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	06/27/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 1 of 8 residents (Resident #27) reviewed for abuse and neglect.The facility did not report to the State Survey Agency (HHSC) an incident in which Resident #27 was slapped in the face by Resident #119 on 05/17/2025. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #27's Face Sheet, dated 06/27/2025, reflected an [AGE] year-old resident with an initial admission date of 02/05/2025, with diagnoses including aphasia (a language disorder that affects a person's ability to communicate), severe intellectual disabilities, and cognitive communication deficit. Record review of Resident #27's Quarterly MDS Assessment, dated 06/15/2025, reflected the resident had a BIMS score of 0, reflecting the resident had severe cognitive impairment. Resident #27's Quarterly MDS Assessment did not reflect behaviors from this resident toward others. Record review of Resident #27's Care Plan, undated, reflected, [Resident #27] has a communication problem d/t Aphasia. Rarely/never understood. With interventions including, Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. With a date initiated of 02/28/2025. Resident #27's Care Plan did not further reflect behaviors towards other residents. Record review of Resident #27's Progress Notes, a note dated 05/17/2025 written by LVN G reflected, resident slapped by a male resident in the face. female resident began to scream. both residents were separated no visible injurys noted to female resident at this time. family notified. mgmt notified. [sic]. Record review of Resident #119's Face Sheet, dated 06/27/2025, reflected an [AGE] year-old resident with an initial admission date of 01/06/2025, with diagnoses including senile degeneration of brain, anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), and insomnia (persistent problems falling and staying asleep). Record review of Resident #119's Quarterly MDS Assessment, dated 04/12/2025, reflected the resident had a BIMS score of 0, reflecting the resident had severe cognitive impairment . Resident #119's Quarterly MDS Assessment did not reflect any behaviors towards others. Record review of Resident #119's Care Plan, undated, reflected, Problematic manner in which resident acts characterized by ineffective coping; verbal/physical Aggression related to: Cognitive impairment r/t dementia 5/18 Resident to be moved to different hall away after physical aggression incident with a date initiated 05/02/2025 and revised on 05/19/2025 with goals including, Resident will not strike others, and interventions including, Be cognizant of not invading the resident's personal space. Record review of Resident #119's Progress Notes, a note dated 05/17/2025 written by LVN G reflected, resident noted to slapped a female resident in the face. female resident began to scream. both residents were separated no visible injurys noted to female resident at this time. mgmt notified. [sic]Interview on 06/27/2025 at 9:42 AM, LVN G stated that she witnessed the incident between Resident #27 and Resident #119. LVN G stated Resident #27 was wheeling past Resident #119 and Resident #119 reached over and slapped Resident #27 in the face. LVN G stated then Resident #27 began screaming. LVN G stated she immediately separated the residents, informed the DON, Administrator, Physician, and both resident's RPs. LVN G stated that she had never seen or heard of Resident #119 having physical behaviors toward residents prior to this incident. LVN G stated there was no apparent reason Resident #119 struck Resident #27. Interview on 06/27/2025 at 11:29 AM, the DON and ADM stated that the incident was not reported to the State Survey Agency because there was no willful intent from Resident #119. The ADM stated it was not possible for Resident #119 to have willful intent, as his BIMS was 0. The DON stated that Resident #119 did not have involuntary movements. The ADM stated they were responsible for reporting incidents of abuse and neglect to the state. The ADM and DON stated Resident #119 had no behaviors towards others prior to this incident. Record review of TULIP (Texas Unified Licensure Information Portal) did not reflect a facility reported incident that corresponded to the allegations in the incident described above.Record review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated revised 4/20212, reflected, Investigate and report any allegations within timeframes required by federal requirements.

