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	02/06/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the assessment accurately reflected the resident's status for one (1) of five (5) residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1 was coded on her Quarterly MDS assessment, signed as completed on 01/12/2026, for a wound that was acquired on 12/03/2025. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Record review of Resident #1's admission Record, dated 02/04/2026, reflected a [AGE] year-old female. She was admitted to the facility on [DATE]. Record review of Resident #1's Medical Diagnosis tab, dated 02/04/2026, reflected diagnoses which included cerebral infarction (a disruption in the blood flow to a part of the brain that can cause death of brain cells) due to unspecified occlusion (blockage) or stenosis (narrowing) of right middle cerebral artery (a blood vessel that supplies blood to the brain), rash and other nonspecific skin eruption, and methicillin resistant staphylococcus aureus infection (an infection caused by a type of staph bacteria that is resistant to many antibiotics making it difficult to treat). Record review of Resident #1's Quarterly MDS Assessment, dated 12/23/2025 and signed as complete by RN Assessment Coordinator A on 01/12/2026, reflected the resident had a BIMS score of 15, which indicated she was cognitively intact. She normally used a wheelchair and was dependent to roll left and right on the bed, to move from sitting to lying, from sitting to standing, and to transfer from the chair/bed-to-chair. She was noted to be at risk of developing pressure ulcers/injuries and was documented to not have any present skin ulcers, wounds, or skin problems. Section M - Skin Conditions of the MDS Assessment was signed as completed by LPN B on 01/01/2026. Record review of Resident #1's Care Plan Report, undated and accessed 02/04/2026 at 06:00 p.m., reflected the following focus and interventions/tasks:- Focus: Wound Management, date initiated 11/04/2025 - Intervention/Task: Provide wound care per treatment order, date initiated 11/04/2025. Record review of Resident #1's NP Progress Note, dated 12/04/2025 and signed on 12/06/2025, reflected: .Last hospitalization reason included.and RLE thigh wound with MRSA. Record review of Resident #1's .Skin Issues Progress Note, dated 12/17/2026, reflected: Skin Issues: Skin Issue: #001: Skin issue has been evaluated. Location: Right medial thigh. Issue type: Abscess. Record review of Resident #1's Treatment Administration Record, dated 01/01/2026 - 01/31/2026, reflected the orders:- Cleanse right distal [situated away from the center of the body] thigh wound.every day shift for spider bite, start date 12/23/2025 at 06:00 a.m. and discontinue date 01/15/2026 at 02:55 p.m.- Cleanse right distal thigh wound.one time a day for Lymphedema [a condition characterized by swelling caused by the accumulation of protein-rich fluid in the body's tissues], start date 01/16/2026 at 08:00 a.m. and discontinue date 01/29/2026 at 02:06 p.m.- Cleanse right distal thigh wound.at bedtime for Lymphedema, start date 01/29/2026 at 08:00 p.m. and without a discontinue date.- Cleanse right distal thigh wound.one time a day for Lymphedema Q Shift and PRN, start date 01/30/2026 at 08:00 a.m. and without a (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	02/06/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinue date. Record review of Resident #1's [company name] SKIN AND WOUND NOTE, dated 01/02/2026 with date of service and signature date of 01/01/2026, reflected: HPI: Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: subsequent encounter for skin and wound care.The resident presented with an atypical [not typical] lesion [damage or change to tissue area, such as a wound, ulcer, abscess, or tumor] to rt thigh, unknown duration.The resident has pre-existing ulcer of the rt thigh .Rt medial [situated in the middle] thigh wound . Wound is buried in lymphatic [relating to the lymphatic system which is a network of organs, vessels, and tissues that protect the body from infection and maintain the body's fluid balance] scar tissue.12/26/2025 Wound is embedded [fixed firmly and deeply in a surrounding mass] in lymphatic scar tissue.WOUND ASSESSMENT:Wound: 1Location: Rt medial thighPrimary Etiology: Lymphatic Ulcer. Record review of Resident #1's Wound Assessment Report, dated 01/28/2026 for date of service and signed 01/29/2026, reflected: Location: Rt medial thigh, Etiology [the cause]: Lymphatic Ulcer, and Date Wound Acquired: 12/03/2025. During an observation on 02/06/2026 at 08:24 a.m., Resident #1's wound care treatment by LPN C was observed. The wound was observed to be approximately the size of a split pea and located on her right inner thigh. During an observation and interview on 02/06/2026 at 11:17 a.m., Resident #1 was observed in her room, lying in bed, with the bed sheets covering her lower body and no wounds or skin issues visible. Resident #1 stated the staff came and were doing wound care on her wounds twice a day. She stated wound care had already been completed once today, 02/06/2026. She denied having any concerns regarding the wound care she had been receiving from the facility and did not believe any wound care treatments had been missed. During an interview on 02/06/2026 at 01:58 p.m., LPN C stated she had been working as the facility's wound care nurse for approximately three (3) weeks and a floor nurse for approximately one and a half (1.5) years. She stated Resident #1 admitted to the facility with her thigh wound and it was initially thought to have been a lymphatic wound. Attempted interview on 02/06/2026 at 03:30 p.m. with RN Assessment Coordinator A. RN Assessment Coordinator A did not answer, and an automated message stated the voicemail was not set up. During an interview on 02/06/2026 at 03:43 p.m., LPN B stated she completed resident assessments for the facility on a as needed basis and had only been needed once or twice. She did not recall Resident #1. LPN B stated she believed Resident #1's wound should have been coded in the MDS Assessment as an open ulcer. She stated if a wound did not specifically fit the options on the assessment, she would refer to the RAI manual and if the wound still did not meet the criteria, then she would have documented none of the above. She stated a lack of coding a resident's wound would not have impacted the resident's care because the resident would have still received the care per her care plan. During an interview on 02/06/2026 at 04:20 p.m., the DON stated she started her position and working for the facility one (1) month and four (4) days ago. The DON stated she was unfamiliar with MDS Assessments or how the assessment accuracy could impact a resident's care but stated if she was a nurse providing direct patient care, she would review the resident's care plan and orders for providing care. During an interview on 02/06/2026 at 05:03 p.m., the ADMIN stated he believed inaccurate wound care documentation in the MDS Assessment could impact the resident. He stated anything documented on the MDS Assessment would result in a trigger for care planning and if something was missing, the resident could be impacted because the care planning for the diagnosis or care need would not have been triggered. Record review of the facility's policy Comprehensive Assessments, dated 03/2022 and updated 02/2025, reflected: Policy StatementComprehensive assessments are conducted to assist in developing person-centered care plans.Policy Interpretation and Implementation1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident (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	02/06/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Instrument (RAI) User Manual.8. A ‘significant error' is an error in an assessment where: a. the resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and .9. A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status. Record review of the facility's policy Charting and Documentation, dated revised 07/2017, reflected: Policy StatementAll services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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	02/06/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (1) of five (5) residents (Resident #1) reviewed for quality of care. 1. LPN D failed to complete Resident #1's wound care on 01/26/2026 per physician order and documented an exception code for resident sleeping. 