.m. the MDS Coordinator stated Baseline Care Plans were done by the RNs on admission. The MDS Coordinator stated the DON or ADON initiated the baseline care plan. The MDS Coordinator stated his understanding was the baseline care plans were done on admission or within 2 days of admission. During an interview on [DATE] at 5:05 p.m. the Administrator stated care plans were the responsibility of the MDS Coordinator and the Social Worker. The Administrator stated the Social Worker was responsible, making sure that all the needs were addressed and voiced. The Administrator stated the MDS Coordinator was responsible for documenting information and addressing the MDS assessment. The Administrator stated the purpose of the care plan was to know what the residents needed. The Administrator further stated by not care planning the staff might not correctly give care to a resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for 1 of 2 residents (Resident #52) reviewed for mechanical lift transfers and for 1 of 2 Residents (Resident 19) reviewed for smoking assessments. 1. Nursing staff failed to lock the wheelchair, the base of the mechanical lift and failed to widened the base of the mechanical lift when transferring Resident #52 from the wheelchair to the bed.2. The facility failed to ensure conducting Resident #19's smoking assessment quarterly. This deficient practice could place residents at risk of having avoidable falls and or accidents.2. Record review of Resident #19's face sheet, dated 02/27/2026, revealed the resident was a 65-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of anxiety disorder (symptoms of intense anxiety or panic that are directly caused by a physical health problem), cystitis (inflammation of the bladder), and psychosis (losing some contact with reality). Record review of Resident #19's quarterly MDS assessment, dated 01/17/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact, and the resident required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand and chair to bed. Record review of Resident #19's smoking assessment, dated 08/21/2025, revealed Resident #19 was smoking and Supervision during smoking at all times / Facility will store cigarettes and lighters / Resident is safe to hold and smoke cigarettes. Further record review of Resident #19's medical record from 08/22/2025 to 02/27/2026 revealed there was no more smoking assessments. Record review of Resident #19's comprehensive care plan, undated, revealed there was no care plan regarding Resident #19's smoking. Interview on 02/24/2026 at 10:32 a.m. Resident #19 stated she was smoking at the scheduled smoking times at the designated smoking area, and she did not have any accidents related to smoke. Interview on 02/27/2026 at 8:33 a.m. the DON stated Resident #19 was smoking since she was admitted to the facility on [DATE], and the facility nurse conducted smoking assessment on 08/21/2025 and did not conduct any smoking assessment since 08/21/2025. However, the facility nurses should have conducted the smoking assessment quarterly. The DON said the facility nurses had responsibility to do the smoking assessment and the DON should oversee it. Further interview with the DON stated Resident #19 did not have any accident related to smoke, and not conducting smoking assessment might affect the resident could have some accidents while the resident was smoking. Record review of the facility policy, titled Smoking Policy - Residents, dated 10/2022, revealed 9. a resident's ability to smoke or chew tobacco safely will be re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Review of Resident #52's face sheet, dated 2/27/26, revealed she was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack (brief blockage of blood flow to the brain), morbid, (severe) obesity due to excess calories (severe chronic condition characterized by a BMI (Body Mass Index) of 40 or higher, significantly increasing the risk of serious health complications), muscle wasting and atrophy (wasting or thinning of muscle mass), not elsewhere classified, right upper arm and muscle wasting and atrophy, not elsewhere classified, left upper arm. Review of Resident #52's annual MDS assessment, dated 11/22/25, revealed her BIMS score was 15 of 15 reflecting no cognitive impairment and she was dependent on nursing staff for chair/bed-to-chair transfer. Review of Resident #52's Care Plan, dated 12/11/25, revealed she had a Risk for Self-Care Deficit; however, it did not address transfers or how many staff should assist during a transfer. Observation and interview on 02/24/2026 at 2:47 PM revealed CNA E and MA F transferred Resident #52 from the