STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	04/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kerrville	1555 Bandera Hwy Kerrville, TX 78028

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observations interviews, and record review the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records, for 11 of 73 residents (Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14) reviewed for the right to personal privacy and confidentiality of his or her personal and medical records. Medication Aide AI left a lap top computer she was assigned unattended, unsupervised, and unlocked displaying Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14 protected health information (PHI). This failure could place residents at risk of a breach of their PHI. The findings included: During an observation and interview on 4/2/2024 at 8:27 AM revealed the medication cart parked on the facility's 300-hall. Further observation revealed the medication cart had a laptop computer atop of the cart. The lap top computer was unattended, unsupervised, and unsecured. The laptop computer was actively displaying PHI for 11 residents, Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14. Continued observations revealed housekeeper AL, driver AK and CNA AJ had alternately ambulated past the computer over 5 minutes elapsed time. At 8:37 AM the surveyor alerted LVN AM the computer was unattended, unsupervised, and unsecured. LVN AM alerted the DON who was observed to lock and close the computer. The DON stated the medication cart, and the computer were assigned to MA AI. The DON summoned MA AI and gave her a report of the computer being unsecured. During an interview on 4/2/2025 at 8:37 AM the DON stated the computer had PHI and when not attended should be secured. During an observation and interview on 4/2/2025 at 8:38 AM MA AI stated she was assigned the medication cart and computer this morning around 7:40 AM by LVN M. MA AI stated she left the cart and computer briefly but had not left the computer display open with residents PHI displayed and stated she always locked the computer when she left the cart. MA AI stated she did not understand how the computer came to be opened. MA AI stated the risk to residents' privacy was a breach of PHI. MA AI stated the PHI displayed concerned Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14. During an interview on 4/5/2025 at 5:10 PM the Administrator stated the risk for harm for residents was a breach of their PHI. (continued on next page)

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's HIPAA Sanctions policy dated 7/2022, revealed, Policy: It is the policy of this facility to apply sanctions against employees who fail to comply with all policies and procedures regarding the protection of personal identifiable health information of our residents. All employees are expected to comply with all policies and procedures regarding the protection of personal identifiable health information of our residents. Examples of violations include, but are not limited to: a. Accessing information that is not within the scope of the employee's duties. b. Misusing, disclosing without proper authorization, or altering confidential information. c. Disclosing to another person login codes and/or password or using another person's login code and/or password for accessing electronic or confidential information or for physical access to restricted areas. d. The intentional or negligent mishandling, altering, or destruction of confidential information or media/workstations that house such information. e. Leaving a secured application unattended while logged on.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure the residents had the right to voice grievances to the facility. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay, for 1 of 8 residents (Resident #2) reviewed for grievances. 1. On February 13, 2025, the previous Administrator and the DON heard a grievance on Resident #2's behalf and failed to initiate the grievance process. 2. On February 27, 2025, the DON heard a complaint on Resident #2's behalf and failed to initiate the grievance process. 3. On February 24,2025 the DON received a complaint via an email on behalf of Resident #2 and failed to initiate the grievance process. 4. On March 3, 2025, the SW received a complaint via an email on behalf of Resident #2 and failed to initiate the grievance process. These failures could place residents at risk of not having their grievances heard. The findings included: A record review of Resident #2's admission record dated 4/3/2025 revealed an admission date of 5/31/2024 with diagnoses which included cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), chronic obstructive pulmonary disease (COPD a term for lung and airway diseases that restrict your breathing. People with COPD have airway inflammation and scarring, damage to the air sacs in their lungs or both.), and cancer of the intestines. A record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 was an [AGE] year-old male admitted for long term care, further review revealed Resident #2 had adequate vision, hearing, could usually understand and could usually understand others. Resident #2 was assessed with mild cognitive impairment and needed assistance with activities of daily life. A record review of Resident #2's care plan dated 4/3/2025 revealed, the Resident has limited physical mobility related to tremors, exertional SOB secondary to COPD and pain. provide analgesic medication . as needed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/1/2025 at 1:01 PM Resident #2's representative stated Resident #2 had lived at the facility since May 2025, and she was frustrated with the previous Administrator and the DON due to the poor communication and lack of acknowledging and resolving grievances. Resident #2's representative stated she and family had been making complaints directly to the previous administrator and the DON for months with no resolutions. Resident #2's representative stated she and family had been making complaints via text messages, emails, and verbally to the previous administrator and the DON. A record review of Resident #2's representatives text messages and emails to and from the previous Administrator and the DON between the time periods of February 2025 to March 2025 revealed: On 2/13/25 at 6:13 PM Resident #2's representative, sent a text message to the previous admin and the DON which revealed, Hi (previous Administrator), my (Resident #2) was just now needing some pain meds I told (Resident #2) lets go in and ring your bell. I was abruptly told she would not come (LVN L) if we pushed the button. (Resident #2) has told me she does not come at night, . this is gravely concerning. The DON replied, Hi ladies I am sorry this happened, and clearly this is not acceptable, so this will be addressed. who said LVN L would not come? . this is the first complaint I have ever gotten from her. The Previous Administrator responded Thank you for letting us know. We will address. An email sent to the DON from Resident #2's representative dated 2/24/2025 at 11:16 AM Hi (DON), I wanted to reach out because as you know, our (Resident #2) is extremely ill, and our (family member) has requested ambulance to come and pick him up to transfer him to the hospital. (facility's) PA is concerned also about him possibly having pneumonia. We are deeply upset and concerned about how the nursing staff, who see him daily and nightly, haven't seemed to recognize the significant changes in his condition-his inability to talk clearly, walk on his own or even transfer safely along with the horrid cough. It's especially alarming that they attempted to collect a urine sample by placing a doughnut in the toilet when he isn't even able to walk to the bathroom. This situation is unacceptable, and I'd appreciate your help in addressing it as soon as possible. Additionally, sic(name), the ADON, mentioned to my family members a couple of months ago, that your (other family members) get in the way. The reality is, if we don't advocate for our parents, things don't seem to get addressed in a timely manner. For example, I have been discussing my Resident #2's needs to restart PT with the DOR and (previous Administrator) for over a month due to his leg weakness, and now he has deteriorated to the point where he can no longer use his legs at all. We are simply trying to ensure our (Resident #2) receive the best care possible, and we need reassurance that these concerns will be taken seriously and addressed appropriately. Thank you for your time and attention to this. On Thursday 2/27/25, at 3:29 PM Resident #2's representative texted the DON with a complaint it revealed, (DON) this is (Resident #2's Representative) Tuesday morning I spoke with my (Resident #2's) hospitalist and she said that my (Resident #2) did have a bad kidney infection. There is a discrepancy here I do not understand . his symptoms of confusion, extremely slurred speech and inability to walk is the reason I requested that an ambulance be called. These symptoms were ignored. All we are asking is for you guys to acknowledge that the nurses on duty Sunday and Monday did not take care of business. The DON responded, I am not going to put blame on anyone nor sit her and argue about what a doctor did or didn't say I am simply stating (Resident #2's) labs show nothing of the sort nor did the dr. put that anywhere on his notes again if you do not feel that we can care properly for your parents I will be more than happy to send paper work to other facilities let me know thanks. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An email sent on 3/3/2025 at 7:54 PM to the SW from Resident #2's representative revealed, Hi (SW) we normally get a copy of our (Resident #2) care plans at the care plan meetings. Since not receiving one last week, could we have them emailed to this email address? Record review of the facility's grievances from August 2024 to March 2025 revealed no evidence of the grievances detailed on 2/13/2025, 2/27/2025, 2/24,2025, and on 3/3/2025. During a joint interview on 4/1/2025 at 9:51 am with the Administrator and the DON, the DON stated Resident #2's representatives were not happy with the care provided to Resident #2 and would often complain, however Resident #2 was happy with his care. The administrator stated he had just begun his position of Administrator on 3/1/25. The Administrator stated he soon recognized the facility needed improvement recognizing and acting upon grievances. The Administrator stated he began working with the staff to recognize and document grievances and the administrator evidenced the grievance log to demonstrate the increased number and quality documentation of grievances during March 2025 to include the resolutions of grievances. During an interview on 4/4/2025 at 4:00 PM the DON stated she began her position as DON on 12/31/2025 and during that time Resident #2's family had made numerous complaints. The DON stated due to the investigations of complaints by the survey process she recognized she had not understood the grievance process and stated the previous Administrator had not trained her on the expectations and procedures for the grievance process. The DON stated the previous Administrator was the abuse, neglect, and exploitation prevention coordinator and believed he would oversee the grievances reported to him and believed he was responsible for the grievance process. The DON stated the previous Administrator was aware of all complaints because all complaints and the previous days business was discussed during the daily interdisciplinary team meetings. During an interview on 4/5/2025 at 5:02 PM the Administrator stated he was not the administrator at the time of the complaints on behalf of Resident #2 and the previous Administrator was responsible for ensuring those complaints were heard, documented, and satisfactorily resolved for Resident #2 and others. The Administrator stated he was the abuse, neglect, and exploitation prevention coordinator. The Administrator stated the failure to hear grievances could place residents at risk for not having their grievances heard. The Administrator stated he had begun training for his team and all the staff to ensure they all understood the grievance process and expected increased documentation and recognition of grievances with satisfactory resolutions. A record review of the facility's Resident and Family Grievances dated July 2022, revealed, Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Definitions: Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Explanation and Compliance Guidelines: . The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC facility stay. Procedure: a. This facility will not retaliate or discriminate against anyone who files a grievance or participates in the investigation of a grievance. b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further potential violations of any resident right. ii. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations. c. Forward the grievance form to the Grievance Official as soon as practicable. d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. i. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance. iii. All staff involved in the grievance investigation or resolution will take steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. f. The facility will take appropriate action in accordance with State law if an alleged violation of resident's rights is confirmed by the facility or an outside entity, such as State Survey Agency, Quality Improvement Organization, or local law enforcement agency. g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concern(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decision was issued. h. For investigations regarding allegations of neglect, abuse, injuries of unknown source, and/or misappropriation of resident property, a report of the investigative results will be submitted to the State Survey Agency, and other officials in accordance with State law, within five working days of the incident. 12. The facility will make prompt efforts to resolve grievances.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure all suspected violations involving abuse, neglect, exploitation, or mistreatment are reported to the state agency not later than 2 hours after the allegation is made, if the allegation does not concern abuse, for 2 of 8 residents (Residents #1, and #2) reviewed for reporting allegations of ANE. 1. On [DATE] LVN A, the ADON, the previous DON, and the Administrator at that time, failed to report an allegation of neglect on behalf of Resident #1 when LVN A performed CPR on Resident #1 while Resident #1 wished to not have CPR and had wished to be DNR status. 2. On [DATE] the previous Administrator and the DON heard an allegation of neglect on Resident #2's behalf and failed to report the allegation to the state agency. 3. On [DATE] the DON received an allegation of neglect via an email on behalf of Resident #2 and failed to report the allegation to the state agency. 4. On [DATE], the DON heard an allegation of neglect on Resident #2's behalf and failed to report the allegation to the state agency. These failures could place residents at risk for harm by not having allegations of ANE reported to the state agency. The findings included: Resident #1 A record reviews of the Texas Unified Licensure Information Portal website; https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F; accessed [DATE] revealed no facility generated reports during [DATE] regarding allegations of ANE on behalf of Resident #1. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #1's admission Record dated [DATE] was documented, a [AGE] year-old, she was admitted on [DATE] with diagnoses of multiple rib fractures, dementia) (a decline in mental ability severe enough to interfere with daily life), Parkinson's disease (a progressive neurological disorder that affects movement, primarily due to a decline in dopamine-producing brain cells, leading to symptoms like tremors, stiffness, and slow movement, but also impacting non-motor functions like sleep and mood.) and cognitive communication deficit. Resident #1 was at facility for 24 days and was discharged on [DATE]. A record review of Resident #1's chart was documented an OODNR dated [DATE]. A record review of Resident #1's consolidated physician orders for [DATE] revealed she had a code status order for DNR. A record review of Resident #1 admission MDS dated [DATE] was documented her BIMs score was 8/15 (moderate cognitive impairment), she had impairment on lower extremity on both sides, she used a walker/wheelchair to mobilize, she required supervision for self-care for eating, oral hygiene, persona hygiene, and maximum/moderate assistance with toileting, showers, and dressing. Resident #1 was incontinent of bowel/bladder, she had diagnoses of fractures, dementia, and Parkinson's. A record review of Resident #1 baseline care plan dated [DATE] was documented her code status was DNR. A record review of Resident #1's care plan conference dated [DATE] was documented her code status was OODNR. A record review of Resident #1's progress note dated [DATE] at 6:13 PM by RN A, was documented, resident was last seen well at 1630 (4:30 PM) when I administered her evening medications. I was notified at 1705 (5:05 PM) that resident was unresponsive. when assessed resident was not breathing and did not respond to sternal chest rub. 911 was called, CPR was initiated after 1 pump of CPR resident moaned out and was now breathing. vitals where 139/78 02 88 heart rate 52. resident still would not open eyes and would not verbally respond. EMS arrived and resident was sent to hospital for further evaluation RN A. Attempted interview on [DATE] at 12:30 PM, [DATE] at 1:26 PM, [DATE] at 12:02 PM with RN A left a voicemail and did not return call before the exit. During an interview on [DATE] at 1:07 PM with CNA B stated that day, she was not sure of exact date, Resident #1 was not breathing, called CNA C on phone and asked her to get nurse, RN A. CNA B stated she automatically grabbed the crash cart, with code status book and went to tell RN A to go to Resident #1's room. CNA B stated RN A started CPR and did 2 compressions, and Resident #1 opened her eye. CNA B stated during the compression, she had opened the code book to Resident #1's code status and told RN A that Resident #1 was a DNR. CNA B stated she had stepped out on the hall to return to her hall, saw EMS and let them know Resident #1 room number, and she left on the stretcher awake. CNA B stated later that day, RN A stated she had looked at Resident #1's admission record and her code status was a DNR. CNA B had stated to RN A that she had told her Resident #1 was a DNR, but she did not listen. CNA B stated that RN A did not hear her. CNA B stated RN A, CNA C were in Resident #1's in room, but was not sure of the other staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:25 PM with CNA C stated RN A did do compressions, she was not sure who found Resident #1. CNA C stated she did not recall if Resident #1 was in pain. CNA C stated the resident code status were in a binder on the crash cart. CNA C stated she was following the nurses' instructions, and she was not sure of Resident #1's code status. CNA C stated she thought surveyor was talking about a different resident when talked last. CNA C was not sure about the incident. During an interview on [DATE] at 2:18 PM the previous DON stated she was the DON at the facility until mid-[DATE] when she resigned. The DON stated the environment was toxic due to the Administrators poor support. The previous DON stated she was unaware of Resident #1's CPR event and could not recall any details of the incident. The DON stated she was employed as the DON during the month of [DATE] but was not the DON effectively stating the administrator and the ADON had cut her out of the loop and the ADON was in effect the DON. The DON stated had she known of the incident she would have reported the incident and investigated the incident. The DON stated if Resident #1 had wished to be a DNR status they should have not provided CPR. Record review of Policy, Communication of Code Status dated 7/22 was documented, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. 