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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 records review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 9 residents (Resident #22) reviewed for MDS accuracy. The annual MDS for Resident #22 failed to accurately document the continuous compression dressings worn by the resident. This failure could lead to residents not receiving the required care and decreased quality of life. Findings included: Record review of Resident #22's face sheet, dated 6/25/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included venous insufficiency (lack of circulation due to impaired veins) and peripheral vascular disease (impaired veins in the arms and/or legs). Review of annual MDS submitted on 5/26/2025 revealed a BIMS score of 13, indicating moderately impaired cognition. Question M1200 of the MDS (application of non-surgical dressings other than to feet) indicated no. Record review of the skin assessment dated [DATE] revealed a check mark in the box no alterations in the skin integrity noted. No documentation as present regarding the dressings. Resident #22 was observed on 6/24/2025 at 11:02 AM to have dressings on both legs, extending from mid-foot to the knee. The dressings were not dated and were observed to be discolored and dirty, with increased discoloration to the area on the bottom of the foot. The resident was not wearing socks and the dressings were in direct contact with the floor. An additional observation of the resident on 6/25/2025 at 8:54 AM revealed the dressings were in the same condition and appeared to be the same dressings as the observation made on the previous day. In an interview with MDS on 6/26/2025, she confirmed the unna boot compression dressings should have been documented in the MDS. She reported potential harm to residents was that they would not receive necessary care. In an interview with the DON on 6/26/2025 at 10:01 AM, she stated her expectation was for nursing assessments to accurately reflect the status of the resident. Review of the facility policy titled Comprehensive Assessments (dated March 2022, updated February 2025) revealed comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals on the interdisciplinary team.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 of 2 residents (Resident #61) reviewed for new admissions. The facility failed to develop a baseline care plan within 48 hours of admission for Resident #61. This failure could lead to residents not receiving necessary care and decreased quality of life. Findings included: Record review of Resident #61's face sheet, dated 6/26/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged to an acute care hospital on 4/14/2025 (10 days total). Relevant diagnoses included traumatic subdural hemorrhage without loss of consciousness (internal head injury with bleeding of the brain) and cognitive communication deficit. Record review of Resident #61's basline care plan report, printed 6/26/2025, revealed a singular focus area indicating full code status. No other areas of care were addressed in the baseline care plan. In an interview with MDS on 6/26/2025 at 10:29 AM, she stated a baseline care plan should include anything a resident needs to receive proper care, including allergies, fall risks, skin conditions, code status, hospice (if applicable), bowel and bladder needs, pain, and nutrition. She also stated Resident #61's baseline care plan had been initiated prior to her employment at the facility, and she felt it was not sufficient to provide care. In an interview with the DON on 6/26/2025 at 10:11 AM, after reviewing Resident #61's baseline care plan together, she stated the document should have contained medications, transfer status, therapy needs, etc. She stated she was aware of the previous MDS nurse's performance issues and had addressed the deficiencies in a performance improvement plan and subsequent termination. She reported the potential harm to residents of having an insufficient care plan was that they may not receive proper care. Upon request of a policy related to care planning, the facility provided a document titled Care Plans, Comprehensive Person-Centered (revised March 2022). This policy did not address baseline care planning for residents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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 observations, interviews, and records review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive care plan for the 1 resident (Resident #22) reviewed for skin conditions. The facility failed to ensure Resident #22 received wound care treatment for over 30 days for his chronic skin impairment as ordered by the physician. This failure could lead to exacerbation of a resident's chronic condition, skin breakdown and injury, or infection. Findings included: Record review of Resident #22's face sheet, dated 6/25/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included venous insufficiency (lack of circulation due to impaired veins) and peripheral vascular disease (impaired veins in the arms and/or legs).Record review of the annual MDS submitted on 5/26/2025 revealed a BIMS score of 13, indicating moderately impaired cognition. Review of Resident #22's active physician orders, printed 6/24/2025, revealed the following orders:1. TED hose- on in AM, off at HS at bedtime for edema [swelling] (start 5/30/2025)2. TED HOSE- on in AM, off at HS every morning and at bedtime for edema DOCUMENT REFUSAL IN NOTE [sic] (start 