wheelchair to the bed using a mechanical lift. MA F operated the lift. She never applied the brakes when lifting Resident #52 from the wheelchair and then when lowering Resident #52 onto the bed. MA F narrowed the base of the lift while Resident #52 was suspended in the air and while positioning the lift under the bed. MA F then lowered Resident #52 onto the bed. Further observation revealed CNA E guided Resident #52 while being transferred. He did not lock the wheelchair before MA F lifted Resident #52 from the wheelchair. Interview with CNA E revealed he did not lock the wheelchair and should have locked it to prevent it from rolling. He stated Resident #52 could hit the wheelchair with her arms or legs and it would cause an injury or Resident #52 could fall if she was not positioned correctly on the sling. Interview with MA F revealed she did not lock the base of the lift at any point during the transfer, and she narrowed the base of the lift when positioning the lift under the bed while Resident #52 was suspended in the air. MA F stated she should have widened the base of the lift for stability. She further stated she should have also locked the base of the lift when lifting Resident #52 from the wheelchair and lowering Resident #52 onto the bed for stability otherwise the lift could tilt and Resident #52 could fall. MA F stated it could cause serious bodily harm. Both CNA E and MA F stated they started working at the facility during [DATE] and they did not receive training for operating a mechanical lift. Interview on 2/27/25 at 5:20 PM with the DON revealed nursing staff reported details about Resident #52's transfer using a mechanical lift. The DON stated Resident #52 was transferred via mechanical lift by two (2) staff because Resident #52 was unable to bear weight. The DON stated nursing staff should always lock the wheelchair when lifting residents from the wheelchair via mechanical lift. She stated nursing staff should always lock the mechanical lift when coming to a stop for stability. The DON stated the wheelchair could roll and the resident could sustain injuries if any body parts hit the wheelchair. She stated the base of the lift should also be widened while transferring a resident from point A to point B and while positioning the lift under the bed to lower the resident onto the bed. The DON stated these were all safe techniques used so that the mechanical lift did not tilt causing the resident to fall. The DON stated Resident #52 was a heavy resident and if she fell, she would likely sustain serious bodily injuries. Review of facility policy Lifting Machine, Using a Mechanical, dated July 2017 read The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lift device. It is not a substitute for manufacturer's training or instructions. General Guidelines (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices used in the facility. Make sure the lift is stable and locked.

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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** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 (Resident #5 and #56) of 3 residents reviewed for incontinence care. 1. When CNA-O was providing incontinent care to Resident #5 on 02/26/2026, the CNA-O did not open the resident's labia area. 2. When CNA-J was providing incontinent care to Resident #56 on 02/26/2026 and the resident was uncircumcised, CNA-J did not pull back the foreskin of the resident's penis, cleaned the perineal area with multiple pass of one wipe. These 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: 1. Record review of Resident #5's face sheet, dated 02/27/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses of epilepsy (a brain disorder that causes people to have recurring seizures), restlessness and agitation (sudden, distressing state of intense restlessness), and schizoaffective (exhibiting symptoms of both schizophrenia and a mood disorder such as bipolar disorder). Record review of Resident #5's admission MDS assessment, dated 02/16/2026 reflected that she was assessed to have a BIMS score was 3 out of 15 indicating she had severe cognitive impairment. Resident #5 was assessed to always incontinence to bowel and bladder. Record review of Resident #5's comprehensive care plan, dated 02/24/2026, reflected the resident had the care plan of The resident has bowel and bladder incontinence. For intervention - Clean peri-area with each incontinence episode. Observation on 02/26/2026 at 2:04 p.m. revealed CNA-O opened Resident #5's old and dirty brief, cleaned the resident's right and left groin areas, and cleaned the resident's genital area (middle area) without opening the resident's labia area, then cleaning the resident's buttock areas. Interview on 02/26/2026 at 2:12 p.m. CNA-O stated when she cleaned Resident #5's genital area, she did not open the resident's labia area. Further interview with the CNA-O said she should have opened Resident #5's labia area. Interview on 02/26/2026 at 3:54 p.m. the DON said CNA-O should have opened Resident #5's labia area to prevent possible infection. 