

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Avir at New Braunfels		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of needs and preferences for one (1) of eight (8) residents (Resident #1) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #1's room was in a position accessible to the resident on 12/29/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. The findings included: Record review of Resident #1's admission Record, dated 12/30/2025, revealed a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 12/30/2025, revealed diagnoses including cerebral ischemia (a condition in which a blockage in an artery restricts the blood flow to the brain resulting in damage to brain tissue), unspecified lack of coordination, muscle wasting and atrophy (the shrinking of muscle or nerve tissue), history of falling, and severe intellectual disabilities (a limitation in cognitive functioning and adaptive behavior which affects a person's ability to learn, communicate, and perform everyday tasks). Record review of Resident #1's Annual MDS, dated [DATE], reflected Resident #1 had a BIMS score of 0.0, indicating he was severely cognitively impaired. Record review of Resident #1's Quarterly MDS, dated [DATE], did not reflect Resident #1's mental status score. Resident #1 was documented as rarely/never understood. He had range of motion impairment on both sides for upper and lower extremities, used a wheelchair, and was dependent for his self-care and mobility needs. Record review of Resident #1's Care Plan, dated last care conference 10/21/2025, reflected Resident #1 was at risk for falls due to impaired mobility, inability to recognize safety/danger, and had a history of attempts to self-transfer, date as edited 08/03/2025. One of the approaches noted was Keep call light in reach at all times., date as edited 03/26/2025. During an observation and attempted interview on 12/29/2025 at 03:46 p.m., Resident #1, was observed in his bed asleep. His call light was observed to be lying across the footboard of his bed and onto the floor. Resident #1 was observed to not have a roommate and the second call light for the room was observed lying on the floor between Resident #1's bed and the unoccupied space his roommate would have occupied. Resident #1 was unrousable and did not wake up enough to follow directions or attempt to demonstrate if he could have reached the call light. During an interview on 12/29/2025 at 03:46 p.m., CNA A stated Resident #1's call light was out of reach as it was located on the end of his bed. She stated Resident #1 would often throw his sheets, clothing, and the call light off his bed. CNA A stated Resident #1 was not impacted by the call light having been out of reach because he was not capable of using or understanding how to use the call light, so staff were to keep an eye on him. During an interview on 12/31/2025 at 04:09 p.m. with the RNC and ADMIN, the RNC stated her expectation was for the call lights to be in reach. She stated that many of the residents may not know or have the capability of knowing how to use the call lights, but the resident should have been tested to determine if having the call light was a benefit or detriment to the resident's safety. She stated the staff should be trained to ensure they review if a resident should be care planned for a call light to be within reach, but if the care plan indicated that, then the call light should be in reach. The ADMIN stated if a resident was care planned for a call light to be within reach, then he expected the call light within reach. He stated the impact of the call light having been out of reach would depend on the situation, since some of the residents were not capable of understanding how or why to use it. Record review of facility policy, Call System, Residents, dated as revised September 2022 and updated January 2025, reflected Policy Statement Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station [sic]. Policy Interpretation and Implementation 1. 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. 4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to post the required signage acknowledging the use of oxygen in resident room per resident care policies and procedures. The polices and procedures for respiratory care and services provided include, but are not limited to, the posting of cautionary and safety signs indicating the use of oxygen for 1 of 1 Resident's for hall. The facility failed to post cautionary and safety signs indicating the use of oxygen on 12/29/2025 for Resident #1's room. This failure could put residents, family members, and all visitors at risk for potential harm due to the flammability of oxygen. The findings included: Record review of Resident #1's admission Record, dated 12/30/2025, revealed a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 12/30/2025, revealed diagnoses including cerebral ischemia (a condition in which a blockage in an artery restricts the blood flow to the brain resulting in damage to brain tissue), unspecified lack of coordination, muscle wasting and atrophy (the shrinking of muscle or nerve tissue), history of falling, and severe intellectual disabilities (a limitation in cognitive functioning and adaptive behavior which affects a person's ability to learn, communicate, and perform everyday tasks). Record review of Resident #1's Annual MDS, dated [DATE], reflected Resident #1 had a BIMS score of 0.0, indicating he was severely