5/30/2025)3. TED Hose- On in AM, off at HS in the morning for edema (start 5/30/2025)Record review on 6/25/2025 of Resident #22's TAR for June 2025 revealed no application of the TED hose.Further record review revealed a physician's order for unna-flex elastic unna boot external miscellaneous dressing was discovered. Further directions included apply to BLE topically one time only for edema and skin integrity for 1 day AND apply to BLE topically one time a day every FRI for edema and skin integrity [sic]. The order was initiated on 2/17/2025 and discontinued on 5/30/2025. Resident #22 was observed on 6/24/2025 at 11:02 AM to have dressings on both legs, extending from mid-foot to the knee. The dressings were not dated and were observed to be discolored and dirty, with increased discoloration to the area on the bottom of the foot. The resident was not wearing socks and the dressings were in direct contact with the floor. An additional observation =on 6/25/2025 at 8:54 AM revealed the dressings were in the same condition and appeared to be the same dressings as the observation made on the previous day. In an interview with RN A on 6/25/2025 at 1:09 PM, she explained Resident #22 refuses to wear the TED hose, so he has the unna boot compression dressings on his legs instead. She stated the dressings are managed by the WCN and changed weekly. RN A was unable to locate Resident #22's TED hose for observation, and she stated she thought maybe they were being ordered. She reported she had not ever seen TED hose present in Resident #22's room for application. In an interview with the WCN on 6/25/2025 at 1:15 PM, she stated Resident #22 no longer wears the unna boot compression dressings and had orders for TED hose instead. She confirmed the change was effective 5/30/2025, and she was unaware the resident had compression dressings on his legs currently. She stated she had informed Resident #22's primary nurse of the order change on 5/30/2025, but they did not discuss who would remove the dressings. In an interview with Resident #22 6/25/2025 at 1:19 PM, he stated the dressings had been on his feet for about 3 weeks. He denied pain. He also denied psychosocial harm related to the state of the dressings. In a subsequent interview on 6/25/2025 at 3:43 PM, the resident denied a history of refusing to wear TED hose. He also denied the staff ever offering him the TED hose to wear. The WCN confirmed in an observation on 6/25/2025 at 1:19 PM that the dressings were unna boots compression dressings and had been applied by her on 5/23/2025. She then removed the dressings, and the resident's skin was observed to be absent of open wounds or breakdown. The resident's right foot had increased swelling. An interview was conducted with NP D on 6/25/2025 at 4:14 PM. She confirmed the unna boots compression dressing has been discontinued previously and the resident was supposed to be wearing TED hose during the day. She was unaware Resident #22 had allegedly been refusing the TED hose and not wearing them during the day. She was also not aware that the resident had been wearing the unna compressions dressings since 5/23/2025. She stated the staff should have reported any issues with orders or changes in condition to her. NP D also reported possible harm the Resident #22 from wearing the unna boots compression dressings continuously was impaired skin integrity. The DON was interviewed on 6/26/2025 at 10:01 AM. She felt the WCN should have removed the dressings. The DON confirmed the facility did not have TED hose for Resident #22 currently, and she stated he frequently refused to wear them, and staff should have been documenting this in the medical record. Record review of the facility policy titled Wound Care (dated 2011, updated July 2024) did not reveal any guidance related to the discontinuation of wound care orders.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents are offered a therapeutic diet when there is a nutritional problem, and the healthcare provider orders a therapeutic diet for 1 of 4 residents (Resident #20) reviewed for food and nutrition. The facility to ensure Resident #20 received nutritional supplement beverages as ordered by the physician. This failure could lead to nutritional deficits and unintended weight loss. Findings included: Record review of Resident #20's face sheet, dated 6/25/2025, revealed an [AGE] year-old female, originally admitted to the facility on [DATE]. Relevant diagnoses included nondisplaced comminuted fracture of shaft of humerus, right arm, sequela (right, upper arm bone fracture). The quarterly MDS submitted 3/12/2025 revealed a BIMS score of 09, indicating moderately impaired cognition. Review of Resident #20's documented weights did not reveal significant loss. Record review of scanned consultation reports for Resident #20 revealed nutrition recommendations signed by the RD and dated 1/8/2025. The recommendations reflected, recommend add house shake [nutritional supplement beverage] daily between BF and lunch for additional kcal/protein. Review of the active physician's orders included the following: Regular diet, regular texture, thin (regular) consistency, add whole milk daily with dinner, add house shake with breakfast (start date 1/8/2025). An observation on 6/24/2025 at 9:46 AM revealed the kitchen had no house shakes. In an observation on 6/25/2025 at 8:40 AM, Resident #20's breakfast service was observed. The printed dietary ticket indicated house shake with breakfast. The tray did not contain a house shake. A