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	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kerrville	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures to prohibit and prevent neglect. The facility failed to ensure that all alleged violations involving neglect were reported immediately, but not later than 2 hours after the significant medication error was discovered for 1 of 3 residents (Resident #1). The facility failed to report an injury from a medication error to HHSC when Resident #1 was noted as receiving twice the ordered daily dose of medication causing confusion and was sent to the hospital on [DATE]. This failure could place residents at risk for further neglect.The findings included: Review of Resident #1's face sheet, dated 10/24/25, revealed she was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by systemic metabolic disturbances) and muscle weakness. Review of Resident #1's quarterly MDS assessment, dated 10/24/25, revealed her BIMS score was 12 out of 15 reflective of moderate cognitive impairment. Review of Resident #1's Care Plan, revised 8/1/25, revealed:She was at risk for falls related to an acute medical condition with impaired mobility requiring encouragement to stay in common areas to promote more supervision.She had a nutritional problem related to swallowing problems that required encouragement and assistance with alternating small bites with thorough chewing and sips of a beverage. Observation and reporting of choking, coughing, and not swallowing food to the nurse.She had impaired coping required evaluation of the cause of fear or anxiety.She was at risk of harm: self-directed or other-directed requiring medication and contacting the provider if the resident posed a potential threat to injure herself or others.Record review of Resident #1's TAR record for September of 2025 and October of 2025 revealed that wound care for the left ankle was to be performed once a day with an order start date of 8. 14.2025. Wound care for the lower left buttocks was to be performed once a day with an order start date of 8. 27.2025. Review of hospital report dated 11/28/25 revealed Resident #1 is an [AGE] year-old Caucasian female with past medical history of advanced dementia who presents with worsening mental status over the last few days. Apparently her donepezil was increased from 10 mg to 20 mg daily accidentally and since then has had worsening in her mentation. On my evaluation she is alert to person only. I do not know what her baseline mental status is so we will need to discuss with her son when he is available. Workup is otherwise negative for any source of infection. Record review of Resident #1s orders on the EMR revealed: A starting dose of Donepezil (dementia medication) HCL Oral Tablet 5 MG (Donepezil Hydrochloride) to be given once per day on 7/1/2025 with an end date of 8/11/2025. The dose was increased on 8/11/2025 to two 5 MG tablets given once per day with an end date of 8/13/25. A replacement order of two 5 MG tablets was placed on 8/14/2025 with an end date of 11/13/25. A replacement order of Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) given two times a day was started on 11/14/25 and ended with the 0800 dose on 11/27/25 following the residents worsening mental status and discovery that the resident was receiving twice the recommended dose per a dose warning next to the order which stated The frequency of 2 times per day exceeds the usual frequency of daily. The ordered dose of Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) given one time a day started on 12/1/25 when the resident returned from the hospital on [DATE] with an end date of 12/10/2025. The identical proceeding dose was ordered for the dates of 12/10/25 with an end date of 12/24/25. Record review of facility's policy with a revision date of April 2021 on Abuse, Neglect, Exploitation and Misappropriation Prevention Program read in the relevant parts: Policy StatementResidents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and ImplementationThe resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to:a. facility staff;5. Establish and maintain a culture of compassion and caring for all residents and particularly those withbehavioral, cognitive or emotional problems. 9. Investigate and report any allegations within timeframes required by federal requirements. Interview and record review on 12/12/25 at 5:15 PM with the ADMIN revealed that the significant medication error for Resident #1 was not reported to HHSC. He revealed that a medication error incident report was created after the incident, and the cause of the error was investigated to determine corrective actions. He provided records showing LPN A

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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 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 3 residents (Resident #1) reviewed for drug administration in that:Resident #1 was administered one tablet of Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) twice a day from 11/14/2025 to 11/26/2025. The physician order was 1 tablet of Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) once a day.The noncompliance was identified as PNC. The facility had corrected the noncompliance before the survey began.This deficient practice could affect residents who receive medications by administering an incorrect dose which could cause injury to the residents.The findings were: Review of Resident #1's face sheet, dated 10/24/25, revealed she was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by systemic metabolic disturbances) and muscle weakness. Review of Resident #1's quarterly MDS assessment, dated 10/24/25, revealed her BIMS score was 12 out of 15 reflective of moderate cognitive impairment. Review of Resident #1's Care Plan, revised 8/1/25, revealed:She was at risk for falls related to an acute medical condition with impaired mobility requiring encouragement to stay in common areas to promote more supervision.She had a nutritional problem related to swallowing problems that required encouragement and assistance with alternating small bites with thorough chewing and sips of a beverage. Observation and reporting of choking, coughing, and not swallowing food to the nurse.She had impaired coping required evaluation of the cause of fear or anxiety. She was at risk of harm: self-directed or other-directed requiring medication and contacting the provider if the resident posed a potential threat to injure herself or others.Record review of Resident #1's TAR record for September of 2025 and October of 2025 revealed that wound care for the left ankle was to be performed once a day with an order start date of 8.14.2025. Wound care for the lower left buttocks was to be performed once a day with an order start date of 8.27.2025. Review of hospital report dated 11/28/25 revealed Resident #1 is an [AGE] year-old Caucasian female with past medical history of advanced dementia who presents with worsening mental status over the last few days, Apparently her donepezil was increased from 10 mg to 20 mg daily accidentally and since then has had worsening in her mentation. On my evaluation she is alert to person only. I do not know what her baseline mental status is so we will