

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/29/2025
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents received adequate supervision, to the extent possible for 2 of 8 residents (Resident #48 and Resident #64) reviewed for safety. The facility failed to ensure Resident #48, and Resident #64 were provided adequate supervision as the residents walked out of the women's secure unit doors and out into the facility parking lot on 8/23/25, where Resident #64 fell in-between staff vehicles and obtained a laceration to the back of her head requiring 2 sutures. An IJ was identified on 08/28/2025. The IJ Template was provided to the facility on [DATE] at 05:02 PM. While the IJ was removed on 08/29/25, the facility remained out of compliance at a scope of isolated and a severity with no actual harm due to the facility's need to complete repairs and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for avoidable accidents, injuries, and possible death. Findings included: Review of Resident #48's undated face sheet, reflected she was a [AGE] year-old female admitted [DATE] to the Secure Unit of the facility with diagnoses of Alzheimer's disease, anxiety disorder, and depression. Review of Resident #48's Quarterly MDS assessment dated [DATE] reflected in Section GG-Functional Abilities, for the task of walking 10 feet, she was coded as 88. Not attempted due to medical condition or safety concerns. Her BIMS was a 03, indicating she had severely impaired cognition. Review of Resident #48's comprehensive care plan dated last revised 8/25/2025 reflected the resident was care planned for following residents/staff around the unit, touches and grabs things that do not belong to her and pushing other residents in their wheelchairs. She also cared planned for being at risk for falls due to impulsive and unsafe behaviors and a new environment on the women's secure unit. Review of Resident #48's progress note dated 8/23/2025 at 7:47pm by LVN A revealed, At approximately 7:25 pm the resident was observed exiting through the back door that leads to the parking lot by staff. A staff member brought the resident back inside. Upon assessment, the resident's skin was intact, and no signs of distress were noted. The resident is alert and oriented to person and place, while the episode happened no alarms had been triggered. Family member, ADON were notified. Review of Resident# 48's Elopement Assessment updated on 8/25/25 reflected that resident had a history of leaving the facility without informing the staff. Review of Resident #64's undated face sheet, revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included non-Alzheimer's dementia, anxiety, depression, and muscle weakness. Review of Resident #64's admission MDS assessment dated [DATE] reflected In Section GG-Functional Abilities, for the task of walking 10 feet, she was coded as '06. Independent - Resident completes the activity by herself with no assistance from a helper'. Her BIMS was a 05, indicating she had severely impaired cognition. Review of Resident #64's comprehensive care plan dated 8/27/25 revealed she was care planned for elopement. Review of Resident #64's secure unit evaluation dated 8/18/25 revealed she exhibited the following behaviors: wandering, physical aggression, verbal aggression, delusions, and paranoia. An updated elopement risk assessment was completed on 8/25/2025 indicating she had wandering behavior. Observation on 8/26/25 at 10:38 AM revealed Resident #48 on the Secure Unit and non-interview able due to low cognitive level. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 8/26/25 at 10:47 AM revealed Resident #64 on the Secure Unit and non-interview able due to low cognitive level. Observation on 8/28/25 at 12:35 PM revealed the maintenance supervisor, MS, tested the door on the Women's Secure unit and after an initial push a loud egress alarm sounded for 15 seconds and then automatically turned off. 2nd alarm sounded when the door was completely separated from the frame. The 2nd alarm did not stop until a staff member used a key to disarm the alarm. Both alarms were loud enough to be heard at the farthest room at the end of the hall with a resident's room door open. When the resident's door was completely closed in the farthest room, the alarm could be heard but it was not loud. Observation on 8/29/25 at 12:13 PM revealed the rear door of the Women's Secure Unit had the 2nd alarm on the back door still. Observed the staff press on the door slightly and the initial egress alarm did sound. They did not fully open the door to set off the 2nd alarm. In an interview on 8/28/2025 at 11:00am with the ADM revealed Residents #48 and #64 were seen by staff outside in the parking lot on 8/23/25. Resident #64 had pushed the door long enough for the emergency egress to activate and allow them out. He said the alarm sounded and he tested it, and it was loud. The CNA and nurse who were working the floor told him they were in resident rooms and could not hear the door. The alarm turned off after 15 seconds. He stated that he was having the alarm permanently replaced to be an alarm that had to be deactivated manually. In the interim he had placed a red alarm that would continue to sound if the door was opened until staff reset it. He said he had already started that process to have the money approved for the work to be done on a permanent fix. In an interview on 8/28/2025 with CNA A she stated she was in the secure unit dining room assisting residents. CNA A thought CNA B was on the hall with Resident #64. CNA A was informed by another hall's staff, that 2 residents from the women's secure unit were