

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Avir at Kerrville		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 Bandera Hwy Kerrville, TX 78028	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain 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 disease and infection for 5 of 7 residents (Residents #1, #2, #3, #4, and #5) reviewed for infection control:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure MA-A sanitized the wrist blood pressure cuff in-between use with Residents #1 and #2 on 06/05/2025. 2. The facility failed to ensure LVN-B sanitized her hands in between feeding and assisting Residents #3, #4 and #5 with their breakfast meal on 06/05/2025. <p>These failures could place residents at risk for infection due to improper care practices.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #1's admission record revealed he was an [AGE] year-old man admitted on [DATE] with diagnoses which included: Essential (Primary) Hypertension. <p>Record review of Resident #1's Order Summary dated 06/05/2025 revealed an order for Labetalol HCL oral table 200mg, give one tablet by mouth three times a day for HTN. Hold for SBP less than 110 DBP less than 60 and/or pulse less than 60.</p> <p>Record review of Resident #2's admission record dated 06/05/2025 revealed she was an 88 -year-old woman admitted on [DATE] with diagnoses which included: Essential (Primary) Hypertension.</p> <p>Record review of Resident #2's Order Summary dated 06/05/2025 revealed an order for Irbesartan Oral Tablet 150 mg - Give one tablet by mouth one time a day for HTN give with 75mg tab to equal 225mg related to Essential (Primary)Hypertension Hold for SBP less than 110, DBP less than 60.</p> <p>During an observation on 06/05/2025 at 06:21 a.m. MA-A was observed to take the blood pressure for Resident #1 using a wrist blood pressure cuff, without first sanitizing the blood pressure cuff, then placed the cuff on the medication cart, proceeded to administer Resident #1 his medications, and then without sanitizing the blood pressure cuff, took Resident #2's blood pressure with that same wrist blood pressure cuff.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER Avir at Kerrville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with MA-A on 06/05/2025 at 06:42 a.m., MA-A stated she had taken the blood pressure for Residents #1 and #2 without sanitizing the wrist blood pressure cuff prior and in-between the two residents. MA-A stated she just forgot, but knew she was supposed to sanitize the blood pressure cuff in between use with different residents. She stated that not sanitizing the blood pressure cuffs in between each resident could result in the spread of germs. MA-A stated she had received training in infection control.</p> <p>Record review of MA-A CNA Proficiency Audit dated 05/23/2025 revealed she was satisfactory in task of prevents cross contamination and infection control awareness.</p> <p>2. Observation on 06/05/2025 starting at 7:12 a.m. in the main dining room revealed LVN-B feeding Resident #3, then after Resident #3 was through eating, LVN-B pushed Resident #3's dishes/glass away and moved to sit next to Resident #4 and without sanitizing her hands started feeding Resident #4. At 7:29 a.m., when Resident #4 was finished with his meal, LVN-B was observed to clear dishes that belonged to Resident #4, and then relieve another staff member who had been feeding Resident #5, and without sanitizing her hands completed feeding Resident #5.</p> <p>During an interview with LVN-B on 06/05/2025 at 7:46 a.m., LVN-B stated she did not wash or sanitize her hands in-between feeding the 3 different residents because she saw Resident #4 had not been feeding himself, and she did not want him to wait, she wanted to make sure all the Residents were fed. LVN-B stated she knew she was supposed to wash/sanitizer her hands in between feeding the different residents and that she had received training in infection control. LVN-B stated that not sanitizing her hands in between feeding different residents could result in the spread of germs.</p> <p>Record review of LVN-B's Licensed Nurse Annual Competency dated 04/09/2025 revealed she was assessed as competent in Hand Hygiene, and Standard and Transmission Based Precautions.</p> <p>During an interview with the DON on 06/05/2025 at 09:23 a.m., the DON stated MA-A should have sanitized the blood pressure cuff in between usage with different residents, and that not sanitizing the cuff could result in the spread of infection. The DON also stated that LVN-B should have washed or sanitized her hands in between feeding the 3 different residents, and not sanitizing her hands could result in cross contamination and the spread of infection. The DON stated that both MA-A and LVN-B had received training in infection control.</p> <p>Record Review of facility policy titled Standard Precautions revised September 2022 revealed hand hygiene is performed with ABHR or soap and water: (1) before and after contact with the resident and Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed.</p>		