2. LPN E failed to complete Resident #1's wound care on the evening shift of 02/04/2026 and 02/05/2026 per physician order. These failures could place residents at risk of not receiving necessary medical care, harm, and hospitalization. The findings included: Record review of Resident #1's admission Record, dated 02/04/2026, reflected a [AGE] year-old female. She was admitted to the facility on [DATE]. Record review of Resident #1's Medical Diagnosis tab, dated 02/04/2026, reflected diagnoses included cerebral infarction (a disruption in the blood flow to a part of the brain that can cause death of brain cells) due to unspecified occlusion (blockage) or stenosis (narrowing) of right middle cerebral artery (a blood vessel that supplies blood to the brain), rash and other nonspecific skin eruption, and methicillin resistant staphylococcus aureus infection (an infection caused by a type of staph bacteria that is resistant to many antibiotics making it difficult to treat). Record review of Resident #1's Quarterly MDS Assessment, dated 12/23/2025, reflected the resident had a BIMS score of 15, which indicated she was cognitively intact. She normally used a wheelchair and was dependent to roll left and right on the bed, to move from sitting to lying, from sitting to standing, and to transfer from the chair/bed-to-chair. She was noted to be at risk of developing pressure ulcers/injuries and was documented to not have any present skin ulcers, wounds, or skin problems. Record review of Resident #1's Care Plan Report, undated and accessed 02/04/2026 at 06:00 p.m., reflected the following focus and interventions/tasks:- Focus: Wound Management, date initiated 11/04/2025 - Intervention/Task: Provide wound care per treatment order, date initiated 11/04/2025. Record review of Resident #1's Order Summary Report, dated active orders as of 02/04/2026, reflected the following order summaries with order status, order date, start date, and end date if available:- Cleanse right distal [situated away from the center of the body] thigh wound. at bedtime for Lymphedema [a condition characterized by swelling caused by the accumulation of protein-rich fluid in the body's tissues], order status active, order date 01/29/2026, start date 01/29/2026, and no end date.- Cleanse right distal thigh wound. one time a day for Lymphedema Q Shift and PRN, order status active, order date 01/29/2026, start date 01/30/2026, and no end date. Record review of Resident #1's Treatment Administration Record, dated 01/01/2026 - 01/31/2026, reflected the order Cleanse right distal thigh wound.one time a day for Lymphedema, start date 01/16/2026 at 08:00 a.m. and discontinue date 01/29/2026 at 02:06 p.m. On 01/26/2026 the exception code for Sleeping was entered and signed by LPN D. Record review of Resident #1's Treatment Administration Record, dated 02/01/2026 - 02/28/2026 and printed on 02/06/2026 at 04:20 p.m., reflected the order Cleanse right distal thigh wound.at bedtime for Lymphedema, start date 01/29/2026 at 08:00 p.m. On 02/04/2026 and 02/05/2026 LPN E documented the treatment was completed. Record review of Resident #1's Progress Notes, date range 01/05/2026 to 02/05/2026 and printed 02/04/2026 at 05:55 p.m. reflected no progress notes were entered on 01/26/2026. During an observation on 02/06/2026 at 08:24 a.m., Resident #1's wound care treatment by LPN C was observed. The wound was observed to be approximately the size of a split pea and located on her right inner thigh. The dressing on the wound prior to the current treatment provision was dated 02/05/2026. During an observation and interview on 02/06/2026 at 11:17 a.m., Resident #1 was observed in her room, lying (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	02/06/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in bed, with bed sheets covering her lower body and no wounds or skin issues visible. Resident #1 stated the staff came and were doing wound care on her wounds twice a day. She stated wound care had already been completed once today, 02/06/2026. She denied having any concerns regarding the wound care she had been receiving from the facility and did not believe any wound care treatments had been missed. During an interview on 02/06/2026 at 01:58 p.m., LPN C stated she had been working as the facility's wound care nurse for approximately three (3) weeks and a floor nurse for approximately one and a half (1.5) years. She stated Resident #1 admitted to the facility with her thigh wound and it was initially thought to have been a lymphatic wound. LPN C stated her expectation for wound care was the staff could complete a resident's treatment before the resident went to bed for the night; they should attempt to perform wound care before bedtime. LPN C stated she noticed wound care scheduled for Resident #1 during the evening shift had been missed a few times. She stated she observed the same bandage that she applied the day prior still on Resident #1's wound when she went to provide wound care the following morning and since Resident #1's wound care was now scheduled twice a day, the prior bandage should have been changed the previous night. LPN C stated she observed this yesterday, 02/05/2026, and today, 02/06/2026. LPN C stated she had not yet reported her findings to anyone but had meant to. LPN C stated the impact of Resident #1 having missed wound care treatments was she would be at risk for infection with the wound not healing properly. She stated Resident #1 did not report any concerns to her or why the treatments were not completed. She stated she was unaware if the night shift staff reported any reasons for the missed treatments, but she knew the treatment order was on their electronic administration record, so if they checked it off, it had not been done. During an interview on 02/06/2026 at 02:26 p.m., LPN D stated she had been working as the facility's ADON for approximately three (3) weeks but had worked at the facility since December 2025. She reported to have been familiar with Resident #1's wound but had not provided Resident #1 with wound care to her thigh recently. She said she expected staff to come back later if a resident was sleeping when wound care treatment was scheduled. She denied having ever skipped a wound care treatment due to a resident sleeping. She stated the impact of skipping a resident's wound care because the resident was sleeping could be that the wound could get worse or become infected. She revealed she and the DON assisted in working on the floor on January 24th through the 26th, 2026 due to the freezing temperatures. She stated she believed she might have missed one of Resident #1's scheduled wound care treatments during that time because she was called in, running late on medication administration, and was not able to get to the scheduled wound care. She said she was unsure on the