outside. CNA A followed behind LVN A and found Resident #64 on the ground in the parking lot, close to the gate of the fence. CNA B stated that she was in a resident's room changing someone at the time of the elopement. CNA A stated she heard LVN A say she didn't hear the alarm sound. CNA A stated the incident could have been prevented. She stated a negative outcome was that a resident could have gotten killed and the residents were on a locked unit for a reason. In an interview on 8/28/2025 with CNA B, she stated that she was in a resident room with the door shut at the end of the hall in the secure unit changing a resident and did not hear the alarm go off. In an interview on 8/28/2025 with LVN A, she stated that she was going in and out of the secured unit courtyard/dining room assisting multiple residents and did not hear an alarm sound. She stated she was notified by other staff that the residents were outside. She stated she went outside and assessed the residents and called 911 for resident #64 who had fallen and hit her head which was bleeding. She stated resident #64 was taken to the emergency room. She stated resident #48 was unharmed and returned to the unit. In a confidential interview on 8/28/2025 it was revealed that Resident #64 was found in the parking lot on the ground between cars and the confidential interviewee had been informed by the facility that the resident had been attempting to climb a fence, when she fell and received a laceration to her head. In an interview with the ADM on 08/28/2025 at 4:20pm he stated that the door alarm on the secure unit was not fixed until 8/27/2025. Review of facility policy dated 2001 and last revised December 2021 titled, Emergency Procedure-Missing Resident reflected the following: Resident elopement resulting in a missing resident is considered a center emergency. Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety. Review of facility policy dated 4/22/25 titled, Wandering and Elopement reflected the following: The facility will ensure that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents. Adequate supervision will be provided to help prevent accidents or elopements. Review of hospital emergency room records for Resident #64 dated 8/23/25 reflect the following: Presented in emergency room (ER) on 8/23/25 at 9:15 Pm for Laceration Repair with staples. ER note indicates Resident 64 arrived at the ER by ambulance transport after she fell backwards on her head as she attempted to flee from the facility. Resident #64 was discharged back to the facility on the same day. The ADM was notified on 08/28/25 at 5:02 PM that an Immediate Jeopardy was identified (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	due to the above failures and the IJ template was provided. The Plan of Removal was accepted on 08/29/25 at 11:44 AM: Plan of Removal Problem: F689 Free from Accidents/ Hazards On 08/28/2025 an abbreviated survey was initiated at the facility. On 08/28/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 2 of 2 residents (Resident #48 and Resident #64) reviewed for accidents. The facility failed to ensure [Resident #48] and [Resident #64] were provided adequate supervision as the residents walked out of the women's secure unit doors out into the facility parking lot, where [Resident #64] fell in between staff vehicles and obtained a laceration to the back of her head requiring 2 sutures. Immediate Action for Residents Affected: Action: [Residents #48 & #64] were assessed with Resident #48 showing unharmed and resident #64 having a head wound from falling. Responsible Party and Medical Director notified. [Resident #64] was sent to the ER for further evaluation and treatment. [Resident #64] returned with 2 staples to back of head with order to monitor daily and remove staples in 7-10 days ; no additional adverse physical findings and residents are behaving per their norm, not showing any signs of mental distress. Start Date: 8/28/2025 Completion Date: 8/28/2025 Responsible: Charge Nurse Identifying Additional Residents That Could be Affected: Action: Updated elopement assessments performed on all residents that reside in the facility, in and out of secured units, to include [Residents #48 and #64]. All new assessments consistent with previous assessment and care plans with no new findings. Start Date: 8/29/2025 Completion Date: 8/29/2025 Responsible: Charge Nurse, Assistant Director of Nursing, Director of Nursing, and/or Designee Action: The Administrator and Director of Nursing educated over Emergency Procedure- Missing Resident & Wandering/Elopement, on what to do when the alarm sounds-key takeaway: staff to perform a head count and search the premises/surrounding area for residents that have potentially eloped, and finally what to implement when a door is not functioning properly Start Date: 8/24/2025 Completion Date: 8/28/2025 Responsible: Senior [NAME] President of Clinical Operations and/or Designee Actions put in Place to Prevent Further Occurrence Action: Education provided for all staff related to the facility's Emergency Procedure- Missing Resident & Wandering/Elopement. Staff will be educated on what to do when the alarm sounds such as the staff is to perform a head count and search the premises/surrounding area for residents that have potentially eloped All staff, including temporary agency staff, PRN staff, new hires, will be educated prior to working their next shift. Start Date: 8/23/2025 Completion Date: 8/28/2025 Responsible: Administrator, Director of Nursing, Assistant Director of Nursing, and/or Designee Action: Elopement drills performed for competency/education retention every shift/rotation