4. The resident's code status should be entered into the resident physician orders in the EMR. 5. Additional means of communication of code status include: Code status will appear at the top of the resident home screen in EMR. 9. The resident's code status will be reviewed at least quarterly and documented in the medical record. Resident #2 A record review of Resident #2's admission record dated [DATE] revealed an admission date of [DATE] with diagnoses which included cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), chronic obstructive pulmonary disease (COPD a term for lung and airway diseases that restrict your breathing. People with COPD have airway inflammation and scarring, damage to the air sacs in their lungs or both.), and cancer of the intestines. A record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 was an [AGE] year-old male admitted for long term care, further review revealed Resident #2 had adequate vision, hearing, could usually understand and could usually understand others. Resident #2 was assessed with mild cognitive impairment and needed assistance with activities of daily life. A record review of Resident #2's care plan dated [DATE] revealed, the Resident has limited physical mobility related to tremors, exertional SOB secondary to COPD and pain. provide analgesic medication . as needed. Record reviews of the Texas Unified Licensure Information Portal website https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F accessed [DATE] revealed no facility generated reports during February through [DATE] regarding allegations of ANE on behalf of Resident #2. A record review of Resident #2's representatives text messages and emails to and from the previous Administrator and the DON between the time periods of February 2025 to [DATE] revealed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 13, 2025, at 6:13 PM Resident #2's representative, sent a text message to the previous admin and the DON which revealed an allegation of neglect on Resident #2's behalf, Hi (previous Administrator), my (Resident #2) was just now needing some pain meds I told (Resident #2) lets go in and ring your bell. I was abruptly told she would not come (LVN L) if we pushed the button. (Resident #2) has told me she does not come at night, . this is gravely concerning. The DON replied, Hi ladies I am sorry this happened, and clearly this is not acceptable, so this will be addressed. who said LVN L would not come? . this is the first complaint I have ever gotten from her. The Previous Administrator responded Thank you for letting us know. We will address. A record review of an email sent to the DON from Resident #2's representative dated [DATE] at 11:16 AM revealed a complaint and an allegation of neglect, Hi (DON), I wanted to reach out because as you know, our (Resident #2) is extremely ill, and our (family member) has requested ambulance to come and pick him up to transfer him to the hospital. (facility's) PA is concerned also about him possibly having pneumonia. We are deeply upset and concerned about how the nursing staff, who see him daily and nightly, haven't seemed to recognize the significant changes in his condition-his inability to talk clearly, walk on his own or even transfer safely along with the horrid cough. It's especially alarming that they attempted to collect a urine sample by placing a doughnut in the toilet when he isn't even able to walk to the bathroom. This situation is unacceptable, and I'd appreciate your help in addressing it as soon as possible. Additionally, sic(name), the ADON, mentioned to my parents a couple of months ago, that your daughters get in the way. The reality is, if we don't advocate for our parents, things don't seem to get addressed in a timely manner. For example, I have been discussing my dad's need to restart PT with the DOR and (previous Administrator) for over a month due to his leg weakness, and now he has deteriorated to the point where he can no longer use his legs at all. We are simply trying to ensure our (Resident #2) receive the best care possible, and we need reassurance that these concerns will be taken seriously and addressed appropriately. Thank you for your time and attention to this. On Thursday February 27, 2025, at 3:29 PM Resident #2's representative texted the DON with a complaint and an allegation of neglect on Resident #2's behalf, (DON) this is (Resident #2's Representative) Tuesday morning I spoke with my (Resident #2's) hospitalist and she said that my (Resident #2) did have a bad kidney infection. There is a discrepancy here I do not understand . his symptoms of confusion, extremely slurred speech and inability to walk is the reason I requested that an ambulance be called. These symptoms were ignored. All we are asking is for you guys to acknowledge that the nurses on duty Sunday and Monday did not take care of business. The DON responded, I am not going to put blame on anyone nor sit her and argue about what a doctor did or didn't say I am simply stating (Resident #2's) labs show nothing of the sort nor did the dr. put that anywhere on his notes again if you do not feel that we can care properly for your parents I will be more than happy to send paper work to other facilities let me know thanks. During a joint interview on [DATE] at 9:51 am with the Administrator and the DON, the DON stated Resident #2's representatives were not happy with the care provided to Resident #2 and would often complain, however Resident #2 was happy with his care. The administrator stated he had just begun his position of Administrator on [DATE]. The Administrator stated he soon recognized the facility needed improvement recognizing and acting upon allegations of ANE. The Administrator stated he began working with the staff to recognize and report allegations of ANE. The administrator evidenced the grievance log to demonstrate the increased number and quality documentation of grievances during [DATE], which were reviewed for potential allegations of ANE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	04/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kerrville	1555 Bandera Hwy Kerrville, TX 78028

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:01 PM Resident #2's representative stated Resident #2 had lived at the facility since [DATE], and she was frustrated with the previous Administrator and the DON due to the poor communication and lack of acknowledging and resolving grievances and allegations of ANE . Resident #2's representative stated she and family had been making allegations directly to the previous administrator and the DON for months with no resolutions. Resident #2's representative stated she and family had been making allegations via text messages, emails, and verbally to the previous administrator and the DON. During an interview on [DATE] at 4:00 PM the DON stated she began her position as DON on [DATE] and during that time Resident #2's family had made numerous complaints. The DON stated due to the investigations of allegations of ANE by the survey process she recognized she understood the reporting of ANE process and stated the previous Administrator was responsible for reporting allegations of ANE to the state agency since he was aware of the allegations and was the ANE prevention coordinator. The DON stated the previous Administrator was aware of all the allegations of ANE because all allegations and the previous days business were discussed during the daily interdisciplinary team meetings. During an interview on [DATE] at 5:02 PM the Administrator stated he was not the administrator at the time of the allegations on behalf of Residents #1 and #2 and the previous The Administrator stated the failure to recognize and report allegations of ANE could place residents at risk for not having their allegations of ANE reported. The Administrator stated he had begun training for his team and all the staff to ensure they all understood the ANE prevention recognizing and reporting process and expected increased documentation and recognition of allegations of ANE with reports to the state agency. A record review of the facility's Abuse, Neglect and Exploitation policy dated [DATE], revealed, 1. The facility will develop and implement written policies and procedures that: . Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property. Reporting procedures, and dementia management and resident abuse prevention; and . The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. Reporting/Response A. The facility will have written procedures that include: I. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. , law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility, in response to allegations of abuse, neglect, exploitation, or mistreatment, failed to ensure all alleged violations were thoroughly investigated and reported the results of all investigations to the State Survey Agency, within 5 working days of the incident, for 2 of 8 residents (Residents #1, and #2) reviewed for investigating and reporting results to the state survey agency. 1. On [DATE] LVN A, the ADON, the previous DON, and the Administrator at that time, failed to investigate an allegation of neglect on behalf of Resident #1 when LVN A performed CPR on Resident #1 while Resident #1 wished to not have CPR and had wished to be DNR status. 2. On [DATE] the previous Administrator and the DON heard an allegation of neglect on Resident #2's behalf and failed to investigate the allegation and report the results to the state agency. 3. On [DATE] the DON received an allegation of neglect via an email on behalf of Resident #2 and failed to investigate the allegation and report the results to the state agency. 4. On [DATE], the DON heard an allegation of neglect on Resident #2's behalf and failed to investigate the allegation and report the results to the state agency. These failures could place residents at risk for harm by not having allegations of ANE reported to the state agency. The findings included: 1.Resident #1 A record review of Resident #1's admission Record dated [DATE] was documented, a [AGE] year-old, she was admitted on [DATE] with diagnoses of multiple rib fractures, dementia) (a decline in mental ability severe enough to interfere with daily life), Parkinson's disease (a progressive neurological disorder that affects movement, primarily due to a decline in dopamine-producing brain cells, leading to symptoms like tremors, stiffness, and slow movement, but also impacting non-motor functions like sleep and mood.) and cognitive communication deficit. Resident #1 was at facility for 24 days and was discharged on [DATE]. A record review of Resident #1's chart was documented an OODNR dated [DATE]. A record review of Resident #1's consolidated physician orders for [DATE] revealed she had a code status order for DNR. A record review of Resident #1 admission MDS dated [DATE] was documented her BIMs score was 8/15 (moderate cognitive impairment), she had impairment on lower extremity on both sides, she used a walker/wheelchair to mobilize, she required supervision for self-care for eating, oral hygiene, persona hygiene, and maximum/moderate assistance with toileting, showers, and dressing. Resident #1 was incontinent of bowel/bladder, she had diagnoses of fractures, dementia, and Parkinson's. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #1 baseline care plan dated [DATE] was documented her code status was DNR. A record review of Resident #1's care plan conference dated [DATE] was documented her code status was OODNR. A record review of Resident #1's progress note dated [DATE] at 6:13 PM by RN A, was documented, resident was last seen well at 1630 (4:30 PM) when I administered her evening medications. I was notified at 1705 (5:05 PM) that resident was unresponsive. when assessed resident was not breathing and did not respond to sternal chest rub. 911 was called, CPR was initiated after 1 pump of CPR resident moaned out and was now breathing. vitals where 139/78 02 88 heart rate 52. resident still would not open eyes and would not verbally respond. EMS arrived and resident was sent to hospital for further evaluation RN A. Attempted interview on [DATE] at 12:30 PM, [DATE] at 1:26 PM, [DATE] at 12:02 PM with RN A left a voicemail and did not return call before the exit. During an interview on [DATE] at 1:07 PM with CNA B stated that day, she was not sure of exact date, Resident #1 was not breathing, called CNA C on phone and asked her to get nurse, RN A. CNA B stated she automatically grabbed the crash cart, with code status book and went to tell RN A to go to Resident #1's room. CNA B stated RN A started CPR and did 2 compressions, and Resident #1 opened her eye. CNA B stated during the compression, she had opened the code book to Resident #1's code status and told RN A that Resident #1 was a DNR. CNA B stated she had stepped out on the hall to return to her hall, saw EMS and let them know Resident #1 room number, and she left on the stretcher awake. CNA B stated later that day, RN A stated she had looked at Resident #1's admission record and her code status was a DNR. CNA B had stated to RN A that she had told her Resident #1 was a DNR, but she did not listen. CNA B stated that RN A did not hear her. CNA B stated RN A, CNA C were in Resident #1's in room, but was not sure of the other staff. During an interview on [DATE] at 12:23 PM with ADON stated she was not present for the incident with Resident #1. ADON stated the family had not shared any complaints and Resident #1 spouse visited her daily. The ADON stated every night the residents code status's get printed by night staff and placed in a binder, on top of crash cart. The ADON stated RN A should have looked at the code status binder. The ADON stated the previous DON did educate her on the code status incident but had no documentation and she did not remember signing anything for code status training. The ADON stated she was not the boss and did not report this incident to the STATE. During an interview on [DATE] at 2:25 PM with CNA C stated RN A did do compressions, she was not sure who found Resident #1. CNA C stated she did not recall if Resident #1 was in pain. CNA C stated the resident code status were in a binder on the crash cart. CNA C stated she was following the nurses' instructions, and she was not sure of Resident #1's code status. CNA C stated she thought surveyor was talking about a different resident when talked last. CNA C was not sure about the incident. During an interview on [DATE] at 5:59 PM with the SW stated residents had a last choice of code status and staff should respect a resident choice. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:18 PM the previous DON stated she was the DON at the facility until mid-[DATE] when she resigned. The DON stated the environment was toxic due to the Administrators poor support. The previous DON stated she was unaware of Resident #1's CPR event and could not recall any details of the incident. The DON stated she was employed as the DON during the month of [DATE] but was not the DON effectively stating the administrator and the ADON had cut her out of the loop and the ADON was in effect the DON. The DON stated had she known of the incident she would have reported the incident and investigated the incident. The DON stated if Resident #1 had wished to be a DNR status they should have not provided CPR. Record review of Policy, Communication of Code Status dated 7/22 was documented, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. 4. The resident's code status should be entered into the resident physician orders in the EMR. 5. Additional means of communication of code status include: Code status will appear at the top of the resident home screen in EMR. 9. The resident's code status will be reviewed at least quarterly and documented in the medical record. Record reviews of the Texas Unified Licensure Information Portal website; https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F; accessed [DATE] revealed no facility generated reports during [DATE] regarding allegations of ANE on behalf of Resident #1. During an interview on [DATE] at 2:18 PM the previous DON stated she was the DON at the facility until mid-[DATE] when she resigned. The DON stated the environment was toxic due to the Administrators poor support. The previous DON stated she was unaware of Resident #1's CPR event and could not recall any details of the incident. The DON stated she was employed as the DON during the month of [DATE] but was not the DON effectively stating the administrator and the ADON had cut her out of the loop and the ADON was in effect the DON. The DON stated had she known of the incident she would have reported the incident and investigated the incident. The DON stated if Resident #1 had wished to be a DNR status they should have not provided CPR 2. Resident #2 A record review of Resident #2's admission record dated [DATE] revealed an admission date of [DATE] with diagnoses which included cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), chronic obstructive pulmonary disease (COPD a term for lung and airway diseases that restrict your breathing. People with COPD have airway inflammation and scarring, damage to the air sacs in their lungs or both.), and cancer of the intestines. A record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 was an [AGE] year-old male admitted for long term care, further review revealed Resident #2 had adequate vision, hearing, could usually understand and could usually understand others. Resident #2 was assessed with mild cognitive impairment and needed assistance with activities of daily life. A record review of Resident #2's care plan dated [DATE] revealed, the Resident has limited physical mobility related to tremors, exertional SOB secondary to COPD and pain. provide analgesic medication . as needed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record reviews of the Texas Unified Licensure Information Portal website https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F accessed [DATE] revealed no facility generated reports during February through [DATE] regarding allegations of ANE on behalf of Resident #2. A record review of Resident #2's representatives text messages and emails to and from the previous Administrator and the DON between the time periods of February 2025 to [DATE] revealed: On February 13, 2025, at 6:13 PM Resident #2's representative, sent a text message to the previous admin and the DON which revealed an allegation of neglect on Resident #2's behalf, Hi (previous Administrator), my (Resident #2) was just now needing some pain meds I told (Resident #2) lets go in and ring your bell. I was abruptly told she would not come (LVN L) if we pushed the button. (Resident #2) has told me she does not come at night, . this is gravely concerning. The DON replied, Hi ladies I am sorry this happened, and clearly this is not acceptable, so this will be addressed. who said LVN L would not come? . this is the first complaint I have ever gotten from her. The Previous Administrator responded Thank you for letting us know. We will address. A record review of an email sent to the DON from Resident #2's representative dated [DATE] at 11:16 AM revealed a complaint and an allegation of neglect, Hi (DON), I wanted to reach out because as you know, our (Resident #2) is extremely ill, and our (family member) has requested ambulance to come and pick him up to transfer him to the hospital. (facility's) PA is concerned also about him possibly having pneumonia. We are deeply upset and concerned about how the nursing staff, who see him daily and nightly, haven't seemed to recognize the significant changes in his condition-his inability to talk clearly, walk on his own or even transfer safely along with the horrid cough. It's especially alarming that they attempted to collect a urine sample by placing a doughnut in the toilet when he isn't even able to walk to the bathroom. This situation is unacceptable, and I'd appreciate your help in addressing it as soon as possible. Additionally, sic(name), the ADON, mentioned to my parents a couple of months ago, that your daughters get in the way. The reality is, if we don't advocate for our parents, things don't seem to get addressed in a timely manner. For example, I have been discussing my dad's need to restart PT with the DOR and (previous Administrator) for over a month due to his leg weakness, and now he has deteriorated to the point where he can no longer use his legs at all. We are simply trying to ensure our (Resident #2) receive the best care possible, and we need reassurance that these concerns will be taken seriously and addressed appropriately. Thank you for your time and attention to this. On Thursday February 27, 2025, at 3:29 PM Resident #2's representative texted the DON with a complaint and an allegation of neglect on Resident #2's behalf, (DON) this is (Resident #2's Representative) Tuesday morning I spoke with my (Resident #2's) hospitalist and she said that my (Resident #2) did have a bad kidney infection. There is a discrepancy here I do not understand . his symptoms of confusion, extremely slurred speech and inability to walk is the reason I requested that an ambulance be called. These symptoms were ignored. All we are asking is for you guys to acknowledge that the nurses on duty Sunday and Monday did not take care of business. The DON responded, I am not going to put blame on anyone nor sit her and argue about what a doctor did or didn't say I am simply stating (Resident #2's) labs show nothing of the sort nor did the dr. put that anywhere on his notes again if you do not feel that we can care properly for your parents I will be more than happy to send paper work to other facilities let me know thanks. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint interview on [DATE] at 9:51 am with the Administrator and the DON, the DON stated Resident #2's representatives were not happy with the care provided to Resident #2 and would often complain, however Resident #2 was happy with his care. The administrator stated he had just begun his position of Administrator on [DATE]. The Administrator stated he soon recognized the facility needed improvement recognizing and acting upon allegations of ANE. The Administrator stated he began working with the staff to recognize and report allegations of ANE. The administrator evidenced the grievance log to demonstrate the increased number and quality documentation of grievances during [DATE], which were reviewed for potential allegations of ANE. During an interview on [DATE] at 1:01 PM Resident #2's representative stated Resident #2 had lived at the facility since [DATE], and she was frustrated with the previous Administrator and the DON due to the poor communication and lack of acknowledging and resolving grievances and allegations of ANE. Resident #2's representative stated she and family had been making allegations directly to the previous administrator and the DON for months with no resolutions. Resident #2's representative stated she and family had been making allegations via text messages, emails, and verbally to the previous administrator and the DON. During an interview on [DATE] at 4:00 PM the DON stated she began her position as DON on [DATE] and during that time Resident #2's family had made numerous complaints. The DON stated due to the investigations of allegations of ANE by the survey process she recognized she understood the reporting of ANE process and stated the previous Administrator was responsible for investigating allegations of ANE and reporting the results of the investigation to the state agency since he was aware of the allegations and was the ANE prevention coordinator. The DON stated the previous Administrator was aware of all the allegations of ANE because all allegations and the previous days business were discussed during the daily interdisciplinary team meetings. During an interview on [DATE] at 5:02 PM the Administrator stated he was not the administrator at the time of the allegations on behalf of Residents #1 and #2 and the previous Administrator was responsible for ensuring those allegations were heard, documented, and investigated for Residents #1 and #2. The Administrator stated he was the current abuse, neglect, and exploitation prevention coordinator. The Administrator stated the failure to recognize and investigate allegations of ANE could place residents at risk for not having their allegations of ANE investigated. The Administrator stated he had begun training for his team and all the staff to ensure they all understood the ANE prevention investigating and reporting process and expected increased documentation and recognition of allegations of ANE with reports to the state agency. A record review of the facility's Abuse, Neglect and Exploitation policy dated [DATE], revealed, 1. The facility will develop and implement written policies and procedures that: . investigate any such allegations; and . an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to ensure personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 4 (#1) residents in that: Resident #1 was administered CPR, 2 compressions which caused Resident #1 to moan in pain, by LVN A after found unresponsive. Resident #1 was a DNR. Resident #1 had an OOH-DNR. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 6 PM. While the IJ was removed on [DATE] at 1:26 PM. The facility remained out of compliance at a scope of isolated and severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to facility's need to evaluate the plan of removal. This facility failure could place residents at risk of not having their rights honored; experiencing worsening of condition; severe injury, and hospitalization. The findings included: A record review of complaint investigation #546794, dated [DATE], revealed Resident #1 had to go to the emergency room, the addendum stated Resident #1 was unresponsive and 911 was called. The complainant stated RN A said she was sorry; I was completely unaware that Resident #1 had a DNR and I administered CPR. The complainant, not realizing that Resident #1 had no pulse and wasn't breathing which complainant took to mean unconscious, sat speechless. complainant then said, You mean she (Resident #1) didn't have a pulse? The RN A replied No. She wasn't breathing, and she did not have a pulse. When I got in there, I assessed for breath and pulse, didn't find either one, and jumped on her and yelled Starting CPR and gave her 2 compressions. At that point her chest came off the bed and she made a loud groaning sound. The nurse went on to explain that she never checked the binder on the crash cart and that there is no protocol for the order things should be done when the crash cart is needed. RN A told complainant she only knew about the DNR because the Dr called over from the hospital to discuss what happened and when the nurse got to the part about the CPR, he stated to her You realize she has a DNR. The nurse said it was after that phone call that she went and checked the binder and saw the non-hospital DNR was in there. The RN A stated that she had called her Director of Nursing, but she wanted us to hear it from her what had happened. A record review of Resident #1's admission Record dated [DATE] was documented, a [AGE] year-old, she was admitted on [DATE] with diagnoses of multiple rib fractures, dementia) (a decline in mental ability severe enough to interfere with daily life), Parkinson's disease (a progressive neurological disorder that affects movement, primarily due to a decline in dopamine-producing brain cells, leading to symptoms like tremors, stiffness, and slow movement, but also impacting non-motor functions like sleep and mood.) and cognitive communication deficit. Resident #1 was at facility for 24 days and was discharged on [DATE]. A record review of Resident #1's electronic chart was documented an OOH-DNR dated [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #1's consolidated physician orders for [DATE] revealed she had a code status order for DNR. A record review of Resident #1 admission MDS dated [DATE] was documented her BIMs score was 8/15 (moderate cognitive impairment), she had impairment on lower extremity on both sides, she used a walker/wheelchair to mobilize, she required supervision for self-care for eating, oral hygiene, persona hygiene, and maximum/moderate assistance with toileting, showers, and dressing. Resident #1 was incontinent of bowel/bladder, she had diagnoses of fractures, dementia, and Parkinson's. A record review of Resident #1 baseline care plan dated [DATE] was documented her code status was DNR. A record review of Resident #1's care plan conference dated [DATE] was documented her code status was OOH-DNR. A record review of Resident #1's Transfer/Discharge Report dated [DATE] at 5:15 PM was documented she was unresponsive and was transferred to hospital. A record review of Resident #1's progress note dated [DATE] by MD was documented Admitting Diagnosis: Right sided rib fractures Chief Complaint: Impaired mobility and self-care. Medical coverage provided by: MD. Interval History: The patient is undergoing rehabilitation at the skilled nursing facility and since the last visit, the patient is participating well in the therapy program. The patient is reporting any pain. New issues since last visit: The patient was assessed while sitting up in the chair with [family member] at her side. The patient reports moderate pain but tolerable with Tylenol and Lidoderm patches, per [family member] Oxycodone attempted and made the patient nauseous requiring Zofran. Patient's [family member] requesting continuation of Zofran PRN with nursing. A record review of Resident #1's progress note dated [DATE] at 4:41 PM was documented Resident #1 presents with weakness and tremors. Request labs for UTI, UA and were ordered. A record review of Resident #1's progress notes dated [DATE] at 4:48 PM Zofran ODT Tablet Dispersible 4 MG, give 1 tablet by mouth every 8 hours as needed for nausea. A record review of Resident #1's progress notes dated [DATE] at 5:43 PM was documented Zofran ODT Tablet Dispersible 4 MG, give 1 tablet by mouth every 8 hours as needed for nausea. PRN Administration was: Effective. A record review of Resident #1's progress note dated [DATE] at 6:13 PM by RN A, was documented, resident was last seen well at 1630 (4:30 PM) when I administered her evening medications. I was notified at 1705 (5:05 PM) that resident was unresponsive. when assessed resident was not breathing and did not respond to sternal chest rub. 911 was called, CPR was initiated after 1 pump of CPR resident moaned out and was now breathing. vitals where 139/78 02 88 heart rate 52. resident still would not open eyes and would not verbally respond. EMS arrived and resident was sent to hospital for further evaluation. (continued on next page)

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	745050	A. Building B. Wing	04/06/2025

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record of Resident #1's hospital record dated [DATE] was documented Resident #1 had an unresponsive episode at her nursing home. Resident #1 was fond by nurse the started 1 chest compression and Resident #1 started moaning so compressions were stopped. Resident #1 was more responsive and CT scan to chest showed a large pleural effusion. Resident #1 had been able to answer questions, began to moan and moving and these were stopped, EMS administer Narcan per report Resident #1 was on narcotics. Resident #1 was at her baseline status and was weaned off oxygen. CT scan was negative and was stable and read for discharge to another facility. During an interview on [DATE] at 4:47 PM, via email, the complainant stated She (LVN A) was also the one who told me she did CPR without knowing there was a DNR in place. She spoke directly to the hospital and was in charge of the ambulance upon its arrival. The last stay at hospital was a severe UTI. Attempted interview on [DATE] at 12:30 PM, [DATE] at 1:26 PM, [DATE] at 12:02 PM with RN A left a voicemail and did not return call before the exit. During an interview on [DATE] at 1:07 PM with CNA B stated that day, she was not sure of exact date, Resident #1 was not breathing, called CNA C on phone and asked her to get nurse, RN A. CNA B stated she automatically grabbed the crash cart, with code status book and went to tell RN A to go to Resident #1's room. CNA B stated RN A started CPR and did 2 compressions, and Resident #1 opened her eye. CNA B stated during the compression, she had opened the code book to Resident #1's code status and told RN A that Resident #1 was a DNR. CNA B stated she had stepped out on the hall to return to her hall, saw EMS and let them know Resident #1's room number, and she left on the stretcher awake. CNA B stated later that day, RN A stated she had looked at Resident #1's admission record and her code status was a DNR. CNA B had stated to RN A that she had told her Resident #1 was a DNR, but she did not listen. CNA B stated that RN A did not hear her. CNA B stated RN A, CNA C were in Resident #1's, but was not sure of the other staff. CNA B stated she was trained for CPR at hospital that she worked at and not at the facility. During an interview on [DATE] at 1:47 PM with LVN AE stated Resident #1 was fine and did not have a change of condition, the night before the incident with the code status. LVN AE stated she worked nights and was not involved with the code status incident with Resident #1. LVN AE stated she knew Resident #1 was a DNR. LVN AE stated she would look at the crash cart, on top had a code status log of all residents with their code states. LVN AE stated the code status was printed out every night. LVN AE stated she was not sure if she was trained at facility for code status. During interview on [DATE] at 2:56 PM with MD stated she was not aware that a CNA, had told LVN A Resident #1 was a DNR, and the LVN A continued to do compressions. During an interview on [DATE] at 11:52 AM with the current DON stated her expectations of nursing would be to document more, document a change of condition, and notify the state agency. The current DON stated the MD had access to resident labs via software system. The current ADON started working after this incident. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:23 PM with ADON stated she was not present for the incident with Resident #1. ADON stated the family had not shared any complaints and Resident #1 family member visited her daily. The ADON stated every night the residents code status's get printed by night staff and placed in a binder, on top of crash cart. The ADON stated RN A should have looked at the code status binder. The ADON stated the previous DON did educate her on the code status incident but had no documentation and she did not remember signing anything for code status training. The ADON stated she was not the boss and did not report this incident to the state agency. During an interview/observation on [DATE] at 10:51 AM with the DON showed the surveyor where they kept the code status of residents in binder, on top of the crash cart near the nurse's station. During an interview on [DATE] at 12:01 PM with the previous DON stated she worked from [DATE] through [DATE]. The previous DON stated she did not remember Resident #1 at this time. The previous DON stated she would expect a nurse to respond to an unresponsive resident, by looking at the binder with all resident code status, call 911. The previous DON stated if resident was a DNR, do not do CPR on resident and call 911. If resident a full code she would expect the nurse to start CPR until EMS came. In regard to this incident, she as a DON would train on code status and what to do, and report to the state agency. During an interview on [DATE] at 2:15 PM with Resident #1's family member/ MPOA stated he was in the room the day Resident #1 went to the hospital. Resident #1's spouse stated he was with Resident #1 in the morning, and at lunch. Family member stated Resident #1 went to lay down and she was unresponsive to him, he called out for a staff, staff grabbed the crash cart, and did see the nurse doing compressions, and went outside room, so staff can care for Resident #1. Family member of Resident #1 stated at the time it happened so fast he did not think about the code status of DNR. Family member stated EMS was able to get Resident #1 stabilized and Resident #1 went to hospital. Family member of Resident #1 stated at the hospital Resident #1 did not have any broken bones and changed her blood pressure medications due to low blood pressure. Family member stated Resident #1 was well and was taking a nap at the time. During an interview on [DATE] at 2:18 PM the previous DON stated she was the DON at the facility until mid-[DATE] when she resigned. The previous DON stated she was unaware of Resident #1's CPR event and could not recall any details of the incident. The DON stated she was employed as the DON during the month of [DATE] but was not the DON effectively stating the administrator and the ADON had cut her out of the loop and the ADON was as a result the DON. The DON stated had she known of the incident she would have reported the incident and investigated the incident. The DON stated if Resident #1 had wished to be a DNR status they should have not provided CPR. During an interview on [DATE] at 2:25 PM with CNA C stated RN A did do compressions, she was not sure who found Resident #1. CNA C stated she did not recall if Resident #1 was in pain. CNA C stated the resident code status were in a binder on the crash cart. CNA C stated she was following the nurses' instructions, and she was not sure of Resident #1's code status. During an interview on [DATE] at 5:59 PM the SW stated the residents last right/choice was to have their code status honored and staff should respect a resident choice. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview in [DATE] at 4:17 PM with LVN L stated she was the overnight nurse that maintained the DNR binder and ensured the binder was accurate nightly and last night [DATE] at 1 AM, he printed out a new page for the binder and placed on crash cart. During an interview on [DATE] at 5:02 PM the Administrator stated he was not the administrator at the time of the allegation on behalf of Residents #1 and the previous Administrator was responsible for ensuring those allegations were heard, documented, and satisfactorily resolved for Residents #1. The Administrator stated he was the current abuse, neglect, and exploitation prevention coordinator. The Administrator stated the failure to recognize and report allegations of ANE could place residents at risk for not having their allegations of ANE reported. The Administrator stated he had begun training for his team and all the staff to ensure they all understood the ANE prevention recognizing and reporting process and expected increased documentation and recognition of allegations of ANE with reports to the state agency. Record review of Policy, Communication of Code Status dated 7/22 was documented, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. 4. The resident's code status should be entered into the resident physician orders in the EMR. 5. Additional means of communication of code status include: Code status will appear at the top of the resident home screen in EMR. 9. The resident's code status will be reviewed at least quarterly and documented in the medical record. The Administrator was notified of an IJ on [DATE] at 6 PM and was given a copy of the IJ Template and a Plan of Removal (POR) was requested. The Plan of Removal accepted on [DATE] at 1:26 PM and included the following: Plan of Removal (POR) for Immediate Jeopardy, dated [DATE] was documented: To Whom it may concern, Summary of Details which lead to outcomes. On [DATE], an abbreviated survey was initiated at 10 am. On [DATE], A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the facility constitute immediate jeopardy to resident health. The notification of the alleged immediate jeopardy states as follows: F678 The facility failed to implement a resident's advance directive on Resident #1. Identify residents who could be affected. All Residents with an advance directive have the potential to be affected. Facility census on [DATE]. Identify responsible staff/ what action taken: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	. Regional VPO and Regional Nurse Consultant provided education on CPR and Advance Directives honoring resident rights to Administrator and Director of Nursing on [DATE]. Director of Nursing and Assistant Director of Nursing conducted education on CPR and Advance Directives for all nurses. A mock code was performed for am and pm shifts on [DATE], with documentation on a Mock Code form. Advance Directive Binder on the crash cart was reviewed and verified to ensure residents code status were listed and correct on [DATE], by the DON. The Regional VPO educated the Administrator and Director of Nursing on reporting guidelines per PL 2014-14 dated [DATE], on [DATE]. Social Worker/designee will be responsible for updating the Advance Directive binder when there is a change in code status. New staff and agency staff (if applicable) will be educated in Advance Directives and the location of the code status binder which is located on the emergency cart by the DON/designee prior to starting their shift. Implementation of Changes Nurses can easily identify and locate the code status for residents, as the advanced directive binder is clearly marked and located on the crash cart. The location of the advance directive binder is documented in the in-service provided to the nursing staff. Nurses will only perform CPR if the resident is designated as a Full Code. Training initiated and completed on [DATE], and after the education sessions, nurses will have a better understanding of code status and the situations in which CPR should or should not be performed. Any new hires and or agency staff (if applicable) will be educated prior to the start of their shift. The Director of Nursing will conduct monthly mock code scenarios for 3 months. Monitoring Administrator, Director of Nursing, or designated staff will monitor the code status of residents daily for 4 weeks, including any changes upon admission and thereafter. Social Worker/designee will be responsible for updating the Advance Directive binder when there is a change in code status. Any negative outcomes will be reported to the QAPI Committee. Involvement of Medical Director Ad hoc QAPI held at 7:35 pm on [DATE], with the Medical Director, Director of Nursing and Administrator for discussion of Immediate Jeopardy and the plan of removal. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Medical Director, 6:28 pm was notified about the immediate Jeopardy on [DATE]. Who is responsible for the implementation of the process? Director of Nursing and/or Designee. POR verification was started on [DATE] was documented: Identify residents who could be affected. Record review of Resident list revealed 71 residents in the building During an interview on [DATE] at 1:13 PM on [DATE] the DON stated prior to [DATE] the entire census of 71 had the potential for their code statuses not being reviewed if a potential event of a resident being discovered unresponsive. Identify responsible staff/ what action taken: Record Review of CPR/Advanced Directive in-service training dated [DATE] was documented the Regional VPO and Regional Nurse Consultant provided education on CPR and Advance Directives to the Administrator and DON. During an interview on [DATE] at 1:18 PM Regional VPO stated he provided education on CPR and Advance Directives honoring resident rights to the Administrator and the Director of Nursing on [DATE],[DATE] and that the Director of Nursing and the Assistant Director of Nursing conducted education on CPR and Advance Directives for all nurses. A mock code was performed for am and pm shifts on [DATE],[DATE] with documentation on a Mock Code form. Record review of in-service training CPR code status mock code, summary: in the event of code blue, immediately delegate for a staff member to retrieve resident code status form binder on crash cart before beginning CPR. Code status binder is updated nightly by nursing staff. (mock code initiated) dated [DATE] included, LVN H, LVN P, CNA Q, PT R, CNA S, CNA T, CNA U, CNA V, and CNA W. The following staff LVN H, LVN P, CNA Q, PT R, CNA S, CNA T, CNA U, CNA V, and CNA W, who received training for supporting a residents' wishes for a code status and participated in the facility's initial Mock Code event on [DATE] training were interviewed as follows: During an interview on [DATE] at 1:46 PM LVN H stated on [DATE] she was trained by the DON for a Mock Code event designed to augment the staffs' in-service regarding a potential CPR event if a Resident was discovered unresponsive. LVN H stated the protocol in the training would have a focus in the training for the staff to identify the Resident in the DNR Binder which was maintained accurately on the cart, and to communicate the information to one and another to specify if the Resident had wishes to receive or not to receive CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on [DATE] from 5:45 PM to 6:33 PM LVN P, CNA Q, PT R, CNA S, CNA T, CNA U, CNA V and CNA W stated she they had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident #1'sSmith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. LVN PThey stated she arrived to discover CNA Q was on her way with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. LVN PThey stated if it were a real CPR event she they would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. During an interview on [DATE] at 5:56 PM CNA Q stated she had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident Smith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. CNA Q stated she arrived at the 100-hall with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. CNA Q stated if it were a real CPR event she would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. During an interview on [DATE] at 6:33 PM PT R stated he had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident Smith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. PT R stated he arrived to discover CNA Q was on her way with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. PT R stated if it were a real CPR event he would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. During an interview on [DATE] at 5:49 PM CNA S stated she had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident Smith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. CNA S stated she arrived to discover CNA Q was on her way with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. CNA S stated if it were a real CPR event she would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. During an interview on [DATE] at 5:50 PM CNA T stated she had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident Smith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. CNA T stated she arrived to discover CNA Q was on her way with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. CNA T stated if it were a real CPR event she would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:47 PM CNA U stated she had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident Smith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. CNA U stated she arrived to discover CNA Q was on her way with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. CNA U stated if it were a real CPR event she would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. During an interview on [DATE] at 5:45 PM CNA V stated she had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident Smith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. CNA V stated she arrived to discover CNA Q was on her way with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. CNA V stated if it were a real CPR event she would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. During an interview on [DATE] at 5:47 PM CNA W stated she had received Resident code status for DNR versus CPR training via a Mock Code event on the afternoon on [DATE] when LVN H in general called out in the facility to unaware staff that a Resident Smith was discovered on the 100-hall unresponsive to which numerus staff reacted and ran down the 100- hall. CNA W stated she arrived to discover CNA Q was on her way with the crash cart and upon arrival of the crash cart the training was for a focus on the Code Status Binder which contained a current accurate list of all residents and their wishes to receive CPR or not. CNA W stated if it were a real CPR event she would not provide CPR if the Resident had wished for a DNR Status and would communicate the residents wishes to all the staff present. Record review of list of nurses provided by the DON revealed at total of 10 nursing staff working in the facility. Interview on [DATE] at 12:15 PM with ADM/DON/Regional nurse stated they had 10 full time nurses working at facility with no agency staff. Record of staffing schedule for [DATE] was documented 7 nursing staff that worked on the AM and PM schedule. The Advance Directive Binder on the crash cart was reviewed and verified to ensure residents code status were listed and correct on [DATE]/4/25, by the DON. Record review of statement from DON dated [DATE] was documented, Reviewed and verified advanced directrices binder on crash cart to ensure all code status were correct. Record review of the Advance Directive Binder on the crash cart was reviewed and verified to and included 71 residents. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Regional VPO educated the Administrator and Director of Nursing on reporting guidelines per PL 2014-14 dated [DATE], on [DATE]. Record review of In-service training dated [DATE] by the Regional VPO was documented ADM and or DON will enforce state/Federal guidelines on state reporting. In addition, the ADM and/or DON will report all significant events to the Regional [NAME] President which included signatures of DON/RN, ADM and ADON. Record review of the LTC provider letter, dated [DATE]. 2024 (PL 2014-14) was attached to in-service. Social Worker/designee will be responsible for updating the Advance Directive binder when there is a change in code status. Record review of statement dated [DATE] was documented I, SW understand that it is my responsibility to update advanced directive binder when there are changes in code status. Upon each admission it will be explained to family and residents their right to make medical decisions, including the right to formulate and have respected advance directives that may be updated and changed anytime at their request, signed and dated by SW. New staff and agency staff (if applicable) will be educated in Advance Directives and the location of the code status binder which is located on the emergency cart by the DON/designee prior to starting their shift. During an interview on [DATE] at 1:13 PM the DON stated new staff and agency staff (if applicable) will be educated about Advance Directives and the location of the code status binder which was located on the emergency cart, prior to starting their shift. Implementation of Changes Record review of in-service training on Code Status/Advanced Directive, where and how do you know what code status they have, and Binder is located on the crash cart with list of resident code status dated [DATE] which included 13 nursing staff. A record review of the facility's full time nursing roster revealed 11 nurses: 1. The DON 2. LVN D 3. ADON LVN E 4. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN F 5. LVN G 6. LVN H 7. LVN I 8. LVN J 9. LVN K 10. LVN L 11. LVN O A record review of the facility's PRN nursing roster revealed 3 nurses: 1. LVN M 2. RN N Of the facility's' 13[TRUNCATED]

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Avir at Kerrville	1555 Bandera Hwy Kerrville, TX 78028

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews, the facility failed to ensure all drugs and biologicals were in locked compartments and permitted only authorized personnel to have access, for 2 of the facility's 7 medication carts (a treatment cart and a medication cart), reviewed for security and supervision. 1. Medication Aide AI left the medication cart unattended, unsupervised, and unlocked. 2. LVN AM left the treatment cart unattended, unsupervised, and unlocked. These failures could place residents at risk for harm by unsecured medications. The findings included: During an observation and interview on 4/2/2024 at 8:27 AM revealed the medication cart and the treatment cart were parked on the facility's 300-hall. Further observation revealed the medication cart, and the treatment cart were unlocked and unattended. Continued observations revealed housekeeper AL, Driver AK and CNA AJ had alternately ambulated past the unlocked carts over 5 minutes elapsed time. At 8:37 AM the surveyor alerted LVN AM the treatment cart, and the medication carts were unattended, unsupervised, and unsecured. LVN AM stated she was in a resident's room providing care and had unintentionally left the treatment cart unlocked. LVN AM observed the medication cart and recognized the cart was unlocked and alerted the DON. The DON approached the medication cart and locked. LVN AM reported to the DON she also had left her cart unsupervised and unlocked while she was in a resident's room. The DON stated the medication cart was assigned to MA AI and then summoned MA AI. The DON gave a report of finding the medication cart unlocked. The DON stated all carts with medications should be locked when not attended. During an observation and interview on 4/2/2025 at 8:38 AM MA AI stated she was assigned the medication cart around 7:40 AM by LVN M. MA AI stated she left the cart briefly but had not left the cart unlocked and stated she always locked the cart when she left the cart. MA AI stated she did not understand how the cart came to be unlocked. MA I stated the risk to residents' medication was unsecured medications. During an interview on 4/5/2025 at 5:10 PM the Administrator stated he had received a report MA AI had left the medication cart unlocked. The Administrator stated the risk for harm for residents was unsecured medications. A record review of the facility's Medication Storage dated 7/2022 revealed, Policy: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments.