2. Record review of Resident #56's face sheet, dated 02/27/2026, revealed the resident was a 38-years-old male and admitted to the facility on [DATE] with diagnosis of encounter for other orthopedic aftercare (intensive physical rehabilitation), fracture of part of neck of right femur (fracture to right thigh bone), and infection following a procedure deep incisional surgical site (infection to surgical site). Record review of Resident #56's admission MDS assessment, dated 02/13/2026, revealed the resident's BIMS score was 0 out of 15 which indicated the resident had severe cognitive impairment, required substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to chair to bed and toilet transfer, and always incontinent to bowel and bladder. Record review of Resident #56's comprehensive care plan, dated 02/16/2026, revealed the resident had the care plan of self-care deficit for bathing, dressing, and feeding. For intervention - provide assistance with activities of daily livings. Observation on 02/26/2026 at 1:25 p.m. revealed when CNA-J opened Resident #56's old and dirty brief, the resident was uncircumcised. CNA-J cleaned the resident's right and left groin area, then cleaned the resident's penis area without pulling back the foreskin of the resident's penis, with multiple pass of one wipe, then turned the resident to side and cleaned the resident's buttock area. Interview on 02/26/2026 at 1:32 p.m. CNA-J stated when she was providing incontinent care to Resident #56, she did not pull back the foreskin of the resident's penis, cleaned with multiple pass of one wipe when cleaning the resident's penis because she was very nervous. Further interview, CNA-J said she should have pulled back the foreskin of Resident #56's penis because the resident was uncircumcised, and should have used a new wipe with each stroke to (continued on next page)

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	676301	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent infection. Interview on 02/26/2026 at 3:52 p.m. the DON said CNA-J should have pulled back the foreskin of Resident #56's penis because the resident was uncircumcised and should have used a new wipe with each stroke to prevent infection. Record review of the facility policy, titled Perineal Care, revised 02/2018, revealed Female - cleanse the peri area with wipes going front to back to dirty and separate the labia and use a new wipe with each stroke. Male - if the resident is uncircumcised gently pull back the foreskin and wipe the head of the penis beginning at the urethral opening working outward and away from the penis head.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the facility acted upon the pharmacist drug regimen report of any irregularities reported to the attending physician for 1 of 2 Residents (Resident #42) reviewed for gradual dose reductions. The DON failed to follow the pharmacist recommendation to change Resident #42's order for Fluoxetine from 50 mg to 40 mg administered QD per pharmacist recommendation. This deficient practice could place residents at risk for not receiving gradual dose reductions per pharmacist recommendations. The findings were: Review of Resident #42's face sheet, dated 2/26/26, revealed he was admitted to the facility on [DATE] with diagnoses including depression and schizoaffective disorder bipolar type (Schizoaffective disorder is a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania. Bipolar type includes bouts of hypomania or mania and sometimes major depression.). Review of Resident #42's quarterly MDS, dated [DATE], reflected that Resident #42 had a diagnosis of depression and schizophrenia. Further review revealed Resident #42's BIMS score was 15 of 15 reflecting he did not have cognitive impairment. Review of Resident #42's Care Plan dated 12/10/25 revealed The resident uses antidepressant medication (Fluoxetine) Interventions included administer anti-depressant medication as ordered by physician. Review of Resident #42's physician orders for February 2026 revealed an order for FLUOXETINE 10MG CAP W Give 1 tablet orally one time a day related to DEPRESSION UNSPECIFIED (F32.A) Give (1) 40mg cap with (1) 10mg cap to equal 50mg-Start Date-08/02/2025 0800 (8:00 