with acknowledgement that they completed the elopement drill and comprehended the education provided. If any concerns are noted during drill, staff re-educated immediately. Start Date: 8/23/2025 Completion Date: 8/28/2025 Responsible: Administrator, Director of Nursing, Assistant Director of Nursing, and/or Designee Action: All doors checked for functionality. Noted door with issue was being monitored and resident head count every 15 minutes. Alarm placed on door that will alarm at a loud enough volume and will continue until manually disabled to alert staff that a resident potentially has exited the door and to follow policy based on the education noted above (head count and search the premises/surrounding area for residents that have potentially eloped). Start Date: 8/28/2025 Completion Date: 8/28/2025 Responsible: Administrator QAPI Action: Ad hoc (Additional meeting for specific problem) QAPI performed to notify the Medical Director of the Immediate Jeopardy Template and the facility's plan to remove the immediacy. Start Date: 8/28/2025 Completion Date: 8/28/2025 Responsible: Administrator, Director of Nursing, and/or Designee The surveyors monitored the POR on 8/29/25 as follows: In an observation on 8/29/25 at 12:13 PM revealed the rear door of the Women's Secure Unit had a 2nd alarm on the back door which when the staff pressed on the door slightly, the initial egress alarm sounded. They did not fully open the door to set off the 2nd (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	alarm. In interviews on 8/29/25 from 12:05 PM-2:00 PM with staff across both shifts (LVN A, LVN C, LVN D LVN F, MA A, CNA F, CNA K, CNA L, CNA O, CNA P, HK, MS) all stated they had been in-serviced before starting their shifts on the elopement binders that were kept at all the nurse's station, how to do a face to name audit on residents, and Code Pink for missing residents. They were told to try and redirect exit seeking residents as needed and to monitor the doors. MS stated the maintenance department was in-serviced on Code Pink, weekly door inspections and 15 second egress door alarms. Interviews with the ADM, DON, and ADON confirmed they had been in-serviced by regional staff on elopements and Code Pink. The ADM, DON, and ADON all stated they had given elopement drills already and QAPI had been completed on 8/28/25. Record review of an in-service titled Emergency Procedure - Missing Resident Elopements & Wandering Residents and dated 8/28/2025 was conducted by the Senior [NAME] President of Operations (SVPO) was given to the DON and the ADM and was signed by the SVPO, ADM, and DON. Record review of sampled Residents #2, #4, #6, #8, #10, #68 who did resided on a secured unit revealed they had Elopement Risk Assessments conducted on 8/29/2025 per the POR. Record review of an Ad hoc QAPI sign in sheet dated 8/28/25 revealed the signatures of the MD, AMD, DON, ADON, SW, MDSC, DM and included the POR. An IJ was identified on 08/28/2025. The IJ Template was provided to the facility on [DATE] at 05:02 PM. While the IJ was removed on 08/29/25, the facility remained out of compliance at a scope of isolated and a severity with no actual harm due to the facility's need to complete repairs and evaluate the effectiveness of the corrective systems.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections for 3 of 3 laundry carts. The facility failed to ensure laundry staff handled and delivered linens in a manner to ensure cleanliness and protect from dust and soil to prevent cross-contamination and the spread of infections. This failure could place residents at risk for development of communicable diseases and infections that could diminish a residents' quality of life. Findings included: Observation on 8/26/25 at 11:15 AM revealed linens being delivered on a laundry cart being pushed down the hall by LS B with a green fitted sheet thrown over the top of the cart. The sheet left the lower part of the hanging clothes, the clothes down in the basket section, and both ends of the hanging clothes exposed to the open air with visitors and staff passing on the same hall. Observation on 8/27/25 at 1:30 PM revealed linens being delivered on a laundry cart being pushed down the hall by LS B with a fitted green sheet thrown over the top of the cart. The sheet left the lower part of the hanging clothes, the clothes down in the basket section, and both ends of the hanging clothes exposed to the open air with visitors and staff passing on the same hall. Observation on 8/27/25 at 2:12 PM revealed linens being delivered on a laundry cart being pushed down the hall by LS B with a fitted green sheet thrown over the top of the cart. The sheet left the lower part of the hanging clothes, the clothes down in the basket section, and both ends of the hanging clothes exposed to the open air with visitors and staff passing on the same hall. In an interview on 8/27/25 at 2:12 PM with LS B, he stated they had always used a sheet to cover the laundry cart when delivering clean clothes. He stated they never had covers designed for the carts. He stated the reason for covering laundry was to prevent contamination of the clothes and to prevent spreading contamination to residents. He was not sure what a contamination could cause for residents. He agreed that the sheet left both ends of the cart clothes and the basket area exposed to air and possible contamination. In an interview on 8/27/25 at 2:20 PM LS C stated they used the green fitted sheets to cover the laundry carts when they deliver clean clothes. She stated they never had fitted covers, and she had never seen them before. She stated the reason they kept