STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455489	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Jeffrey Place	820 Jeffrey Dr Waco, TX 76710

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to ensure food safety by not labeling & dating food correctly, wearing hair restraints, and sanitizing equipment during food service. These failures could place residents at risk for foodborne illnesses.Findings include: Observation in the standalone refrigerator on 04/07/2026 at 8:40 AM revealed the following: Cheese in the Ziplock bag had no open date or use-by date on the bag. Lunch meat in a sealed container had the date 4-3 with no use-by date. A clear container with individual butter packages had no date on the container or the packages. Unknown soup in a metal container was exposed to the air and not dated. Observation in the standalone Freezer on 04/07/2026 at 8:50 AM revealed the following: Raw chicken in a Ziplock bag with no open date or use-by date on the bag. Cooked diced chicken with a date of 4-6 with no use-by date. Packaged waffles with no dates on the bag. Breaded okra with no open date or use-by date on the bag. Dinner Rolls with a date of 4-3-2026 and no use-by date. Observation in the walk-in Pantry on 04/07/2026 at 9:00 AM revealed the following: Breadcrumbs with dates of 2-10 and no use-by date. Tortillas with no open date or use-by date on the package. Fruit Loops cereal in a clear container dated 3-12 with no use-by date. Frosted Flakes cereal in a clear container dated 3-12 with no use-by date. Observation in the kitchen on 04/07/2026 at 9:07 AM revealed the following: The ice scoop holder had dirty water in the bottom of the container, along with a black piece of plastic. Observation of the taking of food temperatures on 04/07/2026 at 9:07 AM revealed the following:CK A had a hairnet covering only the bun on top and the hair that was uncovered was below the cheek. While CK A was taking the temperature of food on the warming table, she wiped the thermometer off with a paper towel, then took the temperature of another food item. CK A did not take the temperature of the beans on the warming table. CK A did not take the temperature of the chicken tenders that were in the basket over the fryer. An interview on 4/09/2026 at 10:04 AM, the DA stated everyone was responsible for labeling and dating food items in the kitchen. The DA stated she was responsible for maintaining the refrigerators and ensuring everything was dated. The DA stated that she was off for two days and did not realize some food items were not labeled and dated. The DA stated all food items in the kitchen should have an open date and a use-by date. The DA stated all food should be covered or wrapped in plastic. The DA stated that she did not put the food item in the refrigerator that was left uncovered. All food items should be labeled and dated. The DA stated hair restraints should always cover the hair. The DA stated residents could get sick if they were served food that was out of date or if hair fell into the food. The DA stated they didn't have in-service training on labeling, hair nets, and sanitation. An interview on 4/09/2026 at 10:13 AM, CK A stated it was everyone's responsibility to label and date food items in the kitchen. CK A stated food items in the refrigerator should be checked daily, and all out-of-date products should be discarded. CK A stated all food items should be labeled and dated. The CK A stated all food items in the kitchen should be covered and not be exposed to air. CK A stated hairnets should cover all hair. The CK A stated that she was not provided with a hair net to cover all her hair. CK A stated when taking food temperatures before (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	service, the thermometer should be sanitized between each food item. The CK A stated that she was in a hurry and got nervous was the reason she did not sanitize the thermometer. The CK A stated residents could get sick if they're served food that was out of date, if hair fell into the food, or if the food's temperature was taken with a dirty thermometer. An interview on 4/09/2026 at 10:41 AM, the DM stated it was everybody's responsibility to label and date food items in the kitchen. The DM stated dates in the refrigerators should be checked daily, and foods in the freezer and pantry should be checked at least once a week. DM stated that she is responsible for checking once a week. The DM stated hairnets should always be worn in the kitchen when hair was exposed. The DM stated all food items in the kitchen should be labeled with the contents of the bag, the date it was opened, and the use-by date. The DM stated that the food content was not on the label because she missed it. The DM stated when taking food temperatures, the thermometer should be sanitized between each food item. The DM stated failing to follow these procedures could result in a resident becoming ill. An interview on 4/9/2026 at 2:00 PM, CK B stated when taking temperatures of food items on the warming table, the thermometer should be sanitized before the temperature was taken for each food. She stated she was nervous and that's why she was using a paper towel to wipe off the thermometer. CK B stated when wearing a hair net, it should cover all her hair. CK B stated she did not have a hair net to cover all her hair, only the top part. CK B stated she would have to ask for a hairnet that could cover all her hair. CK B stated it was everybody's responsibility for labeling and dating food items in the kitchen. CK B stated there were times she forgot to put the use by date on some of the Ziploc bags in the refrigerator. Record review of the facility's Food Preparation and Service Policy, updated on 11-2022, reflected Policy Interpretation and Implementation When verifying food temperatures, staff use a thermometer which is both clean, sanitized, and calibrated to ensure accuracy.Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.All food service equipment and utensils will be sanitized.Expiration dates on unopened food are observed and use by dates are indicated once food is opened.Reviewed the federal food code that the facility had on file.