AM). and an order for FLUOXETINE HCL 40 MG CAPSULE Give 1 tablet orally one time a day related to DEPRESSION, UNSPECIFIED (F32.A) Give (1) 40mg cap with (1) 10mg cap to equal 50mg-Start Date-08/02/2025 0800 (8:00 AM). Review of a pharmacy consultant recommendation, dated 1/25/26, revealed a recommendation for a gradual dose reduction for Fluoxetine. Further review revealed Resident #42's physician agreed and provided a new order for Fluoxetine, to discontinue the 50 mg daily dose and to start 40 mg daily dose on 2/5/26. Review of Resident #42's MAR for February 2026 revealed Resident #42 received the order for Fluoxetine 10 mg and Fluoxetine 40 mg to equal 50 mg daily from 2/1/26 to 2/27/26. Observation and interview on 2/24/26 at 2:54 PM with Resident #42 revealed he was lying in bed. He engaged in conversation and shared his experiences while at the facility. Resident #42 was fixated on discussing his dissatisfaction with services not received at the facility and his dissatisfaction with the food. Interview on 2/27/26 at 5:20 PM with the DON revealed she and the ADON reviewed all pharmacy consultant recommendations and ensured they were followed up on. She stated ultimately, she was responsible. The DON reviewed the pharmacist recommendation for a gradual dose reduction and the physician's new orders to discontinue the 50 mg dose of Fluoxetine and to start an order of 40 mg dose to be administered daily. The DON reviewed Resident #42's MAR for February 2026 and stated Resident #42 was still receiving 50 mg of Fluoxetine daily. The DON stated it was important to follow the pharmacist recommendations and physician orders to ensure Resident #42 received the accurate dose of Fluoxetine. She stated the purpose of a gradual dose reduction was to ensure residents received a therapeutic regimen. Review of a facility policy, Psychotropic Medication Use, dated July 2022, read Residents will not receive medications that are not clinically indicated to treat a specific condition.1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior.2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications:b. Anti-depressants.11. Residents on psychotropic medications receive gradual pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs without adequate indications for its use for 1 of 2 residents (Resident #5) reviewed for psychotropic use. Nursing staff failed to indicate an appropriate indication for Resident #5's use of Trazadone, an anti-depressant. This deficient practice could place residents at risk for the use of unnecessary medications. The findings were:Review of Resident #5's annual MDS assessment, dated 2/21/26, revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease and her BIMS score was 0 of 15 reflecting severe cognitive impairment. Review of Resident #5's consent, dated 7/31/25, for the use of Trazadone 150 mg QHS for depression. Review of Resident #5's physician orders for February 2026 revealed an order for traZODone HCl Oral Tablet 150 MG (Trazodone HCl)[NAME] with the start date, 02/18/2026. Further review revealed the order indicated to give 1 tablet by mouth at bedtime related to ALZHEIMER'S DISEASE, UNSPECIFIED. Review of Resident #5's MAR for February 2026 revealed an order for traZODone HCl Oral Tablet 100 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED -Start Date-01/09/2026 1900(7:00 PM) -D/C Date-02/18/2026 1557(3:57 PM). Further review revealed Resident #5 received the medication from 2/1/17 and then she started receiving an order for traZODone HCl Oral Tablet 150 MG (Trazodone HCl) [NAME]. Give 1 tablet by mouth at bedtime related to ALZHEIMER'S DISEASE, UNSPECIFIED with the Start Date-02/18/2026 1900 (7:00 PM). Interview on 2/27/26 at 5:20 PM with the DON revealed Resident #5 was taking Trazadone for depression and not for Alzheimer's. She reviewed Resident #5's orders and stated it reflected the indication for the use was Alzheimer's which was incorrect. The DON stated the nurse who received the order was responsible for entering it correctly. She stated that she and the DON would review all orders every morning for accuracy. She stated she did not remember reviewing Resident #5's orders. The DON stated the indication could place Resident #5 at risk for staff not monitoring for potential side effects as required for the use of psychotropic medications. Review of facility policy, Psychotropic Medication Use, dated July 2022, read Residents will not receive medications that are not clinically indicated to treat a specific condition.1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior.2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications:b. Anti-depressants.