laundry covered was so it won't become contaminated, but she was not sure what contamination would cause for residents. She agreed the sheets did not cover the entire cart and that it left areas of the clothes exposed in the basket and on the ends. In an interview on 8/27/25 at 2:33 PM LS A stated that they used sheets to cover the laundry carts when delivering clean clothes. She stated that she just started supervising laundry in March or April of this year. She stated that they keep laundry covered when delivering to residents to prevent contamination. She stated that contamination of the clothes could cause residents to get sick. She stated that she has never seen covers made to fit the laundry carts. In an interview on 8/29/25 at 12:05 PM, LVN C stated the policy for transporting clean linens was to have the lid on and keep it covered. She stated it was the responsibility of the transporter or laundry supervisor to make sure this policy was followed. She stated it was important to cover linens, so they don't absorb bacteria during transport from point A to point B. She stated the negative outcome to residents if this was not done was that they could get sick from exposure to what was in the air. In an interview on 8/29/25 at 12:15 PM CNA F stated the policy for transporting clean linens was to keep clean linens in a closed cart and this was important to prevent contamination, to keep everything clean, and to keep other residents out of it. She stated on the secure unit residents grabs things if not covered. She stated the negative outcome to residents if this was not done was, they could get sick from contamination. In an interview on 8/29/25 at 12:36 PM ADON A stated the policy for transporting clean linens was to bag linens going into rooms and for the linen cart to be covered. He stated it was the responsibility of laundry staff to make sure the policy was followed. He stated it was important for infection control and the negative outcome to residents if not done could be infections In an interview on 8/29/25 at 12:52 PM the ADM stated the policy for transporting clean linens was to have (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clean linens fully covered and it was the responsibility of the laundry supervisor to make sure this policy was followed. He stated it was important for infections control to prevent contamination of the residents' laundry which could cause infections for them. Record review of the facility's policy dated June-2025 and titled Handling Clean Linen reflected the following: It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection.'Laundry is hygienically clean and handled to prevent recontamination for dust and dirt during transport.Clean linens must be transported by methods. such as placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned reusable textile material that can be secured to the cart.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to retain and use personal possessions including cigarettes for two (Resident #13 and Resident #37) of four residents reviewed for the right to use personal possessions. The facility failed to return the residents' personal cigarettes for Resident #13 and Resident #37 on 08/13/2025. This failure could place residents at risk of having their rights infringed upon and could lead to the residents not being able to use their personal cigarettes when resident were off facility grounds. Record review of Resident #13's face sheet, dated 08/27/2025, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including Nicotine Dependence (regularly smokes cigarettes), cognitive communication deficit (difficulties in communication stemming from impairments in the cognitive processes), generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about various aspects of life). Record review of Resident #13's quarterly MDS assessment dated [DATE] indicated his BIMS score was a 15, indicating he had intact cognition. Resident #13's functional abilities assessment stated he was coded as a 6 (Independent - Resident completes the activity by themselves with no assistance from a helper). Record review of Resident #13's Smoking Evaluation completed on 08/26/2025 indicated Resident #13 had demonstrated ability to safely smoke. Record review of Resident #13's care plan dated 08/13/2025 indicated Resident #13 was a smoker and that Resident #13 was to be a compliant smoker by following the schedule the next 90 days. Resident #13's care plan regarding Psychosocial Well-Being included to observe for signs of adjustment difficulties such as inability to pursue interests or activities, sad or anxious mood, behavioral symptoms. In an interview on 08/26/2025 at 1:00 PM Resident #13 stated that staff were not treating him with dignity and respect, and they were taking away his rights and freedom by not allowing him to have possession of his personal cigarettes when he left the facility at various times. He also stated that the ADM said he would not allow the residents to take their cigarettes off the property unless they were to sign out for good (indicating at discharge). Resident #13 stated that smoking off the property made him feel normal, like he had freedom to smoke and watch people go by and he stated, I will gladly return the items when I come back into the facility. Record review of Resident #37's face sheet dated 08/28/2025, reflected she was a [AGE] year-old female, who admitted to the facility on [DATE], with diagnosis of congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), hypertension (high blood pressure), mood disturbance (a mental health condition that primarily affects your emotional state and