cognitively impaired. Record review of Resident #1's Quarterly MDS, dated [DATE], did not reflect Resident #1's need for oxygen or mental status score. Resident #1 was documented as rarely/never understood. He had range of motion impairment on both sides for upper and lower extremities, used a wheelchair, and was dependent for his self-care and mobility needs. Record review of Resident #1's Order Summary Report, dated 12/30/205, did not reflect Resident #1 as having an order for oxygen therapy. Record review of Resident #1's Care Plan, dated last care conference 10/21/2025, did not reflect Resident #1 was currently utilizing oxygen therapy for any listed diagnosis. During an observation and attempted interview on 12/29/2025 at 03:46 p.m., Resident #1 was observed in his bed asleep. Portable oxygen tank was in resident room near sink and had no oxygen tubing attached. No noted signage on or around door to room. During an interview with RNC on 12/30/2025 at 9:55a.m. when asked about the oxygen policy for the facility, the response was I told them (facility staff) last week that it needs to be posted even if not scheduled. RNC also stated that Oxygen should be posted if in room, regardless of scheduled or PRN. During an interview on 12/31/2025 at 12:21p.m. LVN floor nurse stated when asked how they let people know that oxygen could be in use in a room that there is supposed to be a sign on the door that says that there is oxygen in the room. When also asked who is responsible for posting the signage floor LVN stated that everybody is responsible for posting or ensuring it is posted. During an interview on 12/31/2025 at 04:09 p.m. with the RNC and ADMIN, both stated that when oxygen is in a room there should be a sign posted noting this, even if oxygen is not actively in use. Record review of facility policy, Oxygen Storage, dated as revised November 2022, reflected 'Policy It is the policy of this center to maintain appropriate and safe storage of oxygen.' Policy also states that 'Storage areas will be clearly identified with a no smoking sign posted on door.' Record review of facility policy. Oxygen Administration, dated October 2010, reflected the steps in the procedure of administering oxygen as 'Placing an 'Oxygen in Use' sign on the outside of the room entrance door.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation and interview, the facility failed to post on a daily basis information that included the facility name, current date, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 13 of 15 days (12/17/2025 - 12/29/2025) reviewed for posting of required information. The facility failed to post the required current nurse staffing and census information from 12/17/2025 to 12/29/2025. This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census. The findings included: During an observation on 12/29/2025 at 03:52 p.m., a document labeled [facility name] Federal Staffing Posting, dated 12/16/2025, was posted on a wall outside the initial nurses' station passed following entry to the facility. The document included the following information: census and the number and hours worked of registered nurses, licensed vocational nurses, medication aides, and certified nurse aides for day shift, evening shift, and night shift. During an interview on 12/29/2025 at 03:55 p.m., ADON B revealed the SC was new to her position and she was unsure if the SC had been taught the process of creating and updating the nurse staffing and census posting. ADON B stated the WC Nurse was working with the SC and initially focused on creating the staff schedule. ADON B stated the prior SC left suddenly the prior week, but the nurse staffing and census posting was usually done every morning and posted. During an interview on 12/30/2025 at 09:55 a.m., the RNC stated the facility did not have a policy on the daily nurse staffing and census posting. She stated it was a state regulation, and the facility followed state regulations. During an interview on 12/31/2025 at 09:20 a.m., the WC Nurse revealed the prior SC resigned two weeks prior and she had been assisting the new SC in creating the schedule for the current month. The WC Nurse stated she had not been involved in posting the nurse staffing and census posting and was unsure on the procedure for the document. During an interview on 12/31/2025 at 11:12 a.m., the SC revealed she had recently changed positions and became the SC. She stated the prior employee who was supposed to orient her in the new position did not stay and she was learning the job responsibilities and procedures day by day, which was resulting in some trial and error. She stated she had just been notified of the procedure for posting the nurse staffing and daily census but had assumed someone else was covering this task. She stated she was unsure how not having the daily census and nurse staffing information posted daily would have impacted residents or facility guests because she was unsure if the residents or guests knew to look for the posting. She stated that when residents or guests asked staff about facility staffing, the staff would be capable of informing the resident or facility guest of the facility's standard staffing expectation for each hall and shift. She stated the staffing schedule was also readily available for staff or facility guests to review. During an interview on 12/31/2025 at 04:09 p.m. with the RNC and ADMIN, the RNC stated the SC was responsible for posting the daily nurse staffing and census posting. She stated she was aware that ADON B had provided the SC some training for her new position but was unsure what the training entailed. The RNC stated the nurse staffing and census posting might possibly have been overlooked. She did not believe the lack of posting the daily nurse staffing and census would impact anyone because the facility had a staffing book readily available. The ADMIN stated he believed there was a breakdown in communication and following the posting procedures after the prior SC left. He stated he had never had a resident or facility guest request to view the posting, only surveyors, and therefore did not feel it impacted anything other than meeting the requirement.