second observation on 6/25/2025 at 11:14 AM again revealed the kitchen had no house shakes. In an interview with Resident #20 on 6/25/2025 at 1:00 PM, she denied receiving a house shake after breakfast, before lunch, or during lunch. She also denied receiving a house shake at any point since admission. During an observation and interview on 6/26/2025 at 1:29 PM, the DM stated he did not have any house shakes in the kitchen and had kept the health shakes in the pantry located in the 100-hall. Further observation at 1:35 PM revealed the 100-hall pantry room was maintained behind a locked door and contained a refrigerator with approximately 10-20 bottles of 4oz health shakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA F was interviewed when the breakfast tray was delivered on 6/25/2025 at 8:40 AM, and she stated the house shake was provided by dietary services and was included on the tray. She reported it was not the responsibility of the nursing staff to include the house shakes on the meal trays. In an interview with the RD on 6/27/2025 at 9:31 AM, she confirmed the recommendation of adding the house shake to Resident #20's prescribed diet to promote healing of the fracture and promote optimal nutrition, as Resident #20 occasionally had variable food intake. She was unaware Resident #20 had not been receiving the recommended house shakes, but she denied concerns about weight loss for Resident #20. In an interview with the DON on 6/27/2025 at 10:44 AM, she stated the house shakes should be delivered on the trays from dietary services, and nursing staff should verify the presence of the shake prior to giving the trays to residents. She reported an expectation that the dietary staff would adhere to physician's orders and serve the house shakes.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #10) reviewed for medication administration.The facility provided Resident #10 with amlodipine without assessing for blood pressure as ordered by the physician.This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: Record review of Resident #10's Face Sheet, dated 06/27/2025, reflected a [AGE] year-old resident with an initial admission date of 04/10/2024 and diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), aphasia (language disorder that affects a person's ability to communicate), and nontraumatic intracerebral hemorrhage (a type of stroke where bleeding occurs within the brain tissue). Record review of Resident #10's MDS assessment, dated 03/15/2025, reflected Resident #10 was assessed with a BIMS score of 12, indicating the resident was moderately cognitively impaired . Interview on 06/27/2025 at 1:20 PM, Resident #10 was unable to say whether they remembered their blood pressure being checked prior to medications being administered. Record review of Resident #10's comprehensive person-centered care plan, dated printed 06/27/2025, reflected that Resident #10 had hypertension and interventions to, Obtain blood pressure readings Take blood pressure readings under the same condition each time. and Give anti hypertensive medications as ordered.Record review of Resident #10's Order Summary Report, dated 06/27/2025, reflected an order for amLODIPine Besylate Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for DBP < 110 SBP< 60 [sic], indicating the medication should not be provided to the resident without ensuring the residents blood pressure was within parameters, with a start date of 05/17/2025.Record review of Resident #10's Medication Administration Records for May and June 2025, dated 06/27/2025, reflected that Resident #10 was provided Amlodipine Besylate 42 times from 05/17/2025 through 06/27/2025, which was once daily since the order began. Resident #10's May and June Medication Administration Records did not reflect Resident #10's blood pressure at the time of medication administration.Record review of Resident #10's Blood Pressure Vitals Record reflected that between 05/17/2025 and 06/27/2025 his blood pressure was taken 5 times. The blood pressure vitals were as follows:1. 05/17/2025 at 9:18 AM, with a blood pressure of 111/62 mmHg taken by MA N.2. 05/18/2025 at 9:16 AM, with a blood pressure of 125/83 mmHg taken by MA N.3. 05/27/2025 at 8:26 AM, with a blood pressure of 119/83 mmHg taken by MA N.4. 06/24/2025 at 7:03 AM, with a blood pressure of 122/68 mmHg taken by LVN O.5. 06/27/2025 at 8:35 AM, with a blood pressure of 120/75 mmHg taken by LVN O.Interview on 06/27/2025 at 9:42 AM, the DON stated that the order was likely not populated in the electronic health record in a way to prompt whoever was giving the medication to input the blood pressure. The DON did not state the risk to residents for blood pressure medications such as amlodipine being given without checking parameters prior, but did state she was certain her staff checked the residents blood pressure.Interview on 06/27/2025 at 2:12 PM, LVN O stated that she checked Resident #10's blood pressure before providing their amlodipine to them. LVN O stated she was unsure why it was not showing that she had input the blood pressure previously into the resident's electronic health record, but stated she was sure she had checked it before providing it to the resident. LVN O was unable to provide evidence that Resident #10's blood pressure was taken prior to administration. Record review of facility policy titled, Administering Medications, dated Revised April 2019 reflected, The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; andb. Vital signs, if necessary.

