STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455020	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at New Braunfels	821 US Hwy 81 W New Braunfels, TX 78130

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 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 observation, interview and record review the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 8 Residents (Resident #2) who were reviewed for homelike environment. The facility failed to ensure Resident #2's shower remodeling project was completed and the floor in the resident room was leveled and safe to walk across. This deficient practice could place residents at risk of unsafe living conditions and avoidable accidents. The findings were:Review of Resident #2's face sheet, dated 11/24/25, revealed she was admitted to the facility on [DATE] with diagnoses including unspecified Dementia (decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), lack of coordination, weakness, pain in right hip and difficulty in walking. Review of Resident #2's quarterly MDS, dated [DATE], revealed her BIMS score was 15 of 15 reflecting she was alert and oriented without cognitive impairment. Resident #2 was independent for most ADLs and she did not have a fall history. Review of Resident #2's Care Plan, dated 9/25/25, revealed Resident #2 was at risk for falls due to: mild cognitive decline, occasional pain to right hip. Tendency to ambulate without walker, frequently wears flip flops. Approaches included If resident is observed without walker, retrieve it for her and encourage use. Assure walker is within reach at all times as able. Review of the incident/accident log from August 2025 to November 2025 revealed Resident #2 had not had any falls. Observation on 11/20/25 at 5:09 PM in Resident #2's room revealed the shower stall in the restroom was sealed off with plastic. Some of the plastic was coming off. Observation revealed the drywall, and tile had been completely removed. It appeared like the shower was in the process of being remodeled. In the resident room revealed a large area, approximately 2 x 2-foot area, in the middle of the floor that was sunk in. The surface was unleveled and had a lip on one side. There were also brown stains on the linoleum floor under the vanity. The room and restroom smelled like mildew. Observation and interview on 11/21/25 at 3:20 PM with the MS in Resident #2's room revealed the shower room was sealed off with plastic, the floor was uneven in the middle of the resident room and there was a brown stain on the linoleum floor underneath the vanity. The MS stated the facility hired a contractor to remodel 7 resident showers including Resident #2's shower. He stated the contractor backed out and stated he wanted to re-negotiate for more money because he noted additional plumbing problems once he removed the drywall and tile. The MS stated the job came to a halt and in the meantime a new company bought out the facility. The MS stated progress had come to a standstill for about 2 months and the ADM had not asked him to call other contractors to complete the job. The MS stated he had not noticed the uneven surface in the middle of the room and thought the floor had probably been opened to get to the plumbing. He Identified the uneven surface as a trip hazard for Resident #2. He stated the building itself was old and needed a lot of repairs and stated the linoleum was stained throughout the facility. Observation and interview on 11/24/25 at 11:45 AM with Resident #2 revealed she was lying in bed. Resident #2 stated her shower had been under construction for 2 months and 2 weeks. She stated she did not like it but commented, it is what it is, she could not do anything about it. Resident #2 stated I'd rather have my own shower but stated she used the main shower room next door to her room. Resident #2 stated the MS told her they would repair the uneven surface in the middle of the room that was sunk in. She stated she did not have any problems walking over it with her rolling walker and had never had any falls. She stated the stain under the vanity did not bother her. Interview on 11/24/25 at 5:00 PM with the ADM revealed the facility hired a contractor to remodel multiple showers including Resident #2's shower right before the facility was bought out. He stated the contractor decided he wanted to negotiate for more money because it was more work than he realized. The ADM stated the company who bought out the facility was legally pursuing the contractor but stated in the meantime the remodeling project had been at a standstill for a couple of months. The ADM stated they secured/locked all restrooms that were under construction except for Resident #2's restroom because she was adamant she wanted access to the toilet. The ADM stated he understood the restroom was not in homelike condition and Resident #2 should not have to wait 2 months to have access to the shower. He stated he understood it was an inconvenience and at this time he was waiting for the new company to give them the go ahead to secure another contractor. Review of the facility's policy, Resident Rights, revised February 2021, read in relevant part Employees shall treat all residents with kindness, respect and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence. Review of the facility's policy

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 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 observation, interview and record review the facility failed to incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care 1 of 2 residents (Resident #1) reviewed for PASARR services. The nursing facility failed to submit a completed (NFSS) application to ensure Resident #1 received a specialized motorized wheelchair based on her rehabilitation assessment. This deficient practice could place residents at risk for not receiving specialized equipment and result in the decline in their physical condition. The findings were: Review of Resident #1's face sheet, dated 11/24/25, revealed she was admitted to the facility on [DATE] with diagnoses including severe intellectual disabilities, unspecified lack of coordination, muscle weakness (generalized), other specified disorders of muscles and unspecified Dementia (a general term for declining mental abilities, like memory, thinking, and reasoning, severe enough to disrupt daily life). Review of Resident #1's quarterly MDS assessment, dated 