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	01/14/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 and failed to determine that drug records were in order and that an account of all controlled drugs was maintained for 2 of 4 residents (Resident #1 and Resident #2) reviewed for narcotic reconciliation. Resident #1 was missing narcotic medication (Tramadol) on 12/23/25. Resident #2 was missing a narcotic medication (Hydrocodone) on 12/23/25. This failure could place residents at risk for not receiving therapeutic effects of treatment. The findings include: Resident #1 Record review of Resident #1's face sheet dated 1/13/26, reflected a female age [AGE] who was admitted on [DATE] with diagnoses that included: fracture of third lumbar vertebra (break in the lower back), cellulitis (bacterial infection of the skin), difficulty walking and cognitive communication deficit. The RP was listed as a family member. Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident's BIMS score was 11 indicative of moderately impaired cognition. Resident #1 required extensive assistance with her activities of daily living. Record review of Resident #1's CP, undated, had the goal of pain management and an intervention was to give the resident opioid medications for the control of pain. Record review of Resident #1's physician orders dated December 1, 2025 reflected the order for Tramadol 50 mg every four hours PRN. Record review of Resident #1's December 2025 MAR reflected: no tramadol given on 12/23/25.[focus or record review was drug diversion in December 2025] Record review of Resident #1's narcotic blister pack for Tramadol 50 mg revealed one tablet was punched out but not reconciled with the narcotic count sheet. Record review of Resident #1's Orders Administration Note dated 12/23/25 at 5:53 AM authored by RN A reflected it was unknown whether the resident received the Tramadol 50 mg PRN on 12/2325. Resident #2 Record review of Resident #2's face sheet dated 1/13/26 reflected the resident was a [AGE] year-old female admitted on 11/ 9/2025 with diagnoses that included: pulmonary embolism (blood clot in the lung), urinary tract infection, and cognitive communication deficit. The RP was listed as the resident. Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident's BIMS score was 13 indicative of no impairment in cognition. ADLs were listed as extensive assistance was required. Record review of Resident #2's CP, undated, had a goal of pain management with the intervention of resident prescribed Hydrocodone PRN every 6 hours. Record review of Resident #2's physician orders dated December 1, 2025, reflected an order for Hydrocodone 10-325 mg PRN every 6 hours for pain management. Record review of Resident #2's narcotic blister pack for Hydrocodone 10-325 mg revealed one tablet was punched out but not reconciled with the narcotic count sheet. Record review of Resident #2's Orders Administration Note dated 12/23/25 at 5:53 AM authored by RN A reflected it was unknown whether the resident received the Hydrocodone 10-325 mg PRN on 12/23/25. Record review of facility's internal investigation file dated 12/24/25 reflected:Details of Incident: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	01/14/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was alleged that Residents #1 and #2 were missing 1 tramadol and 1 Norco and documentation [reconciliation sheets] were not completed. Written statement by RN A dated 12/23/25 reflected there were two missing narcotics on 12/23/25 involving Resident #1 and Resident #2.Written statement by MA B dated 12/23/25 reflected MA B could not remember whether the narcotics were given on 12/23/25 to Resident #1 and Resident #2. MA B admitted in her written statement not documenting or reconciling narcotic medications on 12/23/25. During an interview and observation on 1/13/26 at 10:35 AM, Resident #1 was in her room sitting on a W/C, alert and oriented to person and place. The Resident revealed no signs of pain. The resident had no bruises, skin tears, or injuries. The resident stated she had chronic pain for a past hip problem. She described her pain as mild today (1/13/26). The resident stated she received her pain medication on time. The resident did not remember receiving a pain pill on 12/23/25 involving Tramadol. The resident stated the Tramadol was PRN, at night. Observation and interview on 1/13/26 at 10:53 AM, Resident #2 was in bed watching TV; alert and oriented X3. Catheter was present (no issues). There were no injuries, skin tears, or bruises present on Resident #2. Also, Resident #2 did not exhibit signs of pain. The resident stated she received Norco (Hydrocodone) when needed for her pain. The resident stated that she was asked about the missing Norco on 12/23/25 by nursing staff. The resident stated she did not remember whether she requested the PRN Norco on 12/23/25. The resident