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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. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 2 medication carts (Medication Cart for 200 hall) reviewed for storage of drugs and biologicals.The facility failed on 06/24/2025 when LVN I did not ensure the medication cart for 200 hall was locked and secured.These deficient practices could place residents at risk of medication misuse or drug diversion.The findings included:Observation on 06/24/2025 at 10:35 AM revealed a medication cart was left unlocked and unattended next to the entrance to the 200 hall closest to the resident activities room. Interview and observation on 06/24/2025 at 10:40 AM, LSW stated the cart was assigned to LVN I and 200 hall. LSW proceeded to then lock the medication cart.Interview and observation on 06/24/2025 at 10:40 AM, LVN I stated she was preparing her medications and had walked away from the cart but thought she had locked it. During an interview on 6/18/25 at 4:13 p.m., the DON who stated it was her expectation the medication carts were supposed to be locked when not in use. The DON stated unauthorized persons could have access to medications that did not belong to them and cause them harm. The DON stated the facility had residents who wandered and could have access to the medications in an unlocked cart.During an interview on 06/25/2025 at 2:30 PM, the DON who stated her expectation was for the medication carts to be locked. The DON stated there was risk of someone getting into the medication carts who was not supposed to if they were left unlocked. Record review of the facility policy titled Medication Labeling and Storage dated revised February 2023, revealed in part, Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews the facility failed to ensure food was stored, prepared, and or distributed in accordance with professional standards for food service safety, for 1 of 4 kitchen refrigerators reviewed for professional standards for food service safety, in that: The facility failed on 06/25/2025 when the produce refrigerator presented with 3 boxes, all containing 20lbs. of produce past the best by: date. This failure could place residents at risk for food borne illness. The findings included: During an observation on 6/25/2025 at 11:14 AM revealed the facility's kitchen produce refrigerator contained the following foods which were stored and available for serving: 1. 1 box containing 4, 5lb. bags of salad lettuce. The distributor labeled the box, best if used by: June/20/25 sic[6/20/2025]. 2. 1 box containing 4, 5lb. bags of shred lettuce. The distributor labeled the box, best if used by: June/9/25 sic[6/9/2025]. 3. 1 box containing 4, 5lb. bags of diced green cabbage. The distributor labeled the box, best if used by: June/16/25 sic[6/16/2025]. During an interview on 6/25/2025 at 1:27 PM the FSM stated the kitchen produce refrigerator had 3 boxes of lettuce and cabbage which were beyond the best by date and was not safe to serve. The FSM stated he would dispose of the produce in the trash. The FSM stated the expectation was to review the produce daily and to throw out any produce which had a best by date past the current date. The FSM stated it was his responsibility to review the produce and the risk to residents was potential food borne illness. During an interview on 6/25/2025 at 4:10 PM the Administrator stated the expectation for the kitchen was to follow policy and not keep any foods past the expiration and or best by dates. A record review of the facility's Food Receiving and Storage policy dated November 2022 revealed, . Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation . Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). 7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded.