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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** Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles and stored in locked compartments for 2 (Resident #58 and #53) of 24 residents reviewed for medication storage. 1. Resident #58's insulin Glargine-yfgn Solos Flex Pen for diabetes had no open date, found inside A-hall nursing cart on 02/25/2026. 2. Resident #53's antifungal ointment cream was left unattended on the resident's nightstand in his room on 02/24/2026. These failures could place residents at risk of not using medications correctly and not having therapeutic effects by using old insulins. The findings were: 1. Record review of Resident #58's face sheet, dated 02/27/2026, revealed Resident #58 was a [AGE] year-old female and admitted to the facility 06/09/2020 and re-admitted to the facility 12/20/2025 with diagnoses of schizoaffective (exhibiting symptoms of both schizophrenia and a mood disorder such as bipolar disorder), type 1 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and hypertension (high blood pressure). Record review of Resident #58's quarterly MDS assessment, dated 01/17/2026, revealed the resident's BIMS score was 9 out of 15, which indicated the resident had moderate cognitive impairment, and the resident was receiving insulin injections every day as ordered. Record review of Resident #58's physician's order, dated 08/11/2025, revealed the resident had the order of Lantus Subcutaneous Solution (Insulin Glargine-yfgn) Inject 10 unit subcutaneously at bedtime related to TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS. Observation on 02/25/2026 at 3:43 p.m. revealed Resident #58's Insulin Lantus (Glargine-yfgn) Subcutaneous Solution 100 UNIT/ML, Inject 10 unit subcutaneously at bedtime for diabetes with no open date was found inside the A-hall nursing cart. Further observation revealed the insulin pen had a label, and the label said, discard after 28 days. Interview on 02/25/2026 at 3:55 p.m. with LVN-N stated Resident #58's Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject 10 unit subcutaneously at bedtime for diabetes with no open date was found inside the A-hall nursing cart, and the insulin pen should have been discarded 28 days after opening it per the label from the insulin pen. If the insulin pen did not have any open date, nurses did not know when they have to discard the insulin pen. Interview on 02/26/2026 at 3:46 p.m. with the DON said the facility nurses should have written an open date on Resident #58's Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject Pen because the label from the insulin pen said, discard after 28 days, and using old insulin might affect Resident #58 to not reach therapeutic effects. 2. Record review of Resident #53's face sheet, dated 02/27/2026, revealed the resident was a [AGE] year-old male and admitted to the facility on [DATE] with diagnoses of chronic embolism and thrombosis of vein (blood clot develops in the deep veins), diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and hypertension (high blood pressure). Record review of Resident #53's admission MDS assessment, dated 12/25/2025, revealed the resident's BIMS score was 6 out of 15 which indicated the resident had severe cognitive impairment and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to sit to stand and toilet transfer. Record review of Resident #53's physician order, dated 12/18/2025, revealed the resident had the order of May discontinue medications not administered in 60 days. Further record review of the resident's physician order revealed there was no order regarding Resident #53's antifungal ointment cream. Observation on 02/24/2026 at 10:43 a.m. revealed Resident #53 was sleeping on the bed in his room, and there was one tube of antifungal ointment cream unattended on the resident's nightstand in his room. Interview on 02/24/2026 at 11:26 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m. with LVN-C stated Resident #53 was sleeping on the bed in his room, and there was one tube of antifungal ointment cream unattended on the resident's nightstand in his room. Further interview with the LVN-C said the resident did not have the order regarding antifungal ointment, and the resident's family might bring it from the home. The LVN-C said any medication should have been stored in the locked carts to prevent other residents from using it. Interview on 02/26/2026 at 4:02 p.m. with the DON said any medication, including medications family members brought from the home, should have been stored in the locked carts to prevent other residents from using it. Record review of the facility policy, titled Medication Storage and Labeling, dated 06/2023, revealed Medications and biologicals in the medication rooms, carts, boxes, and refrigerators were maintained within secured (locked) locations, accessible only to designated staff and multi-dose vials which have been opened or accessed should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide or obtain from an outside resource routine dental services for 1 of 1 Resident (Resident #2) reviewed for dental services. The facility failed to follow up and ensure the dental provider filled the prescription for a full set of dentures for Resident #42. This deficient practice could place residents at risk for not being able to chew food properly affecting their quality of life. The findings were: Review of Resident #42's face sheet, dated 2/26/26, revealed he was admitted to the facility on [DATE] with diagnoses including anxiety disorder and type 2 diabetes mellitus without complications (condition where a person has elevated blood sugar levels but has not yet developed any serious health issues related to diabetes.) Review of Resident #42's quarterly MDS, dated [DATE], reflected that Resident #42 had a diagnosis of Diabetes and depression. Further review revealed Resident #42's BIMS score was 15 of 15 reflecting he did not have cognitive impairment. Review of Resident #42's Care Plan dated 12/10/25 revealed it did not address that Resident #42 was