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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. Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the need of each resident. The facility failed to establish a system of record of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation at each shift change on one of two medication carts reviewed for shift change reconciliation documentation This failure could place residents at risk of drug diversions and could result in diminished health and well-being.Findings include: Record review of the Change of Shift Narcotic Count Sheets for the 300 Hall revealed missing documentation for the following: 04/01/2026 6am-2pm Start and End Counts04/03/2026 10pm-6am Oncoming Nurse Signature04/03/2026 6am-2pm Off going Nurse Signature04/04/2026 2pm-10-pm Oncoming Nurse Signature04/05/2026 6am-2pm Start and End Counts04/05/2026 10pm-6am Start and End Counts04/06/2026 6am-2pm Start Counts and Oncoming Nurse Signature04/06/2026 2pm-10pm Off going Nurse Signature04/06/2026 10pm-6am End Count and Off going and Oncoming Nurse Signature04/07/2026 6am-2pm Off going Nurse Signature04/07/2026 10pm-6am Start and End Counts and Oncoming Nurse Signature During an interview with MA C, on 04/09/2026 at 9:35AM, she stated it was required for the off going and oncoming staff to count narcotic medications and sign the Narcotic Count Sheet. She stated sometimes they didn't sign off if it's the same person working the next shift. She stated they received training on the process for change of shift narcotic count and documentation at new hire and then every year. There were also in-services at different times, the last one being about 2 weeks ago. During an interview on 04/09/2026 at 9:48AM with the DON, she stated it was her expectation that the off-going nurse and the on-coming nurse counted the narcotics together at the change of shift. The DON stated a negative outcome of not consistently following the narcotic count expectations was a possibility of drug diversion. The DON stated the staff were trained at New Hire and annually thereafter. She stated there were also in-services throughout the year on this topic, the last one being two weeks ago. During an interview with MA D on 04/09/2026 at 10:00AM, she stated it was required for the off going and oncoming staff to count narcotic medications and sign the Narcotic Count Sheet. She stated she was trained on this process at new hire. Record review of the Controlled Substances Policy, dated November of 2022, reflected, Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of any significant medication errors for 2 of six residents (Resident #4 and Resident #46) reviewed for medication errors.The facility failed to administer scheduled time-sensitive medication to Resident #4 on 04/09/26. The facility failed to administer scheduled medications to Resident #46 on 04/07/2026.This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, worsening or exacerbation of chronic medical conditions, and hospitalization.Findings include: 1, Record review of Resident #4's face sheet, dated 04/09/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had a diagnosis which included partial traumatic amputation of left midfoot, sequela. Record review of Resident #4's care plan, dated 02/13/26, reflected Focus: Resident #4 had pain r/t partial amputation with infected vascular wound on Lt. foot. Goal: Resident #4 will not have an interruption in normal activities due to pain through the review date. Interventions/Tasks: Monitor to pain q shift and administer medication as ordered. Monitor/document for probably cause of each pain episode. Remove/limit causes where possible. Notify physician if interventions are unsuccessful or if current complaint is a significant change from Resident #4's experience of pain. Record review of Resident #4's MDS, dated [DATE], reflected Resident #4 had a BIMS score of 15, which indicated cognitively intact. Record review of Resident #4's MAR, dated 04/2026, reflected oxycodone HCl oral tablet 15 mg given once every 8 hours for pain-severe related to unspecified open wound, left food, sequela at 08:00 AM and 04:00 PM. The MAR did not include reason for late administration. Observation of medication administration on 04/09/26 at 09:20 AM revealed Resident #4 was administered 08:00 AM scheduled medication (Oxycodone) by MA B. In an interview with Resident #4 on 04/09/26 at 09:20 AM, he stated his pain medication was scheduled for 08:00 AM and at 09:20 AM, he still had not received his medication. In a subsequent interview with Resident #4 on 04/09/26 at 11:12 AM, he stated he was not in pain and added he received a PRN pain medication the night before. Resident #4 stated he normally received scheduled meds on time every day, and added this occurrence was unusual. 2. Record review of Resident #46's face sheet, dated 04/07/26, reflected a [AGE] year-old female who was admitted to the facility 06/03/2020. Resident #46 had diagnoses which included fibromyalgia (chronic disorder of unknown etiology characterized by pain, stiffness, and tenderness in the muscles of neck, shoulders, back, hips, arms, and legs), bipolar disorder, current episode manic severe with psychotic features (a period of abnormally elevated, extreme changes in your mood or emotions, energy level or activity level), delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined), acute respiratory failure with hypoxia (a sudden inability of the lungs to provide sufficient oxygen to the blood, defined by a PaOˆ below 60 mmHg without elevated carbon dioxide), edema, unspecified (swelling caused by excess fluid in the body's tissues when the exact cause is not identified). Record review of Resident #46's care plan, dated 02/19/26, reflected Focus: Resident #46 complained of chronic pain R/T fibromyalgia. Goal: Resident #46 would not have an interruption in normal activities due to pain through the review date. Interventions/Tasks: Administer medications as ordered and report adverse side effects. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Notify physician if interventions were unsuccessful or if current complaint was a significant change from Resident #46's experience of pain. Position for comfort with physical support as necessary. Record review of Resident #46's MDS, dated [DATE], reflected Resident #46 had a BIMS score of 15, which indicated cognitively intact.Record review of Resident #46's MAR, dated 12/02/2025, reflected lidocaine external patch 4% apply to affected area topically one time a day related to pain; acetaminophen-codeine oral tablet 300-3-MG give 1 tablet by mouth 2 times a day related to pain. The MAR did not include a reason for late administration. Observation on 4/7/2026 at 11:40 AM, MA A (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #46 was administered AM medication that should have been given between 06:00 AM to 10:00 AM, which are scheduled medications (lidocaine and acetaminophen-codeine) at 11:40 AM. In an interview with Resident #46 on 04/07/26 at 11:20 AM, she stated her pain medication, and her lidocaine patch should have been put on her since early that morning (she didn't give the time), and she still had not received her medication. Resident #46 stated the med tech was late with the medication. Resident #46 stated her pain level was at about seven. She stated MA A was her friend and she normally received her medications from her. In an interview with MA A on 04/07/2026 at 11:36 AM, MA A stated she was late today passing medication. MA A stated Resident #46 was supposed to have her lidocaine patch placed between 6 AM -10 AM. MA A stated Resident #46 took Tylenol 3 that should have been given between 6 AM -10 AM for pain. Resident #46 was given medication and patch at 11:36 AM. In an interview with MA B on 04/09/26 at 10:16 AM, she stated she had been with the facility 4 days. She stated she was licensed since 2011. She stated she knew med passes were an hour before or after the scheduled time. She stated she had not yet learned the resident faces and tried to catch them in their rooms. She stated she was also reading orders to ensure all information matched up because she was real thorough. She stated Resident #4 received amlodipine 10 mg for BP, aspirin 81mg chewable for heart, oxycodone 15 mg for pain, carvedilol 6.25 mg 2 tablets for BP, sennas for constipation, probiotic. She stated his pain med was scheduled for 8 AM while all others were on a block time. She stated risk to resident health because of receiving meds late was him being in pain. She stated the facility policy was to give medications an hour before or after the scheduled time. She stated she was trained by the DON on medication administration. In an interview with the DON on 04/09/26 at 10:27 AM, she stated scheduled medications were to be administered an hour before or after, unless there were special instructions. She stated Resident #4 did not have special instructions for his medications. The DON stated the reason medications were late was because this was MA B's first day by herself. She stated she let the med aide know if she was running late, she needed to inform management. She stated the med aide told her Resident #4 was outside smoking at his scheduled time. She stated Resident #4 sent the med aide away. She stated the risk was poor pain management and poor outcomes for untimely medications. She stated late med administration did not occur regularly. The DON stated she was responsible for training and added she started an in-service on controlled substances and med administration. The DON stated the med aid needed to get the nurse if they had any questions. She stated if the resident had high blood pressure medication and the medication was late, it could run their pressure to high; if it was a diabetic medication, it could elevate their blood sugar unnecessarily. If the resident's medication was late, it could potentially result in a bad outcome. The DON stated Resident #46 was supposed to have the patch put on an hour before or an hour after. That was all meds unless it was a special medication with special instructions attached to the order. Record review of Medication Administration Schedule policy, dated 2001, reflected Policy Statement Medications are administered according to established schedules. Policy Interpretation and Implementation 3. Scheduled medications are administered within one (1) hour of their prescribed time, unless otherwise specified. 4. Scheduled medications designated as time-critical (medications that may cause harm or sub-therapeutic effect if administered before or after the scheduled time) are administered at the scheduled time (for example, rapid-acting insulin) or withing 30 minutes of the scheduled time. 5. Time critical medications are designated by the pharmacy and include: b. scheduled opioids used for chronic pain or palliative care. 7. The exact time of medication administration is documentation in the MAR. If medication is administered early, late (beyond the allowable interval), or is omitted, the reason is also documented. 8. A physician's order for specific times supersedes any routine schedule. Record review of the, undated, Medication Administration Times list reflected:*Hall 200 and 500 - Med Room Located 200 hall (first door on right) 1 Medication Cart and 1 Treatment cart *AC pass begin at 7AM *HS pass begins at 7PM *TID Administration - 6AM, 11AM, 7PM *QID Administration - 7AM, 11AM, 3PM, 7PM Record review of facility in-services reflected: *04/08/26: Competency: Medication Administration*04/09/26: Medication Administration Schedule & Charting and Documentation