exact date the missed wound care occurred. LPN D stated Resident #1 could be adamant about when she did and did not want to be bothered and if her wound care was not completed prior to 10:00 p.m., Resident #1 would not let the staff complete her wound care. During an interview on 02/06/2026 at 03:51 p.m., NP F stated she was the wound care NP and had been seeing residents at the facility for the last two (2) months and visited at least once a week. She stated Resident #1's thigh wound was not progressing well with a new concern for a possible infection. NP F stated she was not aware of any issues or concerns with Resident #1 having not received treatment per order because every time she observed the wound, it was properly dressed. NP F said at the current stage of the wound, she would not say that a missed treatment would have impacted Resident #1's care because she was more worried about the staff addressing the drainage from the wound and the possibility of an infection. NP F stated she did not believe the progression of the wound was due to missed wound care treatments and revealed the order was changed from one time a day to two times per day due to the amount of drainage the wound was producing. Attempted interview on 02/06/2026 at 04:02 p.m. with LPN E. LPN E did not answer, and a voice message (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	02/06/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was left with contact information and a request for a return call. Return call not received. During an interview on 02/06/2026 at 04:20 p.m., the DON stated she had not been notified Resident #1 had missed any wound care treatments. She stated her expectation for if a resident refused wound care was for the staff member to try their hardest to explain to the resident the outcomes should they miss the care. The DON stated the impact to a resident of missed scheduled wound care could be that the wound could progress from stage 1 (wound with intact skin) to stage 2 (an open wound) rapidly. The DON stated she did not believe sleeping was an acceptable exception for providing wound care. During an interview on 02/06/2026 at 05:03 p.m., the ADMIN stated a missed wound care could impact a resident. He stated if a resident was sleeping during a scheduled wound care, the staff member should check back with the resident or attempt to wake them up to give the resident the opportunity to say yes or no. The ADMIN revealed he would expect follow-up documentation. Record review of the facility's policy Wound Care, dated revised 10/2021 and updated 04/2024, reflected: PurposeThe purpose of this procedure is to provide guidelines for the care of wounds to promote healing.DocumentationThe following information should be recorded in the resident's medical record:1. The date the wound care was given.2. The initials of the individual performing the wound care.3. Any change in the resident's condition.4. Any problems or complaints made by the resident related to the procedure.5. If the resident refused the treatment and the reason(s) why.6. the signature and title of the person recording the data. Reporting1. Notify the supervisor if the resident refuses the wound care.2. Report other information in accordance with facility policy and professional standards of practice. Record review of the facility's policy Charting and Documentation, dated revised 07/2017, reflected: Policy StatementAll services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation .2. The following information is to be documented in the resident medical record: . c. Treatments or services performed; .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; . e. whether the resident refused the procedure/treatment; .

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	02/06/2026

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews, and record review, the facility failed to post nurse staffing information data requirements on a daily basis information that included the facility name, current date, total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift to include registered nurses, licensed practical or licensed vocational nurses, certified nurse aides and the resident census for one (1) of three (3) days (02/04/2026) reviewed for posting of required information. The facility failed to post the required current nurse staffing and census information on 02/04/2026. This failure could place residents at risk of not having access to information regarding staffing data and the facility census. The findings included: During an observation on 02/04/2026 from 03:15 p.m. to 04:06 p.m., a document or posting with the daily census and nurse staffing information could not be located during a facility tour. During an observation and interview on 02/04/2026 at 04:45 p.m., the ADMIN stated the daily census and nurse staffing posting was usually posted in front of the DON's office. The ADMIN pointed towards the DON's office door and indicated a clear display holder secured outside the door. The ADMIN stated it was usually the responsibility of the DON to post the document. The ADMIN stated the impact of not having the daily census and nurse staffing documentation posted was if someone were to ask about the information, they should be able to reference the type of staff, how many staff, and how many hours the staff were scheduled to work. He stated the nurse staffing schedule was on the nurses' station and if the posting was not available, the residents and facility guests could ask to view the schedule book. During an observation and record review on 02/04/2026 at 04:56 p.m., the ADMIN provided the document [facility name] 12/19/2025 [facility name]. The document was observed to include for each type of staff (registered nurses, licensed vocational nurses, certified nurse aides, medication aides, and staff training) the number of staff, hours scheduled, and total hours worked for the type of staff. The document also included the total number of hours worked for the day and the daily census. The document did not separate the type of staff, hours scheduled, and hours worked into shifts. During an interview on 02/04/2026 at 07:03 p.m., the ADMIN stated the daily census and nurse staffing document provided at 04:56 p.m. on 02/04/2026 was probably not completed correctly when asked about the 12/19/2025 date. During an interview on 02/06/2026 at 04:40 p.m., the DON stated she had started her position and working for the facility one (1) month and four (4) days ago. The DON stated she was not sure who was responsible for posting the daily census and nurse staffing document previously and did not know when the document was last posted. She stated the facility always had the nursing schedule available on the nurses' station. Record review of the facility's policy Posting Direct Care Daily Staffing Numbers, dated revised 08/2022, reflected: Policy StatementOur facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents.Policy Interpretation and Implementation1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.2.The information recorded on the form shall include the following: . b. The current date (the date for which the information is posted); . d. Twenty-four (24)-hour shift schedule operated by the facility; e. The shift for which the information is posted; f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); g. The actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed and non-licensed nursing staff working for the posted shift.3. Within two (2) hours of the beginning of each (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	02/06/2026

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.