edentulous (without teeth) or a plan to refer him to a dentist for making of dentures. Observation and interview on 2/24/26 at 2:54 PM with Resident #42 revealed he was lying in bed. He engaged in conversation and shared his experiences while at the facility. Resident #42 was fixated on discussing his dissatisfaction with facility services and the dissatisfaction with the food. He stated he had been waiting for his dentures for months and months. Resident #42 stated nursing staff offered him a mechanical soft diet but stated he did not want a mechanical soft diet. He stated he was upset because he wanted to be able to chew his food and shave without his cheeks caving in. He stated he was not able to shave properly. Resident #42 stated the facility changed dental providers multiple times and each time he had to wait or get new moldings for the production of dentures. Interview on 02/25/2026 at 4:40 PM with the SW revealed the facility had changed dental providers about 3 times. She stated the most recent provider completed the exam and moldings for dentures for Resident #42 but did not submit the order to have the dentures made. The SW stated the dental provider was supposed to provide the dentures first part of January 2026 but they did not have the dentures made. The SW stated she talked to Resident #42 regularly and he expressed frustration about not receiving the dentures because of the time it had been prolonged. The SW stated that she initially referred Resident #42 to the facility dental provider during June 2025. She stated a local dentist would not accept his insurance but stated she had not called any community dentist. Interview on 02/26/2026 at 4:39 PM with the SW revealed she spoke with the most recent dental provider in passing when they came into the facility during January 2026. She stated the dental provider stated somehow Resident #42's order for dentures fell between the cracks. She stated she probably did not document it and stated she had not reached back out to them to ensure they were producing the dentures. The SW stated the dental provider came into the facility every 3 months therefore she expected them to return during April 2026. The SW stated she did not have any correspondence from the dental providers related to obtaining dentures for Resident #42. Interview on 2/27/26 at 5:20 PM with the DON revealed she was aware of the history of the facility's efforts in obtaining dentures for Resident #42. She stated during June 2025, the dental provider at the time, completed an evaluation and was supposed to return but then they canceled their contract. She stated during September 2025 the facility changed dental providers. Again, they completed an evaluation, completed a set of upper and lower moldings. The dental provider was supposed to have the dentures made and deliver them on their following scheduled facility visit,1/6/26. The DON stated during their visit the provider stated the order to make the dentures somehow fell between the cracks. She stated the provider told her they would resubmit the order and mail the dentures to the facility within a couple two or three weeks. The DON stated she expected the arrival of the dentures any day but stated had not reached out to the dental provider to ensure they made and mailed the dentures. Review of facility policy, Dental Services, dated December 2016. read Routine and emergency dental (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 1. Routine and 24-hour emergency dental services and provided to our residents through:a. a contract agreement with a licensed dentist that comes to the facility monthly;b. referral to the resident's personal dentist;c. referral to community dentist; ord. referral to other health care organizations that provide dental services. 3. Residents have the right to select dentists, of their choice when dental care of services are needed.5. Medicare and Medicaid residents will be billed for routine and emergency dental services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to follow the menus for 1 of 4 days (2/25/26) observed for meal observation. The DM failed to serve spinach for the lunch meal on 2/26/26 per menu. The DM substituted it with mixed vegetables. This deficient practice could place residents at risk for not being satisfied with the food item substitutions. The findings were: Review of the facility week at a glance monthly menu for the Fall/Winter 2025-26 revealed the following menu would be prepared and served for lunch on 2/26/26: Thursday 2/26/26, Lunch: Sliced Pork with GravyWhipped Sweet PotatoSeasoned Spinach Honey Kissed RollMargarineFruit Cobbler Served Observation on 02/26/2026 at 12:00 PM revealed a posted sign in the dining room included the lunch meal per the menu written in the week at a glance for 2/26/26. Further observation revealed a smaller sign which read there may be substitutions. Observation on 2/26/26 at 12:15 PM of the lunch meal service revealed residents received sliced pork with gravy, whipped sweet potato and mixed vegetables, honey kissed roll, margarine and fruit cobbler. Interview on 02/26/2026 at 2:44 PM with the DM revealed she posted a general sign reflecting there could be substitutions but did not post that mixed veggies were being substituted for seasoned spinach. Interview on 2/26/26 at 4:42 PM with the DM revealed she stated she met with the resident council group every scheduled meeting. She stated the council group would tell her what food items they did not want on the menu. She stated the residents asked she remove spinach from the menu but she did not discuss it with all residents. The DM stated she also did not notify the facility Dietician that she had made changes to the menu. The DM stated she realized not all residents voted on what food items to remove from the menu. She stated some residents might not want the same food items removed or they might not want the substitutions. The DM was asked for a copy of the facility policy for following the menu provided on the week at a glance. It was not provided by the end of the survey, 2/27/26 by 8:30 PM.