uncontrollable worry about various aspects of life). Record Review of Resident #37's MDS assessment dated [DATE] indicated his BIMS score of 15 indicating resident had intact cognition. Resident #37 ADL assessment stated Resident required Supervision - oversight, encouragement or cueing. Record review of Resident #37's Smoking Evaluation completed on 08/26/2025 indicated Resident #37 demonstrated ability to safely smoke. Record Review of Resident # 37's Care Plan indicated the resident prefers to spend most of her time with their friend outdoors smoking. Resident asks other residents and staff to give her cigarettes and/or money for cigarettes. Resident is to be reminded of smoking policy routinely and PRN. In an interview on 08/28/2025 at 4:40 PM, Resident # 37 stated she was denied her cigarettes when she was signing out of the facility on 08/13/2025. She stated she was with Resident #13 and they asked the hall nurse for their cigarettes because they were going to sign out of the facility for a few hours and they wanted to smoke while they were gone. She stated she did not remember the name of the hall nurse. Resident # 37 stated the nurse said no to her and they then went to the ADM and asked him for their cigarettes to which the ADM said they were not supposed to take their cigarettes with them. In an observation on 08/28/2025 at 1:48 PM of an interaction between Resident #13 and Resident #37 and the DM at the facility's (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	designated smoking site. The DM was supervising 5 resident smokers at the facility's designated smoking area. Residents # 13 and # 37 each demonstrated ability to smoke independently. In an interview on 08/28/2025 at 1:48 an interview with the DM was conducted. The DM stated, she and other staff alternate the smoking monitoring assignments. The DM stated, I told [Resident # 13] and [Resident # 37] that they were only allow 2 cigarettes per smoking session. During the interview the DM stated, Per the Smoking Policy [Resident # 13] and [Resident # 37] and all other residents who smoke are not able to bring their personal cigarettes off the facility grounds. The DM stated, We had smoking policy training on Monday, 08/25/2025 but I forget what they talked about. In an interview with ADON B on 08/28/2025 at 11:22 AM, ADON B stated, I was told by [LVN B] that (Resident # 13 and Resident # 37) requested they be given their personal cigarettes to take off the facility grounds. ADON B stated, I told residents including (Resident # 13 I cannot give the cigarettes to any residents upon signing out of the facility due to the smoking policy. She stated, (Resident # 13) told me that the cigarettes the facility was holding for him were his cigarettes, and he should be able to take them with him when he goes out of the facility. ADON B stated, I said to (Resident # 13 and resident # 37), I'm sorry, but we cannot do that. ADON B stated, I was trained in resident rights; we were all in-serviced was last week regarding resident rights. ADON B gave examples of residents' rights such as residents had the right to make choices, to be provided good care, to make decisions about themselves and to have personal property. When ADON B was asked if a resident's cigarettes were considered personal property, ADON B responded, Yes. ADON B stated, If a resident signs out of the facility they are not allowed to take cigarettes with them. In an interview on 08/29/2025 at 10:24 AM with the DON, she stated that an in-service regarding resident rights was conducted both in person and online and she stated it was mandatory for all staff. The DON stated that smoking assessments and observations of residents were done quarterly, and that smoking assessments and resident trainings were mandatory upon admission if the facility knew they were a smoker. She stated that if they found out later that they smoked, the staff would assess them and train them at that time. The DON stated that residents had a right to possess personal property except for their smoking items because their smoking items were locked up and only given to residents according to the facility smoking policy. She stated that residents who smoked were allowed to smoke with supervision while on the property in designated locations and they were not handed their smoking items other than per the policy and residents were not given their smoking items if they checked themselves out of the facility. The DON stated that they would not want the residents to get burned and that the staff monitored the residents in the smoking areas for their safety. The DON stated that if a resident's care plan indicated they could sign themselves out, go off property, they were not allowed to take possession of their personal cigarettes. In an interview on 08/29/2025 at 11:11 AM, the ADM stated that smoking items were considered personal property. The ADM stated, Residents were required to follow the facility policy regarding smoking locations, posted smoking times and smoking items such as cigarettes and lighters. He stated that he told residents they may take possession of their personal smoking items only when they discharge from the facility. He stated that if a resident left the facility grounds, he or she was 100% responsible for themselves. The ADM stated that the residents had a right to smoke off property but the facility did not have to give the residents their cigarettes unless they were being discharged from the facility. Record review of the facility's policy titled, admission Smoking Policy reflected, Residents are not permitted to have tobacco products or lighting devices in their rooms