8/30/25, revealed her BIMS score was 0 out of 15 reflecting severe cognitive impairment. Resident #1 was dependent on staff for most ADLs and she used a manual wheelchair for mobility. Review of Resident #1's Care Plan, edited on 11/12/25, revealed focused area of psychosocial well-being with start date of 1/10/24, revealed Resident #1 was identified as PASRR positive related to severe intellectual disabilities and was receiving habilitation coordination and independent living skills training. The NF was unable to submit NFSS forms for habilitation PT/OT/ST or request a CMWC. The approaches were to coordinate care and services with [name of organization]. Review of PASARR Comprehensive Service Plan Form, dated 11/12/25, revealed a PASARR NFSS was completed and Resident #1 was assessed and measured for the use of a CMWC by the DOR, initial date 1/1/25. The verbiage read Patient will require a tilt in space wheelchair with custom back and cushion to support posture. Patient will use her CMWC to improve her out of bed mobility, to participate in her ADL's like dining, recreation activities, mobility within using while maintaining safe sitting posture. [NAME] approved for Medicaid will be available upon certification by the Nursing Facility. The application was denied because they required a hospice plan of care signed by the physician which was not provided by the hospice provider. Telephone interview on 11/18/25 at 1:46 PM with PASARR representative revealed Resident #1 had not received Medicaid services and a CMWC because of the following: The NF was notified and instructed to submit a NFSS Request by a specific deadline but failed to do so. The NFSS Request submittal by the NF was denied and there was not a follow up submittal to ensure the request was approved to provide specialized services for the resident. The PASARR representative stated she sent the ADM and the DON an email during September 2025 to remind them they needed to submit the NFSS application because they were out of compliance. Observation and attempted interview on 11/19/25 at 12:15 PM with Resident #1 revealed she was sitting in a manual high back wheelchair at one of the tables in the dining room. Resident #1 did not engage in conversation, did not make eye contact and did not speak. Resident #1 was not interviewable. Further observation revealed Resident #1 was leaning forward in the wheelchair and over the table. Interview on 11/19/25 at 12:30 PM with the DOR revealed Resident #1 was PASARR positive and was also receiving hospice services. He stated during an IDT meeting on 1/1/25 with PASARR he recommended Resident #1 would benefit from a specialized wheelchair that had the capability to tilt in space which would help Resident #1 with positioning in the wheelchair to keep her from leaning forward. He stated he assessed Resident #1 and was responsible for submitting the NFSS application because he was recommending a CMWC. He stated he submitted the application, but it was denied because hospice had not provided him with Resident #1's current plan of care signed by the hospice physician. The DOR stated he talked with several hospice staff including the nurse manager for months requesting a signed plan of care to no avail. The DOR stated he had brought up the issue during morning meetings and stated he explained why the NFSS application was denied. He stated he was not able to order a CMWC for Resident #1. He stated he spoke to a company resource person who recommended that he keep asking hospice to provide the resident's plan of care. The DOR stated he never thought about discussing the issue directly with the ADM, who was his immediate supervisor, in an attempt to have him assist with resolving the matter. Interview on 11/19/25 at 1:00 PM with the DOR and hospice DON revealed the DON stated she had not provided a current plan of care for Resident #1 because they had been waiting for the physician's signature. The Hospice DON stated this had been on-going since at least June 2025. Interview with the DOR revealed it

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, in accordance with State and Federal laws, to store all drugs and biologicals under proper temperature controls in 1 of 1 central supply storage room reviewed for medication storage. The facility failed to store their over-the-counter medications (8 bottles of Acetaminophen 325 mg.) in the central supply storage room maintained within 68 to 77 degrees Fahrenheit per medication recommendations. This deficient practice could place residents at risk of the medications not being as effective as they were designed to work. The findings were:Observation and interview on 11/18/25 at 2:01 PM with CNA A in the central supply storage room revealed she was assigned as the charge person for ordering and storing medications in the central supply storage room as of 10/1/25. She stated when she started organizing the storage room, she noted it was hot in the storage room and there was no ventilation. CNA A stated they stored nursing supplies including over the counter medications, enteral feedings and med pass. A thermometer was observed hanging on a top shelf. It was not registering a reading. There was a red line all the way across to the right side into the red area which read danger. It felt very stuffy and hot in the storage room. Observation and interview on 11/18/25 at 3:10 PM with the MS and CNA A in the central supply room revealed the temperature was hot. The MS stated he talked to the ADM about it being too hot in the central supply room. the MS used a laser thermometer to take a reading, and it read 84 degrees. He stated he did not know what the regulation was but would find out. The MS stated he talked to the ADM about adding an AC unit in the back service hall where the central supply storage and laundry were located. He stated the AC unit that should be cooling the service hall did not have a thermostat attached to provide airflow in the service hall. CNA A stated she spoke with a corporate staff person about the temperature in the central supply room. She stated the corporate staff brought the ADM into the storage room while she was in the room and told him he had to get it fixed ASAP because it was too hot. Interview on 11/18/25 at 3:50 PM with the ADM revealed he talked with their previous corporate staff about the temperature in the central supply room. The ADM stated they had other issues they were also