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	02/06/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for four (4) of five (5) residents (Resident #1, Resident #2, Resident #3, and Resident #4) reviewed for clinical records. 1. The facility failed to ensure Resident #1's right thigh wound care treatments were documented in her medical record for 10 of 45 treatments (01/02/2026 during day shift, 01/03/2026 during day shift, 01/05/2026 during day shift, 01/15/2026 during day shift, 01/16/2026 at 08:00 a.m., 01/24/2026 at 08:00 a.m., 01/25/2026 at 08:00 a.m., 01/30/2026 at 08:00 a.m., 02/02/2026 at 08:00 p.m., and 02/03/2026 at 08:00 p.m.) scheduled between 01/01/2026 to 02/06/2026 (at 04:20 p.m.). 2. The facility failed to ensure Resident #1's diagnosis list was complete. 3. The facility failed to ensure Resident #2's tube feeds were documented in her medical record for 4 of 15 administrations (01/25/2026, 01/28/2026, 01/30/2026, 02/04/2026) scheduled between 01/21/2026 to 02/04/2026 (at 06:24 p.m.). 4. The facility failed to ensure Resident #3's imipenem-cilastatin (an antibiotic) was documented in his medical record for 3 of 25 administrations (01/29/2026 at 05:30 p.m., 01/30/2026 at 05:30 p.m., and 02/02/2026 at 05:30 p.m.) scheduled between 01/29/2026 at 05:30 p.m. to 02/04/2026 at 06:02 p.m. 5. The facility failed to ensure Resident #4's weekly weight was documented weekly in her medical record for 1 of 3 weeks (01/07/2026) between 12/22/2025 to 01/07/2026 per physician order. 6. The facility failed to ensure Resident #4's weight was documented 2 of 2 times (01/07/2026 and 01/21/2026) in her medical record per care plan and physician order. These failures could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included: 1. Record review of Resident #1's admission Record, dated 02/04/2026, reflected a [AGE] year-old female. She was admitted on [DATE]. Record review of Resident #1's Medical Diagnosis tab, dated 02/04/2026, reflected diagnoses which included cerebral infarction (a disruption in the blood flow to a part of the brain that can cause death of brain cells) due to unspecified occlusion (blockage) or stenosis (narrowing) of right middle cerebral artery (a blood vessel that supplies blood to the brain), rash and other nonspecific skin eruption, and methicillin resistant staphylococcus aureus infection (an infection caused by a type of staph bacteria that is resistant to many antibiotics making it difficult to treat). Record review of Resident #1's Quarterly MDS Assessment, dated 12/23/2025, reflected the resident had a BIMS score of 15, which indicated she was cognitively intact. She normally used a wheelchair and was dependent to roll left and right on the bed, to move from sitting to lying, from sitting to standing, and to transfer from the chair/bed-to-chair. She was noted to be at risk of developing pressure ulcers/injuries and was documented to not have any present skin ulcers, wounds, or skin problems. Record review of Resident #1's Care Plan Report, undated and accessed on 02/04/2026 at 06:00 p.m., reflected the following focus and interventions/tasks:- Focus: Wound Management, date initiated 11/04/2025 - Intervention/Task: Provide wound care per treatment order, date initiated 11/04/2025. Record review of Resident #1's Order Summary Report, dated active orders as of 02/04/2026, reflected the following order summaries with order status, order date, start date, and end date if available:- Cleanse right distal [situated away from the center of the body] thigh wound. at bedtime for Lymphedema [a condition characterized by swelling caused by the accumulation of protein-rich fluid in the body's tissues], order status active, order date 01/29/2026, start date 01/29/2026, and no end date.- Cleanse right distal thigh wound. one time a day for Lymphedema Q Shift and PRN, order status active, order date 01/29/2026, start (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	02/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date 01/30/2026, and no end date. Record review of Resident #1's Treatment Administration Record, dated 01/01/2026 - 01/31/2026, reflected the orders: - Cleanse right distal thigh wound.every day shift for spider bite, start date 12/23/2025 at 06:00 a.m. and discontinue date 01/15/2026 at 02:55 p.m. - The following dates reflected blanks or no entry into the treatment administration record: 01/02/2026, 01/03/2026, 01/05/2026, 01/12/2026, and 01/15/2026. - Cleanse right distal thigh wound.one time a day for Lymphedema, start date 01/16/2026 at 08:00 a.m. and discontinue date 01/29/2026 at 02:06 p.m. - The following dates reflected blanks or no entry into the treatment administration record: 01/16/2026, 01/24/2026, 01/25/2026, 01/28/2026, and 01/29/2026.Further review of the treatment administration record revealed the following licensed nursing staff provided Resident #1 treatment and/or medication provisions during the administration time of these orders: LPN D on 01/02/2026 and 01/25/2026, RN G on 01/03/2026, LPN I on 01/05/2026, 01/24/2026, and 01/30/2026; and RN H on 01/15/2026 and 01/16/2026. Record review of Resident #1's Treatment Administration Record, dated 02/01/2026 - 02/28/2026 and printed on 02/06/2026 at 04:20 p.m., reflected the order Cleanse right distal thigh wound.at bedtime for Lymphedema, start date 01/29/2026 at 08:00 p.m. and without a discontinue date. The following dates reflected an exemption code for Other / See Progress Notes into the treatment administration record by RN G on 02/02/2026 and by LPN J on 02/03/2026. Record review of Resident #1's Progress Notes, date range 01/01/2026 to 02/05/2026 and printed 02/04/2026 at 05:55 p.m. reflected:- on 01/02/2026, a [company name] SKIN AND WOUND NOTE, dated 01/02/2026 with date of service of 01/01/2026, reflected the wound care NP provided a wound care assessment on 01/01/2026. - on 01/12/2026, a .Skin Issues progress note and a Skin/Wound Note, dated 01/12/2026 were entered by LPN J. Both progress notes indicated wound care had been performed. - on 01/29/2026, a [company name] SKIN AND WOUND NOTE, dated 01/29/2026 with date of service of 01/28/2026, reflected the wound care NP provided a wound care assessment on 01/28/2026. - Progress notes indicating wound care was performed were not found for 01/02/2026, 01/03/2026, 01/05/2026, 01/15/2026, 01/16/2026, 01/24/2026, 01/25/2026, 01/29/2026, 