or possession at any time except designated smoking times while supervised by center staff member. All tobacco products and lighter devices are to be labeled with resident name and are to be kept at nurses' station in a locked place. Residents are prohibited from sharing or loaning tobacco products to others. Residents who smoke will be further assessed, using the [company's] Safe Smoking Evaluation, to determine the level of supervision required for smoking, or if resident is safe to smoke at all. Review of the facility's policy titled; Resident Rights reflected: The resident has a right to be treated with respect and dignity, including: The right to retain and use personal (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at New Braunfels		STREET ADDRESS, CITY, STATE, ZIP CODE 821 US Hwy 81 W New Braunfels, TX 78130	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess a resident using the quarterly review (every 3 months) instrument specified by the State and approved by CMS for 1 of (Resident #92) of 5 residents reviewed for quarterly MDS assessments. The facility failed to complete a quarterly MDS assessment for Resident #92 every 3 months (04/19/2025 through 08/22/2025). This failure could place residents at risk of not having accurate assessments completed timely which could result in the residents not receiving necessary care or receiving inappropriate care for their conditions. Findings included: Record review of Resident #92's face sheet dated 08/28/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis that included Alzheimer's Disease (progressive brain disease that causes memory loss and other cognitive impairments), Major Depressive Disorder (mental disorder characterized by a persistent low mood and loss of interest or pleasure in activities), Psychotic Symptoms (collection of symptoms that indicate a disconnection from reality), Cognitive Communication Deficit (problem with communication due to a disruption in cognitive processes), and Muscle Weakness (muscles cannot work with the expected amount of force). Record review of Resident #92's comprehensive care plan dated 06/18/2025 reflected Resident #92 was dependent on staff and was to be offered assistance as needed and verbal encouragement as needed with mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs while encouraging independence. The goals were for Resident #92 to maintain current level of function with assistance in his daily living care needs. Record review of Resident #92's quarterly MDS assessment dated [DATE] reflected a BIMS Score of 3, which indicated several cognitive impairments. Further record review of Resident #92's MDS assessments reflected Resident #92 had a past due open incomplete quarterly assessment dated [DATE]. In an interview on 08/28/2025 at 1:05 PM with the DON, she stated that the facility didn't have an MDS Coordinator in which there was a covering Regional MDS Coordinator conducting MDS assessments for residents. The DON stated that Resident #92's MDS was missed. The MDS was last completed on 04/19/2025 in which the MDS was processed on 08/22/2025, 125 days in total, and 5 days late out of the quarterly assessment timeframe which is 120 days for review. In an interview on 08/28/2025 at with RMDS Coordinator, he stated he had been RMDS trained in which he had been conducting MDSs for residents since 2019. The RMDS Coordinator stated he had not received any MDS in-service or training by this facility. The RMDS Coordinator stated he was hired by a senior living company overseeing the facility in a regional role. The RMDS Coordinator stated he was hired based on his knowledge and previous training experience. The RMDS Coordinator stated there wasn't an MDS coordinator as of August 8, 2025 when he filled in to cover as the RMDS Coordinator taking over MDS duties for the facility. The RMDS Coordinator stated the process for MDS was to complete an initial admission within 14 days, complete MDS assessments quarterly every 3 months per regulations, and complete annual MDS assessments. The RMDS Coordinator stated under certain circumstances, if there was a change of condition when needed, an MDS assessment was completed. The RMDS Coordinator stated Resident #92's MDS was missed due to him not checking back dates for MDS completion dates and it was going to be late regardless if he checked. The RMDS Coordinator stated his plan was since Resident #92 MDS was late, he was going to change it to an annual MDS assessment. The RMDS Coordinator stated Resident #92 wasn't assessed in a timely manner and he honestly didn't notice it until he did an audit sometime last week when at the facility. The RMDS Coordinator stated he wasn't advised by anyone that Resident #92's MDS was late and it's his responsibility to monitor MDSs to meet timeframes. The RMDS Coordinator stated he owns the fact that Resident #92's MDS was missed. The RMDS Coordinator stated his expectations for residents MDS is to make sure they are all in compliance with regulations and completed in a timely manner. The RMDS Coordinator stated his expectations also included following the MDS assessment cycle (continued on next page)		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	until the resident discharged . The RMDS Coordinator stated the resident's quality of life such as, Resident #92, could be affected if MDSs were not completed mainly in an indirectly affect towards a resident as the facility would continue providing the services to the resident and not have an updated assessment for the residents current person-centered needs. In an interview on 08/28/2025 at 3:21 PM with the DON, she stated she learned