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to store over the counter medications in accordance with currently accepted professional principles for medication storage room in secure Co-ed unit. The facility failed to ensure that the medication storage room held no expired medications per state and federal guidelines. This failure could cause adverse reactions to residents when ingesting expired medications. The findings included: Observation of 4 expired supplemental shakes within the medication room, each with an expiration date of 09/10/2025. Observation of the medication storage room in the secured Co-ed unit on 12/30/2025 at 8:51a.m. revealed 4 expired supplemental shakes on the counter, with expiration dates of 09/10/2025. Interview with CMA on 12/30/2025 at 8:51 surveyor asked CMA where expired liquids, such as medications and supplements, were stored. CMA responded that they are usually taken out of here and stored somewhere else. Surveyor then asked CMA What expiration date do you see on this supplement? CMA responded It says it expires September of 2025. I will let my nurse know so she can handle it. During an interview on 12/31/2025 at 12:10p.m. with RN on unit, surveyor asked RN about supplements in the medication room in the secure Co-ed unit. RN stated that the supplements were there because the resident would sometimes not eat. The dialysis clinic and the primary physician were trying to determine who would write order for resident supplements, so they had an order but it was not filled yet due to this. RN also stated that the medication aides were supposed to pull expired medications. During interview on 12/31/2025 at 04:09p.m. with RNC and ADMIN, RNC stated that all expired medications, whether over the counter or supplements, were to be pulled form medication rooms and disposed of properly.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skills set to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for ten (10) of ten (10) kitchen staff (Cook D, KS C, KS H, KS I, KS J, KS K, KS L, KS M, KS N, KS O) reviewed for qualified dietary staff . 1. The facility failed to ensure all (Cook D, KS C, KS H, KS I, KS J, KS K, KS L, KS M, KS N, KS O) dietary staff maintained their competencies and skills through regular in-service training. 2. The facility failed to ensure KS C met the requirements for food handling by obtaining a current and valid Food Handler's Certificate. These failures could place residents at risk of not having their nutritional needs met and foodborne illnesses. The findings included: 1. During an interview on 12/30/2025 at 08:35 a.m., when asked about providing kitchen staff trainings on completing food temperature logs, food labeling procedures, and sanitation procedures for taking food temperatures, the DDS stated the staff do not get trainings but get a text reminder. She stated the staff get sent a group text because they know what is to be done. The DDS did not state how often or what the content of the group text reminders she had provided to the kitchen staff. During an interview on 12/31/2025 at 01:59 p.m., the RDN revealed she expected the DDS to provide the food service staff with ongoing staff education. She stated she had told the DDS about concerns she had identified regarding the food temperatures in November 2025. The RDN stated she felt the kitchen staff needed training and had been told by the DDS that the DDS was providing training. During an interview on 12/31/2025 at 04:09 p.m., the RNC revealed she could not believe that there was not any documentation of food service staff trainings within the requested timeframe. She stated the DDS was not available today, 12/31/2025, but there should have been some food service training provided by the DDS and some training provided by the RDN. During an interview on 12/31/2025 at 04:09 p.m., the ADMIN revealed he could not locate food service staff in-service training documents dated within the requested 3-month period (09/29/2025- 12/29/2025). He revealed the contracted food service company was changed around 2 months ago and he knew the prior company provided training. 