stated if she requested a Norco and was not given one, she would be in pain. During a telephone interview on 1/14/26 at 9:30 AM, LVN C stated she reconciled the narcotics on 12/23/25 belonging to Resident #1 and Resident #2 on 12/23/25 with RN A and the count was correct for Resident #1 and Resident #2. LVN C stated the latter residents had received PRN narcotics on 12/22/25 LVN C stated she [LVN C] did not reconcile with MA A who was not present at the time reconciliation occurred with RN A. During a telephone interview on 1/14/26 at 9:35 AM, RN A stated she did not reconcile with MA B when the latter [MA B] arrived on duty and took the 200 Hall cart. RN A stated that MA B did not request a reconciliation count involving Resident #1 or Resident #2. RN A stated she did not remember whether she reconciled the narcotics with MA B when MA B was given the cart for 200 Hall RN A stated she only reconciled with LVN C at shift change. During an interview on 1/14/26 at 10:06 AM, the Administrator stated the timeline was as follows:LVN C on 12/23/25 was ending her shift at 6:00 AM and reconciled the narcotic count with RN A. The count revealed that Resident #1 and R#2 had received PRN narcotics on 12/22/25.MA B arrived sometime on 12/23/25 in the morning and took possession of Hall 200 cart without reconciling with RN A.MA B attempted a transfer of the Hall 200 cart with LVN D at shift change at 6:00PM.LVN D refused the cart exchange because two controlled substances were not accounted for Resident #1 and Resident #2; and she notified the Administrator.Internal investigation revealed two narcotics were missing and the blister packs pushed by someone. MA B denied giving the missing narcotics to the residents or pushing the blister packs. MA B only admitted not reconciling the narcotic counts with RN A. During an interview on 1/13/26 at 11:50 AM, the DON stated after the diversion of narcotics was discovered on 12/23/25, nursing staff received in-service training on drug diversion which emphasized the importance of documentation and reconciliation. During an interview on 1/13/26 at 2:54 PM, the Administrator stated: on 12/23/25 he was informed by LVN D that there were two narcotic discrepancies; Resident #2 was short 1 Norco medication and Resident #1 was missing 1 Tramadol medication. The Administrator stated based on a narcotic drug count confirmed the said medications were missing. The Administrator stated he called Law Enforcement, and a Case number was assigned; but not investigated. The Administrator stated drug tests were done on the nursing staff that had access to the missing narcotics, and the results were negative to include MA B. The Administrator stated MA B revealed she did not reconcile the narcotics for Cart 200 when she (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	01/14/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	came on duty with RN A. The Administrator stated MA B had no excuse for not reconciling when on duty (6:00 AM-6:00 PM). The Administrator stated the missing narcotics could not be found or explained. The Administrator stated MA B did not know whether the PRN medications were given to Resident #1 and Resident #2 on 12/23/25. The Administrator stated he interviewed Resident #1 and Resident #2 and neither resident could remember receiving the PRN narcotic medications on 12/23/25. The Administrator stated the residents suffered no harm from no administration of PRN medications on 12/23/25. The Administrator stated a preventative measure put in place was in-service training on documentation and reconciliation for all nursing staff. During a telephone interview on 1/13/26 at 3:51PM, the NP stated Resident #1 and Resident #2 suffered no ill effects by not getting PRN narcotics on 12/23/25. The NP stated she closely monitored the residents' pain levels and would give additional pain orders in the event the residents were in uncontrolled pain. During a telephone interview on 1/13/26 at 3:20 PM, DLVN stated she refused to reconcile the narcotic sheets on 12/23/25 with MA B. LVN D stated that MA B had no explanation for the missing narcotics and could not remember whether the medications were administered. During a telephone interview on 1/13/26 at 3:25 PM, MA B stated she did not count the narcotic medications because she was overwhelmed and got distracted on 12/23/25. MA B stated she did not give the missing medications to the residents on 12/23/25. MA B stated she noticed the missing medications when involved in shift change with LVN D and the narcotics count was not reconciled for Resident #1 and Resident #2. MA B stated she attended training on drug diversion, and the highlight was to reconcile and document the reconciled narcotics. Record review of facility's Drug Discrepancies/Diversion of Medications policy dated 12/2025 read: .All discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report file.