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	745050	A. Building B. Wing	06/27/2025

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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	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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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 interviews and record reviews the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 2 of 8 residents (Resident #6 and Resident ##42) reviewed for accurate medical records, in that:A) Resident #6's June 2025 medication and treatment administration report (MAR and TAR) had no documentation for her prescribed:1. olodaterol and tiotropium (a combination medicine used to prevent airflow obstruction and reduce flare-ups in adults with COPD [chronic obstructive pulmonary disease] on 6/8/2025.2. Apply nystatin paste to bilateral buttocks related to rash and skin prep to the left heel (a liquid that when applied to the skin forms a protective film or barrier) on 6/17/2025.3. Change oxygen tubing and administration devices weekly on 6/15/2025.4. Insulin glargine injection on 6/8/2025. 5. Insulin glulisine injection on 6/8/2025 and on 6/17/2025. B) The facility failed to obtain written consent for Resident #42's Wander guard device. These failures could place residents at risk for inaccurate and unorganized medical records.The findings included:A) A record review of Resident #6's admission record dated 6/26/2025 revealed an admission date of 6/5/2025 with diagnoses which included chronic obstructive pulmonary disease (COPD, damage to the lungs results in swelling and irritation inside the airways that limit airflow into and out of the lungs, symptoms include trouble breathing) and diabetes mellitus type II (a disease where the cells cannot utilize the sugar in the bloodstream causing high blood sugar levels which are damaging to the body's functions causing tissue damage and poor healing).A record review of Resident #6's admission MDS assessment dated [DATE] revealed Resident #6 was an [AGE] year-old female admitted for rehabilitation and assessed with a BIMS score of 12 out of a possible 15 which indicated moderately impaired cognition. A record review of Resident #6's care plan dated 6/26/2025 revealed, The resident has actual impairment to skin integrity of the L heel r/t sic[related to] unstageable DTI sic[deep tissue injury]. Date Initiated: 06/06/2025 . Weekly treatment documentation to include measurement of each area of skin A record review of Resident #6's physician order summary dated 6/26/2025, revealed the physician prescribed orders which included: Apply nystatin paste (an antifungal medication used to treat various fungal infections, yeast infections, and skin infections) once per shift to bilateral buttocks for rash / skin integrity. Apply skin prep to left heel daily and as needed for unstageable DTI of left heel. Every, day shift for skin integrity. Insulin glulisine 100 units/ml inject per sliding scale before meals for type II diabetes. Insulin glargine 100 units/ml inject 5 units subcutaneously two times a day for diabetes. olodaterol and tiotropium inhalation aerosol, inhale once a day.A record review of Resident #6's June 2025 medication and treatment administration report revealed, on: 6/8/2024 LVN I did not document Resident #6 received her 4:30 PM injection of insulin glulisine. 6/8/2025 MA M did not document Resident #6 received her olodaterol and tiotropium breathing treatment. 6/15/2025 LVN L did not document Resident #6 had her oxygen nasal cannula tubing exchanged. 6/16/2025 LVN K did not document Resident #6 received her insulin glargine injection at 9:30 PM 6/17/2025 LVN J did not document Resident #6 received her insulin glulisine injection at 4:30 PM. 6/17/2025 the ADON did not document Resident #6 received her nystatin cream to her buttocks and skin prep to her heels.During an interview on at LVN I stated she reviewed Resident #6's Mar and Tar for June 2025 and identified missing medication and treatment documentations and identified them as holes in the MAR TAR. LVN I stated she had administered all of Resident #6's medication and treatments from her Nurse MAR TAR on 6/8/2025 to include Resident #6's insulin injection. LVN I stated she made an error and did not document the administration. LVN I stated she had not reviewed the MAR TAR for errors at the end of her shift. LVN I stated the risk to residents could have been inaccurate records. During an interview on 6/ at PM MA M stated she had administered all of Resident #6's medications and treatments from the MA MAR to include Resident #6's olodaterol and tiotropium breathing treatment but had not documented the administration. MA M stated the hole in the MAR was an error and she had not recognized the error. During an interview on 6/26/2025 at 4:02 PM the Administrator and the DON stated the expectation for nursing staff was to document the medication administrations and treatment administrations immediately after the medication and or treatment was provided. The DON stated she had reviewed the holes in the MAR TAR for Resident #6 and had evidenced the Resident had received the medications and treatments and the nursing staff had failed to document the medication and treatment administrations. The DON stated the risks to residents was inaccurate medical records. A policy was requested, and the Administrator and the DON stated the facility followed HHSC guidelines A record review of the United States