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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 have 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 2 (Residents #18 and #61) of 24 residents reviewed, in that: 1. Resident #18's personal refrigerator located in his room was observed on 02/24/2026. There was a small plastic cup inside the refrigerator with no date and no label on the plastic cup. 2. Resident #61's personal refrigerator had unlabeled, undated food and no temperature logs. The failure could place the residents at risk for food borne illness. The findings included: 2. Record review of Resident #61's face sheet, dated 02/27/2026, revealed he was admitted to the facility on [DATE], original admission date 08/20/2021 with diagnoses which included: multiple sclerosis, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and unspecified focal traumatic brain injury with loss of consciousness status unknown, sequela. Record review of Resident #61 Quarterly MDS assessment, dated 01/16/2026, revealed the resident's BIMS score of 15 indicating intact cognition and required set-up or clean up assistance (helper sets up or cleans up; resident completed activity. Helper assists only prior to or following the activity) for eating, substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for chair/bed-to-chair transfer, dependent (helper does all of the effort, Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the residents to complete the activity) for upper body dressing. Record review of Resident #61's comprehensive care plan, revised 02/24/2026, revealed a Focus of Knowledge Deficit with Interventions of Educate Resident/Representative on proper food portions, Educate Resident/Representative on reading nutrition labels, Educate Resident/Representative on the benefits of weight loss. Observation and interview on 02/24/2026 at 11:45 a.m. Resident #61 had a personal refrigerator inside her room with ice buildup around the small freezer box, thermometer in the back of the refrigerator, 6 small cups with Jello and pudding from the kitchen in disposable cups not dated, and 4 glasses apple juice not dated. Resident #61 stated she would eat the items when she did not like what the kitchen had, or she would mix her fruit with the Jello. Resident #61 stated the staff did not check her refrigerator, they did not check the temperatures of the refrigerator, and she was not able to say when the cupped snacks were placed in the refrigerator. Observation and interview on 02/27/2026 at 1:53 p.m. Resident #61's personal refrigerator revealed the thermometer was moved and hanging on the inside of the door within view. Resident #61's refrigerator continued to have 4 dessert cups from the kitchen with 3 of them showing beads of clear liquid on inside of the clear lids with not dates on the dessert cups. Resident #61 was up in her wheelchair in the room and stated she doesn't eat her desserts right away and will put them in the fridge for later and that she liked to keep things on hand. Resident #61 stated she was unsure when she had placed the dessert cups in the fridge. During an interview and observation on 02/27/2026 at 2:00 p.m., LVN C stated refrigerator temperatures should be taken by 6pm to 6am shift, but she did not see a log on the refrigerator. LVN C (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she could not tell if the temperatures had been taken. Observed LVN C look in Resident #61's refrigerator and she stated the dessert cups did not have dates on them because they came on her meal tray so they would not be dated, but when she gets a snack from the kitchen it typically had a date on the cup. LVN C stated food items should have dates as it would help to ensure freshness of the items. LVN C stated the staff do not go through resident refrigerators. Resident #61 informed LVN C that she better not throw anything away of which LVN C reassured Resident #61 she was not going throw anything away. During an interview on 02/27/2026 at 4:40 p.m., the DON stated the facility did not monitor the residents' personal refrigerators. The DON further stated that a lot of the residents who had refrigerators were independent and managed their stuff. The DON stated she was not aware personal refrigerators needed to be monitored. The DON further stated she thought whatever food came from the kitchen or the facility should be dated. The DON stated by personal refrigerators not being monitored or checked it could put the residents at risk of eating bad food, they could