01/30/2026, 02/02/2026, and 02/03/2026. Record review of Resident #1's MD Progress Note, dated 01/29/2026, reflected wound care was provided on 01/29/2026. During an observation on 02/06/2026 at 08:24 a.m., Resident #1's wound care treatment by LPN C was observed. The wound was observed to be approximately the size of a split pea and located on her right inner thigh. The dressing on the wound prior to the current treatment provision was dated 02/05/2026. During an observation and interview on 02/06/2026 at 11:17 a.m., Resident #1 was observed in her room, lying in bed, with bed sheets covering her lower body and no wounds or skin issues visible. Resident #1 stated the staff came and were doing wound care on her wounds twice a day. She stated wound care had already been completed once today, 02/06/2026. She denied having any concerns regarding the wound care she was receiving from the facility and did not believe any wound care treatments were missed. During an interview on 02/06/2026 at 01:58 p.m., LPN C stated she had been working as the facility's wound care nurse for approximately three (3) weeks and a floor nurse for approximately one and a half (1.5) years. She stated if a treatment or administration was not documented, then it was not done. She stated even if the staff member performed the treatment or administration, if they did not document then there was no proof the administration was done. She said Resident #1 did not report any concerns regarding missed treatments. She stated she knew the treatment order was on the licensed nurses' electronic administration record. During an interview on 02/06/2026 at 02:26 p.m., LPN D stated she had been working as the facility's ADON for approximately three (3) weeks but worked at the facility since December 2025. She reported to have been familiar with Resident #1's wound but had not provided Resident #1 with wound care to her thigh recently. She stated her process for documenting an administration or (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	02/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment was to check off the task prior to performing it and then save the administration or treatment as having been performed after the task was completed. She denied having ever skipped providing wound care treatment. She said between January 24th through the 26th, 2026, she believed she might have missed one of Resident #1's scheduled wound care treatments during that time because she was called in, running late on medication administration, and was not able to get to the scheduled wound care. She stated she was unsure on the exact date the missed wound care occurred. LPN D stated Resident #1 could be adamant about when she did and did not want to be bothered and if her wound care was not completed prior to 10:00 p.m., Resident #1 would not let the staff complete her wound care. She stated the impact of a resident having missed a scheduled wound care treatment could be that the wound could get worse or become infected. During an interview on 02/06/2026 at 03:51 p.m., NP F stated she was the wound care NP and had been seeing residents at the facility for the last two (2) months and visited at least once a week. She stated Resident #1's thigh wound was not progressing well with a new concern for a possible infection. NP F stated she was not aware of any issues or concerns with Resident #1 having not received treatment per order because every time she observed the wound, it was properly dressed. NP F stated at the current stage of the wound, she would not say that a missed treatment would have impacted Resident #1's care because she was more worried about the staff addressing the drainage from the wound and the possibility of an infection. NP F stated she did not believe the progression of the wound was due to missed wound care treatments and said the order was changed from one time a day to two times per day due to the amount of drainage the wound was producing. Attempted interview on 02/06/2026 at 03:50 p.m. with RN H. RN H did not answer, and the call failed, not allowing a voice message to be left. Attempted interview on 02/06/2026 at 03:57 p.m. with LPN I. LPN I did not answer, and a voice message was left with contact information and a request for a return call. Return call not received. Attempted interview on 02/06/2026 at 03:59 p.m. with RN G. RN G did not answer, and a voice message was left with contact information and a request for a return call. Return call not received. Attempted interview on 02/06/2026 at 04:01 p.m. with LPN J. LPN J did not answer, and an automated voice message stated the person was not accepting calls at this time. During an interview on 02/06/2026 at 04:20 p.m., the DON stated she had not been notified Resident #1 had missed any wound care treatments. The DON stated she viewed a blank in the administration record as though the administration was not documented and therefore was not done. The DON stated the impact to a resident of missed scheduled wound care could be that the wound could progress from stage 1 (wound with intact skin) to stage 2 (an open wound) rapidly. During an interview on 02/06/2026 at 05:03 p.m., the ADMIN stated he would interpret a blank as something he would need to investigate, to determine if the care was provided and if not, then it would constitute a medication error. He stated missed wound care could impact a resident especially if the resident did not receive the scheduled medication or treatment and a blank in the record could impact how another staff member would read the resident's record. Record review of the facility's policy Wound Care, dated revised 10/2010, reflected: PurposeThe purpose of this procedure is to provide guidelines for the care of wounds to promote healing.DocumentationThe following information should be recorded in the resident's medical record: 1. The date the wound care was given. 