addressing at the time and then the new company bought them out about 2 months ago. He stated he had not talked to the current corporate staff about it yet. The ADM stated he knew there was a regulation for maintaining the storage area at a safe range but was not sure about the specifics. He stated if the medications were not stored within acceptable parameters, it could compromise the efficacy of the medications, and the medications would not work effectively on the residents. The ADM was asked for a policy on storage of over-the-counter medications on. It was not provided by the end of the investigation period on 11/24/25. Observation and interview in the central supply room on 11/19/25 at 2:49 PM with the DON revealed she stated it was really hot in the storage room. She stated she talked with the ADM about it but they had not had a discussion about a plan to cool the storage room. She stated she checked the temperature requirements for the over-the-counter medications and found the bottles of Acetaminophen 325 mg. read they should be stored at temperature within 68 to 77 degrees. Fahrenheit. The DON stated storing the medication exceeding the recommended storage temperature could affect the efficacy of the medication and not effectively help the residents. Observation revealed there were 8 bottles of Acetaminophen 325 mg. on a shelf. The label on the box read Store at 20-25 degree C (68-77 degrees F).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 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 observation, interview and record review the facility failed to provide a safe, functional, sanitary and comfortable environment for residents for 1 of 8 Residents (Resident #3) reviewed for sanitary conditions. The facility failed to ensure the damaged linoleum tile was replaced, the walls were painted, the baseboard behind the bed was sanded and painted in Resident #3's room for a period of approximately 2 months. This deficient practice could place residents at risk of living in uncomfortable and unsanitary conditions. The findings were:Review of Resident #3's face sheet, dated 11/24/25, revealed he was admitted to the facility on [DATE] with diagnosis including unspecified Dementia (decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). Review of Resident #3's BIMS assessment dated [DATE] revealed his score was 7 of 15 reflective of moderate cognitive impairment. Observation on 11/20/25 at 5:12 PM in Resident #3's room revealed there were multiple holes covered with [NAME] on the far wall by the window. Under the window unit there was a piece of linoleum missing and the exposed area was black/brown color. The baseboard behind the head of the bed was chipped and splintered. In the bathroom, the floor tiles entering the shower stall were uneven. There was a shower curtain rod leaning against the tile inside the shower, there was a second shower curtain rod hanging on the back of the shower. Neither shower rod had a shower curtain. There was a shower chair in the shower. The top of the toilet seat on the shower chair was pealing. The back of the shower chair was wedged underneath the safety bar along the back of the shower. Observation and interview with the MS on 11/20/25 at 3:22 PM in Resident #3's room revealed the wall along the far back near the window needed painting. He stated the baseboard behind the bed was splintered and the wood needed sanding and painting. The MS stated rainwater would seep through the sewer lines in the walls and gathered under the AC unit causing a section of the linoleum to come off. He stated the brown/black area was the glue that was exposed. The MS stated the ADM had staff send him a work order of all areas needing repairs and areas needing painting when the new company bought the facility about 2 months ago. He stated the work orders were entered into their internal application program. The MS stated he started working for the facility for about 6 weeks and was working his way through the list. He stated he had an assistant, but the assistant was not experienced, and the facility was an old building and there were multiple rooms that needed repairs and painting. The MS stated Resident #3's restroom was ugly. He stated the floor was uneven leading to the shower stall and could be an accident hazard. He stated he did not know why there were multiple shower curtain rods in the stall but were not being used. He stated the shower chair was old and the seat was peeling. The MS stated Resident #3's room and shower room should be presentable, the resident equipment should be in good condition and the areas should be in good repair and homelike. The MS stated no resident should live in these conditions and commented he would not want a family member living under the same conditions. Interview on 11/20/25 at 3:35 PM with Resident #3 revealed he presented as being alert to person and place with confusion. He kept repeating the same information when questions were asked of him. Resident #3 stated the condition of the room and restroom did not bother him. He stated he showered in the shower even though staff told him he should use the main shower room. Interview on 11/24/25 at 5:00 PM with the ADM revealed the facility was an old building, there were multiple rooms, common areas which needed repairing and painting. He stated unfortunately he and most of the administrative staff were fairly new and a new company bought out the facility about 2 months ago. He stated he talked to the corporate staff and the buyer when they initially expressed interest in buying the facility and toured them through the facility. He stated everyone knew the condition of the facility and the plan was to complete repairs and paint areas which needed painting, but it would take time. He stated at this point there were other factors that took priority. The ADM stated he understood that some of the residents might not be happy with the environmental conditions, and they deserved better but again stated it would take time. Review of the facility's policy Maintenance Services, revised December 2009, read in relevant part Maintenance services shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance in federal, state and local laws, regulations and guidelines. b. maintaining the building in good repair and free from hazards. Review of the facility's policy, Resident Rights, revised February 2021, read in relevant part Employees shall treat all