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews revealed the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, for 1 of 1 Resident's food / snack pantry reviewed for food safety. The facility's Resident food snack pantry located on the residents hall had a refrigerator with 15 containers of food. The containers had various food safety concerns to include old, expired food available for residents' consumption. These failures could place residents at risk for harm by food borne illnesses. The findings included: During an observation and interview on 4/1/2025 at 2:56 PM revealed the facility's Resident food and snack pantry room with CNA AN revealed the refrigerator had a temperature of 45 degrees Fahrenheit and held the following items: 1. A 32-ounce tub of yogurt with manufactures use by date of 1/13/2025 and a handwritten date of 3/25/2025 and written upon the lid was the word residents. 2. An individual sealed serving cup of a name brand yogurt with the manufactures use by date of 2/21/2025. 3. A facility made cup of pudding with the date of 3/7. 4. A 16-ounce plastic container of a grocery store's prepared fruit blend labeled best if used by 3/19/2025, perishable, (Resident #15). further observation revealed wet soft pieces of grapes, melon, blueberries, and other assorted fruits. 5. A sandwich size clear plastic zip bag contained half an avocado. The avocado had a spotted dark brown and black wet colored flesh. The bag had no markings and or label. 6. A 15-ounce plastic container of a grocery store prepared Cole slaw ready to eat. The container had a handwritten date of 3/25/2025 and Resident #18's name. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. A small clear plastic cup of cubed watermelon. The plastic container had no label or date other than the name of (Resident #16.) 8. An approximately 3 round plastic reusable bowl with a lid. The bowl presented semi filled with soft discolored and malodorous pieces of fruit to include brown pineapple, brown spotted melon, and grapes. 9. An approximately 4 rectangle reuseable semi clear plastic food container with Resident #17's name written upon the container. Further observation revealed the container had malodorous noodles and a shriveled egg roll. 10. 2 small plastic semi clear containers of an unknown beige off white pudding sauce. The containers were within a brown paper bag with an unknown resident's name written upon the bag. The bag and the containers had no date labels. 11. A small 4-ounce fast food dairy dessert container without any labels and or names. The container revealed an of white watery slurry. 12. A small 8-ounce fast food dairy dessert container with resident's #/'s name written on the cup. The container revealed a dark brown watery slurry. 13. A half-eaten open paper plate serving of a fast-food taco meal with condiments. The was no label to indicate a Resident and or date on the meal. 14. A clear plastic container of a grocery store prepared Cranberry Pecan Turkey Salad Medium revealed a semi full container and a handwritten name of Resident #18. The containers' label revealed, packed on 3/26/2025 sell by 3/29/2025 09:58 AM. 0.775 lbs. 15. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 restaurant plastic to-go food containers with a handwritten name of Resident #18. The containers were observed to have leftovers from a previous meal. The containers did not have any other labels other than Resident #18's name. CNA AN stated this refrigerator was for residents' snacks and foods brought by families. CNA AN stated she was unaware of labeling practices for food safety. CNA AN stated she could not say whether the foods were safe to serve. CNA AN stated some of the foods appeared not safe to serve and would report to the nurse immediately. CNA AN stated she was unaware if anyone was responsible for checking the refrigerator for food safety. During an interview on 4/1/2025 at 6:00 PM the FSM stated he had received a report about the resident's food snack pantry located on the resident's floor . The FSM stated prior to today's report he was unaware of the resident's food snack pantry and the refrigerator within. The FSM stated he was now aware the refrigerator was his responsibility for food safety. The FSM stated and demonstrated the expectations for food safety as follows: Foods made by the facility must have a label to indicate 2 dates: o A date the food was prepared. o A date the food would be thrown out. Foods brought from other sources should be presented to the FSM for food safety inspection and would receive a label to indicate: o A date the food was presented. o A date the food would be thrown out. Any foods past 3 days of preparation and or presentation would be thrown out. Any foods past the manufacture's expiration dates would be thrown out. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint interview on 4/5/2025 at 5:20 PM with the Administrator and the DON, the Administrator stated he had received a report of the expired foods discovered in the resident's food snack pantry. The Administrator stated the foods should have been supervised for safety by the FSM and the nursing staff. The Administrator stated he had collaborated with the IDT and developed and implemented food safety training for the dietary and nursing staff to include the food safety monitoring of resident's facility prepared foods and foods brought into the facility by families and or visitors. The Administrator stated the risk for harm for residents by the foods discovered in the pantry were food borne illnesses. The DON verbally concurred with the Administrator. A record review of the facility's Date Marking for Food Safety dated 7/2022, revealed, Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Policy Explanation and Compliance Guidelines for Staffing: 1. Refrigerated, ready-to-eat, time/temperature control for safety food (i.e. perishable food) shall be held at a temperature of 41°F or less for a maximum of 7 days. 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. 5. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday.) 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed. 8. Note: prepared foods that are delivered to the nursing units shall be discarded within two hours, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified.

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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. Based on observations, interviews, and record reviews the facility failed to ensure personnel handled, stored, processed, and transported linens so as to prevent the spread of infection, for 1 of 1 laundry departments reviewed for infection prevention and control. 1. The laundry department presented with resident's clean blankets stored with soiled infectious laundry. 2. Laundry Aide AO and Laundry Aide AP donned only gloves and did not don full PPE while handling soiled infectious laundry. These failures could place residents and staff for cross-contamination of infectious diseases. The findings included: During an interview on 4/1/2025 at 9:10 AM the Administrator and the DON stated their census was 73 with some residents were on isolation for potential communicable diseases with some residents on droplet precautions due to influenza, some residents were on EBP, and others were on contact precautions. During an observation of the laundry department on 4/2/2025 at 3:22 PM revealed residents' clean blankets were stored in the soiled laundry room alongside 4 boxes of soiled infectious disease laundry. During an observation and interview on 4/2/2025 at 3:23 PM LA AO stated she was employed as a housekeeper and laundry aide at the facility for the past 8 months. LA AO stated the laundry department included 3 separate rooms connected by 2 doors. The first room was a soiled laundry room connected to the washing machine room by an open door. The third room was the dying machine room connected to the washer room by an open door. Further observation revealed the soiled laundry room contained four cardboard boxes which contained soiled laundry in plastic bags. The boxes were imprinted biohazard . caution; contains medical waste which may be biohazardous. The soiled linen room revealed numerous blankets and quilts hung upon 2 metal wheeled clothing carts. LA AO stated the blankets were clean and wet and could not go in to the dryers, so the blankets were hung upon the carts to dry out. LA AO identified the 4 cardboard boxes in the same room as laundry from residents' rooms which were under isolation precautions due to infections. LA AO stated only PPE in the laundry department were gloves. LA AO stated and demonstrated she practiced hand hygiene, wore gloves, placed soiled infectious disease laundry into the washing machine, doffed the gloves, and practiced hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the laundry department and joint interviews with the Housekeeping Director (HK Dir), LA AP, and LA AO on 4/3/2025 at 9:10 AM revealed the laundry department only had gloves for PPE, continued with the four biohazard boxes stored in the soiled laundry room alongside the clean blankets and continued with the doors to the soiled laundry room, washing machine room, and the dyer room were opened while soiled laundry was washed and clean laundry was dried and folded. LA AP and AO stated they were long term employees and had not been trained on how to handle soiled infectious disease laundry. LA AP stated she used common sense to handle soiled infectious disease laundry and used gloves for the handling of soiled infectious disease laundry. LA AP stated the soiled infectious disease laundry was stored in cardboard boxes and stored in the soiled laundry room. LA AP stated the laundry department was small and the clean wet blankets needed to be hung to dry in the soiled laundry room alongside of the soiled infectious disease laundry. LA AO agreed. The HK Dir stated training for infectious disease prevention and control was outside of his scope, but he had received training from the DON on general infection prevention and control measures for example donning and doffing PPE while providing direct care to residents who were under isolation precautions. The HK Dir stated soiled laundry from residents' rooms which were under infection isolation would be placed into plastic bags and then into biohazard cardboard boxes and then delivered to the soiled laundry room. The HK Dir stated he would report the lack of training, lack of PPE, and potential cross-contamination of clean and soiled laundry to the DON. During an interview on 4/5/2025 at 5:15 PM with the DON and the Administrator, the Administrator stated he had received a report of potential cross-contamination in the laundry department. The Administrator stated storing clean laundry in the soiled laundry room and not wearing full PPE while handling soiled infectious laundry placed residents and staff at risk for cross-contamination and at risk for contracting an infection; the DON concurred. A record review of the facility's Infection Prevention and Control Program dated 3/2022, revealed, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. 5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Clean linen shall be separated from soiled linen at all times. A record review of the United States of America's Centers for disease Prevention and Control's website Long-term Care Facilities; Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html Accessed 4/5/2025, revealed, Residents in nursing homes are at increased risk of becoming colonized and developing infection with MDROs. Enhanced Barrier Precautions require staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading an MDRO. These include the following residents: - Residents known to be infected or colonized with an MDRO; - Residents with an indwelling medical device including central venous catheter, urinary catheter, feeding tube (PEG tube, G-tube), tracheostomy/ventilator regardless of their MDRO status; - Residents with a wound, regardless of their MDRO status High-contact resident care activities where a gown and gloves should be used, which are often bundled together as part of morning or evening care, include: - Bathing/showering, - Changing bed linens, . Should Environmental Services (EVS) or housekeeping personnel wear gowns and gloves when cleaning and disinfecting rooms of residents on Enhanced Barrier Precautions? . The research that was the basis for the current guidance evaluated high-contact resident care activities, not specifically the risk of transmission of MDROs to the hands or clothing of Environmental Services (EVS) or housekeeping personnel. However, changing linen is considered a high contact resident care activity; gowns and gloves should be worn by EVS personnel if they are changing the linen of residents on Enhanced Barrier Precautions and could be considered for additional environmental services or housekeeping responsibilities that involve extensive contact with the resident or the resident's environment.