2. The initials of the individual performing the wound care. 5. If the resident refused the treatment and the reason(s) why. 6. the signature and title of the person recording the data.Reporting 1. Notify the supervisor if the resident refuses the wound care. 2. Record review of Resident #1's Medical Diagnosis tab, dated 02/04/2026, did not reflect diagnoses for lymphatic ulcer or lymphedema. Record review of Resident #1's [company name] SKIN AND WOUND NOTE, dated 01/02/2026 with date of service and signature date of 01/01/2026, reflected: HPI: (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	02/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: subsequent encounter for skin and wound care.The resident presented with an atypical [not typical] lesion [damage or change to tissue area, such as a wound, ulcer, abscess, or tumor] to rt thigh, unknown duration.The resident has pre-existing ulcer of the rt thigh .Rt medial [situated in the middle] thigh wound . Wound is buried in lymphatic [relating to the lymphatic system which is a network of organs, vessels, and tissues that protect the body from infection and maintain the body's fluid balance] scar tissue.12/26/2025 Wound is embedded [fixed firmly and deeply in a surrounding mass] in lymphatic scar tissue.WOUND ASSESSMENT:Wound: 1Location: Rt medial thighPrimary Etiology: Lymphatic Ulcer . Record review of Resident #1's Wound Assessment Report, dated 01/28/2026 for date of service and signed 01/29/2026, reflected: Location: Rt medial thigh, Etiology [the cause]: Lymphatic Ulcer, and Date Wound Acquired: 12/03/2025. Record review of MD Progress Note, dated 01/29/2026, reflected CC/HPI THIS VISITChief Complaint/Reason for this VisitMedically necessary visit to follow up on the Pt's Lymphatic wound.HPI Relating to this VisitPt.I was asked to see by [LPN C], the wound care nurse. Patient has a lymphatic ulcer on her right inner leg right above her knee.Lymphatic Wound: appears to have a lot of increased drainage . Record review of Resident #1's Order Summary Report, dated active orders as of 02/04/2026, reflected the following order summaries with order status, order date, start date, and end date if available:- Cleanse right distal thigh wound. at bedtime for Lymphedema, order status active, order date 01/29/2026, start date 01/29/2026, and no end date.- Cleanse right distal thigh wound. one time a day for Lymphedema Q Shift and PRN, order status active, order date 01/29/2026, start date 01/30/2026, and no end date. Record review of Resident #1's Wound Assessment Report, dated 02/04/2026 for date of service and signed 02/05/2026, reflected: Location: Rt medial thigh, Etiology [the cause]: Lymphatic Ulcer, and Date Wound Acquired: 12/03/2025. During an interview on 02/06/2026 at 01:58 p.m., LPN C stated she had been working as the facility's wound care nurse for approximately three (3) weeks and a floor nurse for approximately one and a half (1.5) years. She revealed Resident #1 admitted to the facility with her thigh wound and it was initially thought to have been a lymphatic wound. During an interview on 02/06/2026 at 04:20 p.m., the DON stated the process for adding a diagnosis to a resident's diagnosis list was the diagnosis would be added when the resident had an issue that came up during their admission and had not had the issue previously or it was not part of their initial admission diagnoses. The DON stated for Resident #1 lymphedema should be part of her diagnosis care. She revealed a missing diagnosis might impact care because it could result in the issue or concern not being provided proper care and the concern might worsen. During an interview on 02/06/2026 at 05:03 p.m., the ADMIN stated his expectation was for diagnoses to be added to a resident's diagnoses list if the diagnoses were concerns that were not resolved following hospitalization. He stated not having a diagnoses listed might impact a resident's treatment. 3. Record review of Resident #2's admission Record, dated 02/05/2026, reflected an [AGE] year-old female. She was initially/originally admitted to the facility on [DATE] and readmitted on [DATE]. She discharged on 02/04/2026 at 11:00 p.m. Record review of Resident #2's Medical Diagnosis tab, dated 02/04/2026, reflected diagnoses which included metabolic encephalopathy (a brain dysfunction caused by problems with the body's metabolism resulting in either the brain having been deprived of something it needs or having excess of something that is not needed), unspecified protein-calorie malnutrition (occurs when the body does not receive enough protein and calories to maintain proper health and functioning), and dysphagia (difficulty swallowing). Record review of Resident #2's five (5)-Day MDS Assessment, dated 01/26/2026, did not reflect the resident's BIMS score. She was documented as dependent for eating and all mobility performances. She was noted to be (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	02/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on a feeding tube on admission, while not a resident, and while a resident. Record review of Resident #2's Care Plan Report, undated and accessed on 02/04/2026 at 06:30 p.m., reflected the following focus and interventions/tasks:- Focus: Impaired Nutrition Diet NPO diet, NPO texture, NPO consistency, Nepro 1.8 [a type and concentration of a tube feed formula that is typically given to people with kidney problems] fs) continuously @ 35 ml/hr via PEG Tube, date initiated and revised 01/22/2026. - Intervention/Task: Ensure Resident is in proper position for eating, date initiated 01/22/2026. - Intervention/Task: Establish appropriate short and long term eating goals, date initiated 01/22/2026.- Focus: The resident requires PEG Tube feeding r/t Dysphagia, date initiated and revised on 01/22/2026. - Intervention/Task: The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders, date initiated 01/22/2026. Record review of Resident #2's Order Summary Report, dated active orders as of 02/04/2026, reflected the following order summary with order status, order date, start date, and end date if available:- Enteral [the delivery of nutrition directly into the digestive system, typically via a feeding tube] Feed Order one time a day for enteral feeding (Nepro 1.8 fs) continuously @ 35 ml/hr, order status active, order date 01/20/2026, start date 01/21/2026, and no end date. Record review of Resident #2's Medication Administration Record, dated 01/01/2026 - 01/31/2026, reflected the order: - Enteral Feed Order one time a day for enteral feeding (Nepro 1.8 fs) continuously @ 35 ml/hr, start date 01/21/2026 at 09:30 a.m. and no discontinue date. The treatment was documented as scheduled at 09:30 a.m. - On 01/23/2026 and 01/28/2026, the exemption code for Other / See Progress Notes was entered into the treatment administration record by LPN K. - On 01/25/2026 