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #14) reviewed for infection control. The facility failed to ensure staff performed proper hand hygiene and PPE utilization while performing indwelling catheter care for Resident #14. This failure could lead to infection, illness, and decreased quality of life. Findings included: Record review of Resident #14's face sheet, dated 6/26/2025 revealed a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included benign prostatic hyperplasic without lower urinary tract symptoms (swelling of the prostate gland causing difficulty or inability to urinate). Review of the admission MDS submitted 4/8/2025 revealed a BIMS score of 14, indicating intact cognition. Record review of Resident #14's physician orders included the following: EBP: Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff (start 5/28/2025) In an observation of routine indwelling foley catheter care performed 6/26/2025 at 2:27 PM, CNA A and CNA C were observed donning disposable gowns and gloves prior to entering Resident #14's room. CNA C was observed assisting Resident #14 from his wheelchair into bed. CNA C then assisted Resident #14 with removing his clothing and disposable brief. CNA C then initiated care to the catheter without changing gloves and without performing hand hygiene. After performing initial cleansing of Resident #14's right and left thigh creases, CNA C was observed disposing of soiled gloves, CNA C did not perform hand hygiene before applying new gloves. After cleansing the catheter tubing, CNA C again disposed the soiled gloves and applied new gloves without performing hand hygiene. In an interview conducted 6/26/2025 at 2:35 PM, CNA A acknowledged she should have performed hand hygiene between all glove changes. CNA C reported the potential harm to residents was the spread of infection. In an interview with DON on 6/26/2025 at 2:45 PM, she reported her expectation of staff was to perform hand hygiene between glove changes and to change gloves appropriately. The DON reported possible harm to residents by not adhering to hand hygiene was the spread of infection. Record review of the facility policy titled Standard Precautions (revised September 2022), revealed the following: Hand hygiene is performed with ABHR or soap and water: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Before and after contact with the resident 2. After removing gloves

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, interviews, and record reviews the facility failed to ensure maintenance of all mechanical, electrical, and patient care equipment was in safe operating condition, for 1 of 1 facility reviewed for safe and functioning mechanical, electrical, and patient care equipment. The facility failed when the following occurred: 1. The facility's commercial electric dishwasher had a malfunctioning temperature gauge on 06/24/2025. 2. The facility did not equip 1 of 2 beds in an occupied resident room with a mattress on 06/26/2025. These failures could place residents at risk for unsafe patient care equipment. The findings included: 1. A record review of the facility's dishwasher temperature logs dated June 2025, revealed from 6/1/2025 to 6/24/2025 the temperature ranged from 100°F to 120°F. During an observation and interview on 6/24/2025 at 9:46 AM revealed the facility's kitchen dirty dish area presented with dirty breakfast dishes and an operating commercial dishwashing machine. The commercial dishwashing machine had a manufactures metal label affixed to the front of the machine which read, . commercial electric dishwasher . operating requirements 1. Water temperature 120°F minimum. Further observation revealed the soiled dishes were washed by Dietary Aide H (DA H). DA H stated she had worked in the facility since April 2025 and was assigned many duties to include washing dishes. DA H stated she worked from 6:30 AM to 2:30 PM. DA H stated the dishwasher was tested for operating temperature and chemical sanitization levels. DA H demonstrated the check logs for the dishwasher for temperatures and sanitization chemical levels. DA H stated the logs revealed a variance in washing temperatures between 110°F through 120°F. DA H stated the dishwasher manufactures' recommendation was for the temperature to reach a minimum of 120°F to effectively sanitize the dishes. DA H stated the gauge had been malfunctioning since April. DA H stated the FSM was aware of the malfunctioning gauge. DA H stated the current temperature reading was 111°F. DA H stated she believed the gauge was incorrect and the water temperature was over 120°F. During an interview and observation on 6/24/2025 at 10:08 AM revealed the dishwashing machine's temperature gauge read 110°F while the FSM checked the water temperature of the dishwasher. The handheld portable temperature gauge revealed the temperature of 126.1°F. The FSM stated the gauge was malfunctioning and was reading below 