2. Record review of a Certificate of Training Awarded to [KS C] For successfully completing the Food Handler Essentials Course awarded to KS C, dated as issued 11/30/2023, reflected the certificate was valid for 2 years indicating the certificate expired on 11/30/2025. During an interview on 12/31/2025 at 04:09 p.m., the ADMIN revealed KS C was out of the country and stated the DDS notified him she was sure KS C had retested for a current Food Handler Certification, but they did not have the documentation. Record review of facility policy. Food Preparation and Service, dated revised November 2022, did not reflect mention of food service staff training expectations or qualifications. Record review of facility policy. Sanitation, dated revised November 2022, did not reflect mention of food service staff training expectations or qualifications. Record review of TFER accessed on 01/02/2026 at 04:27 p.m. at https://www.dshs.texas.gov/licensing-foodhandler-training-programs, (Licensing of Food Handler Training Programs Texas DSHS) indicated: Licensing of Food Handler Training ProgramsTexas requires that many food service employees complete an accredited food handler training course within 30 days of getting a job. These courses train employees on food safety including good hygiene practices, how to avoid cross contamination, and more.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to serve foods that were palatable and prepare food by methods that conserve nutritive value, flavor, and appearance for one (1) of one (1) kitchen observed and one (1) of eight (8) residents (Resident #3) reviewed for food and nutrition services. The facility failed to serve warm food to residents. These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life. The findings included: Record review of Resident #3's admission Record, dated 12/30/2025, revealed a [AGE] year-old female admitted on [DATE]. Record review of Resident #3's Diagnosis Report, dated 12/30/2025, revealed diagnoses including moderate intellectual disabilities (a limitation in cognitive functioning and adaptive behavior which affects a person's ability to learn, communicate, and perform everyday tasks), gastro-esophageal reflux disease (also known as acid-reflux disease or GERD, when the stomach contents flow back into the esophagus and cause discomfort such as heartburn), and dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #3's Quarterly MDS, dated [DATE], reflected Resident #3 had a BIMS score of 13.0, indicating she was cognitively intact. Resident #3 was documented as not having had any hallucinations or delusions. She used a walker and required supervision or touching assistance when eating and walking. She had not lost or gained any significant weight in the last month or more than 6 months and received a regular diet type and texture. Record review of Concern/Grievance Forms revealed two (2) grievance forms regarding food temperature. 1. Concern/Grievance Form, dated 12/05/2025, communicated by Resident Council, reflected under describe concern in detail, food cold. The DDS was noted as the staff member assigned responsibility for the investigation, and it was noted that the food temperature logs were reviewed to assure the temperatures were within the required standard. The ADMIN signed the form on 12/09/2025. 2. Concern/Grievance Form, dated 12/05/2025, communicated by Resident #3's family/representative pertaining to Resident #3, reflected under describe concern in detail, food is served too cold or not edible. The DDS was noted as the staff member assigned responsibility for the investigation, and it was noted that the temperature log for the meal was reviewed and was within required standards at the time of service. The DDS and the ADMIN signed the form on 12/08/2025. Record review of document titled Resident council December 5, 2025, 2:00pm, reflected under Residents Concerned. Thanksgiving lunch was cold. And [sic] Residents [sic] want better meals [sic] presentation. Dinning [sic] information was giving [sic] to [the DDS] Dietary Manager. During an observation on 12/30/2025 at 08:05 a.m., the temperature of the food on the service line was checked by a food service staff member directly after the last meal was served. The dining room was observed to be the last service location for the residents' meals. The temperatures were observed to be: - oatmeal at 130 degrees Fahrenheit or 5 degrees below the minimum temperature, - grits at 132 degrees Fahrenheit or 3 degrees below the minimum temperature, - scrambled eggs at 146 degrees Fahrenheit or 11 degrees above the minimum temperature,- sausage patties and links at 150 degrees Fahrenheit or 15 degrees above the minimum temperature,- pureed bread at 132 degrees Fahrenheit or 3 degrees below the minimum temperature,- pureed sausage at 112 degrees Fahrenheit or 23 degrees below the minimum temperature,- pureed egg at 126 degrees Fahrenheit or 9 degrees below the minimum temperature, and - cream of wheat at 142 degrees Fahrenheit or 7 degrees above the minimum temperature. During an interview on 12/30/2025 at 08:35 a.m., the DDS stated she had not received recent complaints regarding cold food. She stated she tried to do temperature checks of the food on trays probably once a week, but she did not record her checks. She stated she was just checking to ensure the food was hot. She stated her expectation was for the food on the service line to be between 135-140 degrees Fahrenheit or higher. She stated food below that range was not right. She stated the cooks took the temperature of the food before service but only she would take the temperature of the food after service or on a tray and she did not document that temperature. She stated if the food service staff did not document food temperatures, then they would not know if residents were getting cold food. During an interview on 12/31/2025 at 10:50 a.m., Resident #3 revealed she thought the food served was gross. She stated the food was cold and she did not feel good after she ate. She stated that the food made her sick and she was unsure if she had lost weight. She stated she would eat in the dining room per her preference. During an interview on 12/31/2025 at 01:59 p.m., the RDN revealed she had observed food temperatures taken off the hot service line in November with all the temperatures within appropriate range. She stated she had received complaints from residents</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 (Kitchen 1) of 1 kitchen reviewed for food safety requirements. 