and 01/30/2026, a blank or no entry was found in the treatment administration record. Further review of the treatment administration record revealed the following licensed nursing staff provided Resident #2 treatment and/or medication provisions during the administration time of these orders, LPN C on 01/25/2026. A licensed nursing staff for 01/30/2026 was not identified. Record review of Resident #2's Medication Administration Record, dated 02/01/2026 - 02/28/2026 and printed on 02/04/2026 at 06:24 p.m., reflected the order: - Enteral Feed Order one time a day for enteral feeding (Nepro 1.8 fs) continuously @ 35 ml/hr, start date 01/21/2026 at 09:30 a.m. and no discontinue date. The treatment was documented as scheduled at 09:30 a.m. - On 02/04/2026, a blank or no entry was found in the treatment administration record. Further review of the treatment administration record revealed the following licensed nursing staff provided Resident #2 treatment and/or medication provisions during the administration time of these orders, LPN C on 02/04/2026. Record review of Resident #2's Progress Notes, date range 01/05/2026 to 02/05/2026 and printed 02/04/2026 at 06:28 p.m. reflected:- on 01/23/2026 at 09:40 a.m., LPN K documented Per Registered dietitian [dietitian's name] giving Jevity 1.2 [a type and concentration of a tube feed formula] @35ml/hr with 100ml q4hr flushes. - on 02/04/2026, one (1) progress note by the DON and five (5) progress notes by LPN D were entered regarding medication administration via the G-tube. The progress notes do not mention provision of the tube feeding order. No additional progress notes were found on 02/04/2026 during the day shift. - Progress notes indicating tube feeding was provided and/or exemptions for tube feeding orders were not found for 01/25/2026, 01/28/2026, and 01/30/2026. Record review of the facility document Nurse Days January 2026, undated, reflected the scheduled nursing staff for each day from 01/01/2026 to 01/31/2026 with a space for open spots. Notations for schedule changes were noted to be handwritten onto the document. On 01/25/2026, LPN I was documented as scheduled with 6-2 [06:00 a.m. to 02:00 p.m.] handwritten next to her name. On 01/30/2026, LPN K and LPN I were documented as scheduled. LPN I had 6-2 typed next to her name. During an observation on 02/04/2026 at 03:55 p.m., Resident #2 was observed from the hallway lying in her bed in her room with her head elevated. Resident #2 was (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	02/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed to have been receiving her tube feeding. During an interview on 02/06/2026 at 01:58 p.m., LPN C revealed the floor nurses were responsible for administering the feeding administrations, but she was monitoring the area around Resident #2's tube feed and had not observed any irritation. During an interview on 02/06/2026 at 02:26 p.m., LPN D revealed she had provided Resident #2's tube feeding administration once, did not provide date, and did not have any issues with the administration. Attempted interview on 02/06/2026 at 03:57 p.m. with LPN I. LPN I did not answer, and a voice message was left with contact information and a request for a return call. Return call not received. Attempted interview on 02/06/2026 at 04:03 p.m. with LPN K. LPN K did not answer, and a voice message was left with contact information and a request for a return call. Return call not received. During an interview on 02/06/2026 at 04:20 p.m., the DON stated she had closely monitored Resident #2's tube feeding administration and she was unaware of Resident #2 having missed any scheduled tube feeds. She stated she was positive Resident #2 never missed a scheduled feeding. She stated she believed the nursing staff might not have charted the tube feed into the administration record because at the time the administration was scheduled, the tube feed might have been ongoing from the previous administration. The DON stated her expectation was for staff to still chart the administration, regardless of if they had to start the administration during their shift and/or start the administration during the time the administration was scheduled in the administration record. 4. Record review of Resident #3's admission Record, dated 02/04/2026, reflected a [AGE] year-old male. He was initially/originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #3's Medical Diagnosis tab, dated 02/04/2026, reflected diagnoses which included nontraumatic intracerebral hemorrhage (a severe medical event characterized by bleeding into the brain tissue and not caused by an external injury), urinary tract infection (an infection in any part of the urinary system), and personal history of urinary tract infections. Record review of Resident #3's Quarterly MDS Assessment, dated 12/16/2025, reflected the resident had a BIMS score of 15, which indicated he was cognitively intact. He had functional range of motion limitations on both sides of his upper and lower extremities and normally used a wheelchair. He was dependent for all mobility performances. He was documented to have received an antibiotic during the last seven (7) days or since admission/entry or reentry but had not had IV Access on admission, while a resident, or at discharge. The observation assessment end date was documented as 12/16/2025. Record review of Resident #3's Care Plan Report, undated and accessed on 02/04/2026 at 06:07 p.m., reflected the following focus and interventions/tasks:- Focus: I require the use of a colostomy [a surgical opening in the abdomen to allow stool from the colon to exit the body] and am at risk for infection and excoriation [wearing off the skin], date initiated and revised 04/15/2024. - Intervention/Task: Perform TX as ordered, date initiated 04/15/2024. Record review of Resident #3's Order Summary Report, dated active orders as of 02/04/2026, reflected the following order summary with order status, order date, start date, and end date if available:- Imipenem-Cilastatin Intravenous [administered into a vein] Solution Reconstituted 500 MG (Imipenem-Cilastatin) use 1 dose intravenously four times a day for UTI until 02/06/2026 23:59 [11:59 p.m.], order status active, order date 01/29/2026, start date 01/29/2026, and end date 02/06/2026. Record review of Resident #3's Medication Administration Record, dated 01/01/2026 - 