120°F. The FSM stated the contracted equipment maintenance technician had reviewed the equipment 2 weeks ago on 5/29/2025 but had no evidence of the visit and or work order for the gauge. The FSM stated his crew had been documenting the dishwasher temperatures ranging from 120°F to 110°F this past month, as evidenced by the logs. A record review of the commercial dishwashers' operating recommendations, website: https://www.autochlor.net/WPS/FileOperator.aspx?FileKey=b51d3025-69e0-403c-8f0e-80a0078a1407accessed 6/28/2025, revealed, Low temp machines provide energy and cost savings by being able to sanitize with 120°F rinse water instead of the 180°F typically required with hot water sanitizing machines. specifications: . water supply temp 120°F minimum (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 06/24/2025 at 10:52 AM revealed a metal bed frame in a resident room. The bed frame did not have a mattress equipped. Interview and observation on 06/25/2025 at 2:08 PM, CNA P stated that she believed the bed had been without a mattress since the previous hospice resident who lived in that room had passed away. CNA P stated it had been approximately a month, as the resident had passed away on 06/25/2025, and the bed did not have a mattress because usually hospice will bring air mattresses for people they care for. CNA P stated she was uncertain why a new mattress had not been put on the bed. Interview and observation on 06/26/2025 at 2:30 PM, the bed was observed with the DON to have a mattress equipped. The DON stated she had requested that maintenance put a mattress on the bed last week, and was not sure why it had not been completed until today. The DON stated she was aware that there were risks to residents for a metal frame to be without a mattress. The DON stated someone could have fallen onto the metal frame. A record review of the facility's EQUIPMENT SAFETY AND MAINTENANCE POLICY dated 5/1/2025, revealed, . Purpose: The purpose of this policy is to establish guidelines for the safe use, maintenance, and inspection of all electrical and mechanical therapy equipment within the facility. Malfunction Reporting: Implementing a clear process for reporting any equipment malfunctions, defects, or safety concerns. This policy is part of [Facility Name]'s broader safety framework, ensuring that all therapeutic activities are conducted in a safe and controlled environment .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relays the call directly to a staff member or a centralized staff work area from toilet and bathing facilities for 11 of 15 resident rooms (rooms #101, #103, #105, #107, #111, #117, #202, #210, #308, #315, and #405) reviewed for call lights. The facility failed to ensure emergency call lights in resident room bathrooms were able to be accessed and used from the floor on 06/24/2025. This failure could place residents at risk of injury, pain, hospitalization, and a diminished quality of life.Findings included:Observation on 06/24/2025 at 10:27 AM, room [ROOM NUMBER] was observed to have the call light wrapped around the metal assistance bar next to the toilet. The call light cable was not reachable from the floor and was approximately 2 feet above the floor. If pulled, the call light did not activate, and only put tension from the call light cable onto the metal assistance bar next to the toilet. Observation on 06/24/2025 at 10:52 AM, room [ROOM NUMBER] was observed to have the call light wrapped around the metal assistance bar next to the toilet. The call light cable was not reachable from the floor and was approximately 2 feet above the floor. If pulled, the call light did not activate, and only put tension from the call light cable onto the metal assistance bar next to the toilet. On 06/25/2025 between 4:30 PM and 4:50 PM, many observations of resident rooms occurred to assess for call light accessibility in resident restrooms. The following resident rooms were observed to have the call lights wrapped around the metal assistance bar next to the toilet. When attempts to pull on the part of the call light cable closest to the ground, tension was placed on the metal assistance bar and the call light system did not register the call light being pulled due to the cord being wrapped around the bar . The resident rooms are as follows: room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. Further observation revealed that so long as the call light cables were pulled appropriately, and not impeded by bars, to activate the call system, the call system was in functioning condition. During an interview on 06/26/2025 at 2:35 PM, the DON stated that the call light cables are very long, and they do not want residents to slip on them, so they wrap them around the metal bar. The DON stated that it was possible to shorten the length of the call light cables so they were able to be used as intended. The DON stated that no one had fallen and was not able to use the cable. The DON stated there could be a safety risk to residents for not being able to pull the call light in the restroom. Record review of facility policy titled, Call System, Residents dated updated January 2025, reflected, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.