1. The facility failed to label and date a container of cheesecake, a container of mashed potatoes, and a container of carrots in the walk-in refrigerator. 2. Food service staff failed to ensure temperatures of foods were checked as required for food safety for all three meals on 12/24/2025, 12/25/2025, and 12/28/2025; for breakfast on 12/26/2025 and 12/27/2025, and for breakfast and lunch on 12/29/2025. 3. [NAME] D failed to utilize the food safe appropriate temperature probe wipes when sanitizing the temperature probe between food items. This failure could place residents at risk for spread of infections, food contaminations, food-borne illnesses, and diminished quality of life. The findings included: 1. During an observation and interview on 12/29/2025 at 04:59 p.m., three sealed plastic containers: one with a white dense substance, one with a brownish white dense substance, and one with what appeared to be sliced carrots were identified in the walk-in refrigerator. The three containers were undated or labeled. [NAME] D identified the containers as having been without a label and date and stated the items were cheesecake, mashed potatoes, and carrots from yesterday's (12/28/2025) service. He was observed to take the items out of the walk-in refrigerator and stated he was going to throw the items out. 2. Record review of Serving Temperatures, dated December 2025, provided by [NAME] D on 12/29/2025 at 05:04 p.m. reflected:12/24/2025- no temperatures were documented for Breakfast, Lunch, or Dinner.12/25/2025- no temperatures were documented for Breakfast, Lunch, or Dinner.12/26/2025- no temperatures were documented for Breakfast.12/27/2025- no temperatures were documented for Breakfast.12/28/2025- no temperatures were documented for Breakfast, Lunch, or Dinner.12/29/2025- no temperatures were documented for Breakfast or Lunch. Dinner service had not started. The temperature log did not have any staff names, initials, signatures, or times to indicate who checked the temperatures, when the temperatures were checked, or who was responsible for checking them. During an interview on 12/29/2025 at 05:00 p.m., [NAME] D stated he worked 12/28/2025 in the morning, Breakfast and Lunch service, and due to having been so busy, he had not taken food temperatures at all. He revealed he had also worked 12/24/2025 and was not sure why the food temperatures were not documented. He stated he did not work on the other dates noted. 3. During an observation on 12/29/2025 at 05:25 p.m., [NAME] D was observed taking food temperatures of the food on the hot line. He was observed after taking the temperature of one food item, to wipe the food thermometer probe with a Sani-Cloth before inserting the food temperature probe into the next food item. Record review of Safety Data Sheet for Super Sani-Cloth Germicidal Wipes, dated revised 06/03/2020, reflected under Recommended use, Use as a disinfectant on hard, non-porous surfaces. Under Toxicological [the study of the harmful effects of chemicals, substances, or environmental agents on living systems] information, for Ingestion [swallowing], Specific test data for the substance or mixture is not available. Ingestion may cause gastrointestinal irritation, nausea, vomiting and diarrhea. May be harmful if swallowed. During an interview on 12/30/2025 at 08:35 a.m., the DDS stated she was not told about unlabeled foods having been identified the day prior, 12/29/2025. She revealed she had completed a walk-through inspection herself that morning, 12/30/2025 and found some unlabeled food items. She stated she had sent a group text to her food service staff because they knew what is to be done. She did not specify the contents or specific subject matter of the group texts she was sending to the food service staff. She stated the impact of foods not having a date was that if the staff used the food, the food could be old and residents could get sick. She stated she did not provide staff with training on labeling the food but did send a reminder to them. She stated she had not provided training to staff regarding logging and taking food temperatures but had reminded them. She stated, a lot of times, they (the food service staff) have a habit of writing down the temperatures on a piece of paper and then don't record them. She stated the impact of the staff not writing down the food temperatures was that they could not determine if the residents were getting cold food or not. She stated she expected staff to use a napkin or paper towel and then a probe wipe when cleaning the temperature probe between foods. She stated staff were not to use the Sani-Cloths. She stated she did not know staff had used the Sani-Cloths, but the dietitian had recommended to not use them, and staff were aware of that recommendation. During an interview on 12/31/2025 at 01:59 p.m., the RDN revealed she had completed kitchen tours in November and December of 2025 and had noted unlabeled and</p>		