need to discuss with her son when he is available. Workup is otherwise negative for any source of infection. Record review of Resident #1s orders on the EMR revealed: A starting dose of Donepezil (dementia medication) HCL Oral Tablet 5 MG (Donepezil Hydrochloride) to be given once per day on 7/1/2025 with an end date of 8/11/2025. The dose was increased on 8/11/2025 to two 5 MG tablets given once per day with an end date of 8/13/25. A replacement order of two 5 MG tablets was placed on 8/14/2025 with an end date of 11/13/25. A replacement order of Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) given two times a day was started on 11/14/25 and ended with the 0800 dose on 11/27/25 following the residents worsening mental status and discovery that the resident was receiving twice the recommended dose per a dose warning next to the order which stated The frequency of 2 times per day exceeds the usual frequency of daily. The ordered dose of Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) given one time a day was started on 12/1/25 when the resident returned from the hospital on [DATE] with an end date of 12/10/2025. The identical proceeding dose was ordered for the dates of 12/10/25 with an end date of 12/24/25. Record review of the MAR for the month of November revealed that Resident #1 was administered Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) twice a day starting on 11/14/2025 through 11/26/2025. Observation and interview on 12/11/25 at 11:07 AM revealed Resident #1 was sitting in her wheelchair in the entrance common area alone reading a magazine. Resident #1 easily engaged in conversation and stated that her stay was going beautifully. Resident #1 did not always provide answers to this surveyor's questions that made sense. She spoke about her family in detail. The interview was concluded early because answers did not align with the questions. Interview on 12/12/25 at 1:03 PM with the ADON revealed that the ordered Donepezil dose for Resident #1 was 10 MG one time per day. She stated Resident #1 received a larger dose of Donepezil 10 MG twice a day for roughly 2 weeks. She stated that the error was realized after the daughter communicated to the facility that the insurance would not cover the administration of more than one Donepezil 10 mg tablet per day. She stated that the injury to Resident #1 that she was aware of was an

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 6 of 8 residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7). The facility failed to ensure Resident #2's treatment administration record noted wound care treatments on 12/6/2025, 12/8/2025 and 12/9/2025 as required by the orders noted on the electronic medical record. The facility failed to ensure Resident #3's treatment administration record noted wound care treatments on 12/4/2025, 12/6/2025, 12/7/25, and 12/8/2025 as required by the orders noted on the electronic medical record. The facility failed to ensure Resident #4's treatment administration record noted wound care treatments on 12/4/2025, 12/6/2025, 12/7/2025, and 12/8/2025 as required by the orders noted on the electronic medical record. The facility failed to ensure Resident #5's treatment administration record noted wound care treatments on 12/8/2025 and 12/10/2025 as required by the orders noted on the electronic medical record. The facility failed to ensure Resident #6's treatment administration record noted wound care treatments on 12/3/2025 and 12/6/2025 as required by the orders noted on the electronic medical record. The facility failed to ensure Resident #7's treatment administration record noted wound care treatments on 12/4/2025, 12/6/2025, 12/7/2025, and 12/8/2025 as required by the orders noted on the electronic medical record. This failure could place residents at risk of not receiving necessary care and services daily as ordered by the physician to promote proper healing of active wounds.Findings include:Record review of Resident #2's admission record, printed on 12/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 was diagnosed with unspecified cirrhosis of the liver (late-stage liver disease).Record review of Resident #2's treatment administration record for December of 2025 reflected wound care to a right-hand skin tear was to be performed once a day with an order start date of 11/15/2025 and an end date of 12/11/2025. Record review of Resident #2's treatment administration record for the month of December of 2025 reflected staff failed to mark completion of wound care treatment on 12/6/2025, 12/8/2025 and 12/9/2025 as required by the orders noted on the electronic medical record.Record review of Resident #3's admission record, printed on 12/12/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 was diagnosed with atherosclerosis (plaque buildup) of native arteries of extremities with gangrene (tissue death due to lack of blood supply), left leg.Record review of Resident #3's treatment administration record for December of 2025 reflected wound care to an above knee amputation, right groin, and left groin was to be performed once a day with an order start date of 11/21/2025 and no end date specified for the amputation. An end date of 12/11/25 for the right and left groin transitioning to a new order. Record review of Resident #3's treatment administration record for the month of December of 2025 reflected staff failed to mark completion of wound care treatment on 12/4/2025, 12/6/2025, 12/7/25, and 12/8/2025 as required by the orders noted on the electronic medical record.Record review of Resident #4's admission record, printed on 12/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 was diagnosed with spinal stenosis (narrowing of the spinal canal), lumbar region with neurogenic claudication (leg pain caused by nerve compression).Record review of Resident #4's treatment administration record for December of 2025 reflected wound care to an incision on the right upper back and staples to the medial and lateral back was to be performed once a day with an order start date of 12/3/2025 and no end date specified. Record review of Resident #4's treatment administration record for the month of December of 2025 reflected staff failed to mark completion of wound care treatment on 12/4/2025, 12/6/2025, 12/7/25, and 12/8/2025 as required by the orders noted on the electronic medical record.Record review of Resident #5's admission record, printed on 12/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 was diagnosed with cerebral infarction (stroke) due to unspecified occlusion (blockage) or stenosis (narrowing of the spinal canal) of right middle cerebral artery. Record review of Resident #5's treatment administration record for December of 2025 reflected wound care to a right distal thigh was to be performed once every other day with an order start date of 11/16/2025 and no end date specified. Record review of Resident #5's treatment administration record for the month of December of 2025 reflected staff failed to mark completion of wound care treatment on 12/8/2025 and 12/10/2025 as required by the orders noted on the electronic medical record.Record review of Resident #6's admission record, printed on 12/12/2025, reflected a [AGE] year-old female who was admitted to the facility