her MDS training prior to being hired within the facility as she had been the DON for 3 weeks. The DON stated the MDS process is to complete an initial MDS assessment, complete a quarterly MDS assessment, complete an annual MDS assessment which is regulations. The DON stated she wasn't able to conduct the MDS assessment since that was the job of the MDS Coordinator or Regional MDS Coordinator that oversaw the facility. The DON stated there had not been any in-servicing and training by the facility. The DON stated since she was hired 3 weeks ago as the DON, there wasn't a MDS Coordinator onsite besides there being a Regional MDS Coordinator. The DON stated Resident #92 wasn't assessed in a timely manner and was missed by the Regional MDS Coordinator. The DON stated Resident #92's MDS should have been monitored by the Regional MDS Coordinator as it's the Regional MDS Coordinator's responsibility to complete initial, quarterly, and annual MDS assessments. The DON stated it's her expectations for residents' MDSs to be completed and entered in timely along with a calendar timeframe as to make sure all MDS assessments was completed during each recurring cycle. The DON stated residents could be negatively impacted or their quality of life could be affected if MDS assessments aren't completed such as, weight loss, wound care treatments, decline in ADL's, and all the resident's needs being provided to by the facility. In an interview on 08/28/2025 at 3:38 PM with the ADM, he stated that he had not been trained on MDS assessments since he was not a nurse. The ADM stated he checked to see if MDS assessments were completed or there was missing information. The ADM stated the RMDS Coordinator managed all the MDS aspects and monitored to make sure they were completed. The ADM stated he wasn't aware of any MDSs being past due for any residents. The ADM stated he did not oversee Resident #92's MDS assessment to have knowledge when it was due or that it was late. The ADM stated there had not been an MDS Coordinator since the beginning of August 2025, and that was when the RMDS Coordinator took over the role. The ADM stated the facility had hired a new MDS Coordinator to help fill the role and assist the RMDS Coordinator with working on residents MDS assessments. The ADM stated if an MDS was not finished, it put things on hold for additional staff to assist with the MDS tasks, and he did not see how it affected residents physically as it would cause issues with the company. The ADM stated Resident #92 was not assessed and was late if it had been over 125 days. The ADM stated the previous the MDS assessment for Resident #92 would continue and default, which the facility would not be able to provide Resident #92 updated treatment to meet the resident's needs. The ADM stated his expectations was that residents' MDS assessments to be completed correctly, timely, and be accurate for the residents. Record review of facility In-services reflected: the facility did not have MDS in-service trainings or education for January 2025 to August 2025. Record review of facility policy for MDS Completion dated 07/2025 reflected the following: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. OBRA Assessment refers to an assessment mandated by the Omnibus Budget Reconciliation Act of 1987, which specifies a Minimum Data Set of core elements for use in assessing nursing home residents. PPS Assessment refers to an assessment used in the skilled nursing facility prospective payment system to classify residents into categories for payment purposes. ARD, or Assessment Reference Date, refers to the specific endpoint in the MDS assessment process (last day of MDS observation period). Comprehensive Assessment refers to the completion of the MDS, Care Area Assessment (CAA) process, and development and/or review of the comprehensive care plan. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. Quarterly Assessment - completed using an ARD no >92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD). (continued on next page)		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Annual Assessment - a comprehensive assessment completed using an ARD no, >366 days from the most recent prior comprehensive assessment and no >92 days from the most recent quarterly assessment (counting ARD to ARD).		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were discarded before the expiration date for 2 medications stored in 1 of 2 medication rooms observed for medications. The facility failed to ensure that Med room [ROOM NUMBER] did not have expired OTC medications in the drawer/room. The failures could result in residents receiving ineffective, expired medications which could be harmful. An observation and audit were conducted 08/28/2025 at 10:21 AM of Med room [ROOM NUMBER] which was located in the main lobby revealed that inside a mini fridge were expired insulin and Bisacodyl. The insulin had an expiration date of 08/21/2025. The Bisacodyl had an expiration date of 04/29/2025. An interview was conducted on 08/28/2025 at 4:38PM with the ADM who reported working at the facility for 2.5 months. The ADM stated the ADON and DON provided training for labeling/dating medication. The ADM stated that the policy for labeling/dating medications was everything that came from the pharmacy should be labeled already. The ADM stated it could negatively affect a resident to have expired medications by the potential for the medication to lose some of its potency. The ADM stated this could indicate a possibility that a resident did not receive that medication. An interview was conducted on 08/28/2025 at 4:50PM with the DON who reported working at the facility for 3 weeks. The DON stated that the policy for labeling/dating medications was that staff need to have an open date of when they had opened the medications for OTC meds. The DON also stated that the policy for expired medication is that they should not be in the cart and should have been removed. The DON stated that pharmacy will audit the med carts once a month but there is no official document to provide. The DON stated it negatively affected a resident to have undated/expired meds in the med cart by the medication could lose their effectiveness. Record review of a document provided by the facility titled Medication Storage undated, revealed that medications should be labeled, dated and stored in proper areas according to the label.		