01/31/2026, reflected the order: - Imipenem-Cilastatin Intravenous Solution.Use 1 dose Intravenously four times a day for UTI until 02/06/2026 23:59 [11:59 p.m.], start date 01/29/2026 at 05:30 p.m. The medication was documented as scheduled at 09:30 a.m., 01:30 p.m., 05:30 p.m., and 09:30 p.m. - On 01/29/2026 at 05:30 p.m., the exemption code for Other / See Progress Notes was entered. - On 01/30/2026 at 05:30 p.m., a blank or no entry was documented. Further review of the treatment administration record reflected the (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	02/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following licensed nursing staff provided Resident #3 treatment and/or medication provisions during the administration time of these order, LPN E on 01/29/2026 and LPN I on 01/30/2026. Record review of Resident #3's Medication Administration Record, dated 02/01/2026 - 02/28/2026 and printed on 02/04/2026 at 06:02 p.m., reflected the order: - Imipenem-Cilastatin Intravenous Solution.Use 1 dose Intravenously four times a day for UTI until 02/06/2026 23:59 [11:59 p.m.], start date 01/29/2026 at 05:30 p.m. The medication was documented as scheduled at 09:30 a.m., 01:30 p.m., 05:30 p.m., and 09:30 p.m. - On 02/02/2026 at 05:30 p.m., a blank or no entry was documented. Further review of the treatment administration record reflected the following licensed nursing staff provided Resident #3 treatment and/or medication provisions during the administration time of this order, LPN I on 02/02/2026. Record review of Resident #3's Progress Notes, date range 01/01/2026 to 02/05/2026 and printed 02/04/2026 at 06:07 p.m. did not reflect progress notes indicating antibiotic IV medication administration on 01/29/2026, 01/30/2026, and 02/02/2026 at 05:30 p.m. During an observation on 02/06/2026 at approximately 09:00 a.m., revealed Resident #3's received his IV antibiotic medication administration. During an observation on 02/06/2026 at 10:18 a.m., revealed Resident #3 completed his IV antibiotic medication administration. During an interview on 02/06/2026 at 11:10 a.m., Resident #3 revealed when he was prescribed his IV antibiotic the nursing staff explained the treatment with him, and he had not experienced any medication issues or tolerance issues with the medication. He stated he did not believe he missed any of his scheduled IV treatments. Attempted interview on 02/06/2026 at 03:57 p.m. with LPN I. LPN I did not answer, and a voice message was left with contact information and a request for a return call. Return call not received. Attempted interview on 02/06/2026 at 04:02 p.m. with LPN E. LPN E did not answer, and a voice message was left with contact information and a request for a return call. Return call not received. Record review of the facility's policy Administering Medications, dated revised 04/2019, reflected: Policy headingMedications are administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation .4. Medications are administered in accordance with prescriber orders, including any required time frame.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).20. For residents not in their rooms or otherwise unavailable to receive medication on pass, the MAR may be 'flagged.' After completing the medication pass, the nurse will return to the missed resident to administer the medication. Record review of the facility's policy Adverse Consequences and Medication Errors, dated revised 07/2023, reflected: Policy headingThe interdisciplinary team monitors medication usage in order to prevent and detect medication- related problems such as adverse drug reactions (ADRs) and side effects.Policy Interpretation and Implementation .Medication Errors1. A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.2. Examples of medication errors include: a. Omission - a drug is ordered but not administered; . 5 and 6. Record review of Resident #4's admission Record, dated 02/04/2026, reflected an [AGE] year-old female. She was admitted to the facility on [DATE]. Record review of Resident #4's Medical Diagnosis tab, dated 02/04/2026, reflected diagnoses which included chronic obstructive pulmonary disease (a lung disease that causes airflow blockage and breathing-related problems), anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and protein-calorie malnutrition. Record review of Resident #4's five (5)-Day MDS Assessment, dated 12/16/2025, reflected the resident had a BIMS score of 15, which indicated she was cognitively intact. She had functional range of motion limitations on one side of (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	02/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a lower extremity and normally used a walker or wheelchair. She required setup or clean-up assistance for rolling left and right and moving from sitting to lying flat on the bed and required supervision or touching assistance for moving from sitting to standing and to transfer from the chair or bed to a chair. She did not have a known weight loss or gain within the last six (6) months. Record review of Resident #4's Care Plan Report, undated and accessed on 02/04/2026 at 06:45 p.m., reflected the following focuses and interventions/tasks:- Focus: DIET- Resident requires a Regular Diet, regular texture, regular liquids, to meet nutritional needs and maintain adequate intake, date initiated 12/12/2025. - Intervention/Task: Monitor weight per protocol and report significant changes to the provider, date initiated 12/12/2025. - Focus: Disease Management at Bedside, date initiated 12/11/2025. - Intervention/Task: Implement physician-ordered treatments related to disease management., date initiated 12/12/2025. - Intervention/Task: Evaluate exact weight, date initiated 12/11/2025. - Intervention/Task: Evaluate Resident's weight, date initiated 12/11/2025. - Intervention/Task: Monitor weight for gain, date initiated 12/11/2025. Record review of Resident #4's Order Summary Report, dated active orders as of 02/04/2026, did not reflect current orders regarding weight monitoring. Record review of Order Details for Resident #4 reflected: Order Date: 01/21/2026 at 08:17 p.m. by NP L with order description Please obtain a weight for [DATE]. The order was scheduled as: start date 01/21/2026 at 08:17 p.m. and end date 01/21/2026 at 11:59 p.m. The order was confirmed by the DON on 01/22/2026 at 06:12 a.m. Record review of Resid