get sick or things could be outdated. The DON stated she did not believe the facility had a policy regarding personal refrigerators. During an interview on 02/27/2026 at 5:12 p.m., the Administrator stated the personal refrigerators were brought into the facility and the facility did not provide them. The administrator stated they did not have a policy regarding personal refrigerators and who was responsible for them. During an interview on 02/27/2026 at 5:13 p.m., the RNC state it was the facility's responsibility to monitor the personal refrigerators and keep temperature logs. The RNC further stated the continents should have been checked for expiration dates and the families contacted to assist with removing the items when necessary. They are going to make a sweep on the fridges. The RNC stated by not having dates it would not be known how long an item had been in the refrigerator and by not knowing how long an item had been in the refrigerator could potentially make a resident sick. The RNC stated there was not a policy regarding personal refrigerators. 1. Record review of Resident #18's face sheet, dated 02/27/2026, revealed the resident was an [AGE] year-old male and admitted to the facility on [DATE] with diagnoses of protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), pressure ulcer of buttock – stage 3 (wound that from as a direct result of pressure over a bony prominence to the buttock area), and gastrostomy status (surgical opening into the stomach for nutritional support or gastric decompression). Record review of Resident #18's quarterly MDS assessment, dated 01/28/2026, revealed the resident's BIMS score was 14 out of 15, which indicated the resident's cognitive was intact. Further record review of the MDS assessment revealed the resident had Mechanically altered diet which was required change in texture of food or liquids, for example, pureed food or thickened liquids in Section K (Swallowing/Nutritional Status). Record review of Resident #18's comprehensive care plan, dated 12/10/2025, revealed the resident had the care plan of Impaired Nutrition. For interventions - Encourage intake of nutritional supplements between meals, Encourage Resident / Representative participation in meal planning, Encourage use of seasoning, if not contraindicated by diet order, and Ensure Resident is in proper position for eating. (continued on next page)

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	676301	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/24/2026 at 11:03 a.m. revealed Resident #18 was on the bed and sleeping in his room. There was a personal refrigerator in the room, and inside the refrigerator there was a small plastic cup with food, but no date and no label on the cup. Interview on 02/24/2026 at 11:15 a.m. with LVN-D stated Resident #18's refrigerator in his room had a small plastic cup with food, but it was not dated and labeled. LVN-D said that he did not know what this food was because of no label, and the nurse said the facility night nurses were supposed to check it every day. Interview on 02/26/2026 at 4:04 p.m. the DON stated facility night nurses were responsible for overseeing Resident #18's personal refrigerator and also responsible for monitoring it daily. The DON stated the resident might have food illness. Record review of the facility policy, titled Foods brought by family/visitors, dated 03/2022, revealed . 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food. B. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item, and the use by date.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. 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 the facility's QAPI program for 1 of 8 staff unlicensed staff (MA G) and 1 of 4 licensed staff (LVN H) whose records were reviewed for training The facility failed to ensure all unlicensed and licensed staff completed QAPI training. This deficient practice could place residents at risk of receiving care from nursing staff who did not understand the purpose of the QAPI program. The findings were: Review of personnel files for MA G's and LVN H they had not completed QAPI training. Interview on 2/27/26 at 4:15 PM with the HR staff revealed she had been in her position for a few months. She stated she was responsible for ensuring all employees completed the required training. She stated MA G and LVN H had not completed QAPI training. The HR staff was asked for the facility policy on completing QAPI training and it was not provided by the end of the survey on 2/27/26 at 8:30 PM.