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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 in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments, under proper temperature control and labeled in accordance with currently accepted professional principles for 2 (medication cart #1 and medication cart #3) of 4 medication carts reviewed for medication storage. The facility failed to ensure that MC #1 did not have loose unknown NARC medications in the drawer. The facility failed to ensure that MC #1 and MC #3 did not have medications that were undated in the drawer. This failure could put residents at risk for missed medications and/or receiving unidentified medications. An observation and audit conducted on 08/27/2025 at 12:50 PM revealed Med Cart #1 which was stationed on the 50 hall, contained loose and unlabeled medications. The observation revealed half of a white circle tablet loose in the locked narcotics bin. It was identified by INV and LVN G that the medication was not a current medication in the narcotics bin. Med Cart #1 contained undated over the counter medication bottle which should be labeled with a date when opened. An interview was conducted on 08/27/2025 at 1:15PM with LVN G who reported being employed at the facility for 1 year. LVN G stated that she had received training on labeling and dating medications. LVN G stated that they were expected to label the bottle of OTC medications when they opened them. LVN G stated undated and opened medication could negatively affect the residents by the medication not being as effective if it was expired. LVN G stated that loose unaccounted medications could negatively affect a resident by not having the medication available to the resident. LVN G stated the loose narcotic medication could negatively affect a resident for pharmacy delivery. LVN G stated pharmacy orders could be delayed. An observation and audit conducted on 08/28/2025 at 10:05AM revealed Med Cart #3 which was stationed in the men's locked unit, contained undated/unlabeled Vitamin D medications. The medication should have been labeled with a date of when the medication was first opened. An interview was conducted on 08/28/2025 at 10:15AM with LVN F who reported being employed at the facility for 2 months. LVN F stated that they had received training on labeling and dating medications. LVN F stated that the training included ensuring that they checked expiration dates, and whenever a medication was opened, they labeled and dated it. LVN F reported that if medications were not labeled it could negatively affect a resident by the medications not being effective. LVN F stated that a negative effect of loose narcotic medications would be the resident potentially had not received the medication. An interview was conducted on 08/28/2025 at 4:38PM with the ADM who reported working at the facility for 2.5 months. The ADM stated the ADON and DON provided training for labeling/dating medication. The ADM stated that the policy for labeling/dating medications was everything that came from the pharmacy should be labeled already. OTC meds should be dated and labeled when they opened them. The ADM stated the policy for loose medications was that staff should not use them and throw them away. The ADM stated that the med carts were audited by nursing management monthly but there were no formal records to provide. The ADM stated it could negatively affect a resident to have undated meds in the med cart by receiving expired medications. The ADM additionally added it could negatively affect a resident to have loose medications in the NARC drawer by not knowing what the medication is and that it could be contaminated. The ADM stated this could indicate a possibility that a resident did not receive that medication. An interview was conducted on 08/028/2025 at 4:50PM with the DON who reported working at the facility for 3 weeks. The DON stated that the policy for labeling/dating medications was that staff need to have an open date of when they had opened the medications for OTC meds. The DON stated the policy for loose medications was that there shouldn't be any loose pills. The DON stated that pharmacy will audit the med carts once a month but there is no official document to provide. The DON stated it negatively affected a resident to have undated/expired meds in the med (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cart by the medication could lose their effectiveness. The DON stated it negatively affect a resident to have loose medications in the NARC drawer by the potential that the resident did not receive that particular medication. The DON confirmed that this could potentially be a med error. Record review of a document provided by the facility titled Medication Storage undated, revealed that medications should be labeled, dated and stored in proper areas according to the label.		