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	01/14/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and controlled drugs must be stored in separately locked, permanently affixed compartments for 1 of 1 container reviewed (Resident #3) for proper storage for destruction of narcotics. Resident #3's, a DEA controlled substance (valium), was not stored appropriately in a double locked container. This failure could place residents at risk of not receiving prescribed medications as ordered and drug diversions. The findings include: Record review of Resident #3's face sheet dated 1/13/26 reflected the resident was a [AGE] year-old male admitted on [DATE]. The resident's diagnoses included: surgical aftercare on the digestive system, vertigo (dizziness) and intestinal obstruction. The RP was listed as a family member. Record review of Resident #3's quarterly MDS dated [DATE] reflected the resident's BIMS score was 13 indicative of no impairment in cognition. The resident's ADLs indicated the resident was continent and only required supervision for transfer and mobility. The resident had no range of motion impairments and used a walker as an assistive device. Record review of Resident #3's physician orders for December 2025 reflected no order for diazepam (valium). Record review of Resident #3's December 2025 reflected no administration of diazepam (valium). Observation on 1/13/26 from 11:15 AM to 12:30 PM of medication carts, and medication room revealed all narcotic medications were reconciled. [Cart 100, Cart 200, Cart 300, and Cart 400]. Further observation of the drug storage room (DON's Office) revealed there was a double lock system in place. Further there was a locked container with narcotics and a biological waste box with multiple medications in the vicinity of the locked container. Observation of inventory and reconciliation of the locked narcotic cabinet revealed all narcotic drugs, and resident sheets were reconciled by LVN E. Also, observation of the biological waste box no [NAME] locked with multiple medications revealed one narcotic blister pack without a resident sheet in the waste box belonging to Resident #3. The narcotic medication was diazepam 5 mg 1 tab PRN 30 minutes prior to imaging (dated 1/5/2026) for Resident #3. During an interview on 1/13/26 at 12:25 PM, LVN E stated the narcotic blister pack found in the biological waste basket was not correct for narcotic storage. LVN E stated the said medication was also missing a corresponding resident medication sheet detailing the medication, dosage, and administration. LVN E stated the lack of a resident medication sheet could lead to drug diversion. LVN E stated she had no explanation why a narcotic sheet was not present with the narcotic medication found in the biological waste box for destruction. During a telephone interview on 1/13/26 at 12:35 PM, the Pharmacist stated that narcotic medications intended for destruction needed to be stored with other narcotics in a locked container with the corresponding resident sheet. The Pharmacist stated the facility did not follow correct storage procedures based on the narcotic blister sheet found in a waste box. The Pharmacist stated that not safely storing narcotics and not having corresponding medication sheets could lead to drug diversion. During an interview on 1/13/26 at 3:19 PM, the Administrator stated by per their drug diversion policy, -controlled substances scheduled for destruction need to be stored in a 2-lock system. The Administrator stated the facility's two lock system was a locked storage room in DON's Office with a locked container. The Administrator stated the controlled substance needed a corresponding resident sheet. The Administrator stated he had no explanation for Resident #3's blister pack found in a waste box not safely stored and no resident sheet. The Administrator stated the former DON responsible for the destruction of storage room left employment 12/12/25. During an interview on 1/13/26 at 3:57 PM, the current DON stated (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	01/14/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she started employment on 1/2/2026. The DON stated the controlled substances needed to be stored in a 2-lock system and stored in locked container. The DON stated narcotics should not be stored in a biological waste box with other medications. Also, the DON stated any narcotic scheduled for destruction needed to have a corresponding resident sheet. During an interview on 1/13/26 at 4:35 PM, the ADON stated: Resident #3 went out on pass and came back with the medication (diazepam (valium) around 1/6/26 and gave the medication to an unknown nurse. ADON stated she, a few days later, found the said medication in medication cart 100 and threw it in the biological waste box in the locked DON storage room; and did not store it in the double locked container or completed a resident narcotic sheet. During a telephone interview on 1/14/26 at 10:45 AM, Resident #3 stated he brought into the facility a urologist medication (blister pack) around New Years and gave it to an unknown nurse. Resident #3 stated he did not know the purpose of the medication and did not remember whether he ever received the medication [diazepam 5 mg] he brought in from the outside into the facility. Record review of facility's Controlled Substances policy dated revised November 2022 read: .Controlled substances remaining in the facility after the order has been discontinued or the resident has been discontinued, or the resident has been discharged are securely locked in an area with restricted access until destroyed.