STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455550	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Center	280 Moffitt Dr Center, TX 75935

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure residents maintained the right to receive visitors of his or her choosing at the time of his or her choosing for 1 of 1 facility. The facility failed to ensure all residents had the right to receive visitors between 10:00 PM and 6:00 AM.The deficient practice could place residents at risk of isolation, decreased emotional well-being, and diminished quality of life. Findings include:Observation on 07/22/2025 at 6:15 AM revealed a sign posted on the main entrance Visitation hours: 6:00 AM to 10:00 PM During a confidential resident council meeting on 07/22/2025 the residents in attendance were not aware of limitation of visiting hours.Record review of a letter dated 06/24/2025 presented on 7/22/2025 by the Administrator addressed to families and visitors indicated the designated visiting hours as daily 6:00 AM to 10:00 PM. The letter indicated any visits outside of regular visiting hours were to be arranged with the administrative staff. The letter was signed by the social service director. During an interview with the interim Administrator on 07/23/2025 at 8:20 AM, he stated visiting hours were enacted in the middle of June 2025 due to complaints by more than one resident, relating to family members coming to the facility late at night and disturbing residents in the facility. He stated a family member had visited the facility after midnight while under the influence of intoxicants. He stated late night visits occurred on more than one occasion and involved more than one resident. The decision was made to limit visiting hours from 6:00 AM to 10:00 PM. He stated phone calls were made to all resident representatives regarding visiting hours and there were no complaints or concerns with limiting the visiting hours. The administrator stated a letter was sent to all resident representatives notifying them of the facility's visiting hours. He stated the decision was made to limit visiting hours to all visitors so that one family or resident would not be singled out, and equal treatment was being provided to all residents. He stated he has not received any resident complaint related to establishing visiting hours. The administrator stated the hours were to deter late night visitations that would disturb other residents. He stated limiting visitation hours could have a negative impact on the residents by causing emotional distress and fear related to the inability to see their family members.In an interview with the social worker on 07/23/2025, she stated the decision was made to limit visitation hours in the facility after complaints by residents related to family members visiting the facility late at night and waking them. She said one resident had a family member who had come into the facility on several occasions after midnight under the influence of intoxicants and disturbed the roommate and other residents. She stated a meeting was conducted with the family member related to the complaint and discussed how the late visits were disturbing other residents during hours of rest and the family member verbalized understanding of the concern but continued to make late night visits. After complaints continued by the residents, the administrative staff made the decision to limit visitation hours. The social worker stated phone calls were made to all family representatives to inform them of the visitation hours and there were no concerns or complaints during the telephone communications. The social worker stated no residents had voiced concern or complained about the visiting hours. She stated a letter was mailed to all resident representatives that indicated visiting hours were daily from 6:00 AM to 10:00 PM. She stated there has been no complaints or signs of negative effects to the residents related to limiting visitation hours. Record review of facility admission packet, a document titled Resident Rights revised 12/1/2018 indicated residents have the right to receive visitors.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews 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 development and transmission of communicable diseases and infections for 2 of 6 residents (Resident #10 and Resident #17) and 2 of 5 staff (LVN A and CNA B) reviewed for infection control. The facility failed to ensure LVN A and CNA B followed enhanced barrier precautions for Residents #10 and #17 on 07/21/2025. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included:Resident #10Record review of Resident #10's facility face sheet dated 07/21/2025 revealed that Resident #10 was a [AGE] year old female that admitted on [DATE]. Record review of Resident #10's order summary report dated 07/21/2024 revealed Resident #10 had a diagnosis of dementia and required EBP every shift related to pressure wound. Record review of Resident #10's Quarterly MDS assessment dated [DATE] revealed Resident #10 had a BIMS of 9 indicating moderately impaired cognition, required maximal assistance with toileting and was incontinent of bowel and bladder. Record review of Resident #10's comprehensive care plan dated 07/03/2025 revealed Resident #10 required EBP during contact care and staff to provide and utilize appropriate PPE along with standard precautions while providing resident care. During an observation and interview on 07/21/2025 at 9:45 am Resident #10 had a yellow dot by her name outside her room. She said the staff wore gloves but not a gown when providing care to her. During an observation on 07/21/2025 at 2:45 pm CNA B provided incontinent care to Resident #10 with the ADON present for assistance. CNA B removed Resident #10's linens, provided incontinent care and turned and positioned Resident #10 with only gloves in place. Resident #17Record review of Resident #17's facility face sheet dated 07/22/2025 revealed that Resident #17 was a [AGE] year-old male that admitted on [DATE]. Record review of Resident #17's order summary report dated 07/22/2024 revealed Resident #17 had a diagnosis of cerebral infarction (stroke) and required EBP every shift related to urinary tract infection. Record review of Resident #17's Annual MDS assessment dated [DATE] revealed Resident #17 had a BIMS of 9 indicating moderately impaired cognition, required maximal assistance with toileting and was incontinent of bowel and bladder. Record review of Resident #17's comprehensive care plan dated 07/21/2025 revealed Resident #17 required EBP during contact care and staff to provide and utilize appropriate PPE along with standard precautions while providing resident care. During an observation and interview on 07/21/2025 at 10:00 am Resident #17's name at his door had a yellow dot and he said the staff did not wear a gown when providing care. During an observation on 07/21/2025 at 4:05 pm CNA B was observed providing incontinent care to Resident #17. CNA B performed incontinent care, changed the resident's linens and gown and assisted with positioning the resident with only gloves in place. During an observation and interview on 07/21/2025 at 4:30 PM LVN A did not wear a gown while administering intravenous medication to Resident #17. LVN A stated the resident had a yellow dot indicator on his name plate outside his door. She stated the yellow dot indicated the resident was on enhanced barrier precautions. She stated staff were to wear gowns, gloves and mask when providing care to residents on enhanced barrier precautions. LVN A stated staff should wear proper PPE when providing care to residents on enhanced barrier precautions to prevent the possible exposure and spread of germs to other residents and staff. During an interview on 07/21/2025 at 4:34 pm CNA B said the yellow dot on the name at the door meant the resident required a gown and gloves for EBP. She said she overlooked that Residents #10 and #17 had a yellow dot and should have applied a gown along with gloves. She said she knew what EBP was but could not recall the specific training she received. She said by not following EBP infections could spread. During an interview on 07/21/2025 at 4:37 pm the DON said she oversaw the infection control program, and all staff were educated on EBP along with other infection control measures on hire, annually and as needed. She said LVN A and CNA B had been trained and expected that the staff to follow the infection control program to prevent the spread of infections. During an interview on 07/23/2025 at 8:44 am the Administrator said that the DON was responsible for the infection control program. He said all staff were trained on hire and throughout the year on infection control including EBP. He said when a resident required EBP the resident name outside the door would have a yellow dot and the staff should wear a gown and gloves to provide care. He said he expected all staff followed the facilities infection control program to prevent the spread of infections. Record review of LVN A's nurse proficiency dated 08/30/2024 revealed LVN

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, interviews, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for essential equipment. The facility did not ensure the gas stove was in safe operating condition with the pilot light burner staying lit for 1 of 6 burners and allowing gas to leak on 07/21/25 and 07/22/25. This failure could place the residents at risk of a fire and not receiving their meals in a timely manner.Findings included: During an observation on 07/21/25 at 9:00 a.m. the back right burner on the stovetop was observed to not light. Dietary Manager retrieved a striker and proceeded to light the pilot light with the striker. Pilot light behind the back right burner was observed behind the back right burner and was observed to be out. Dietary manager was unable to relight pilot light with striker and proceeded to light the burner. The burner lit with the striker. During an observation and interview on 07/22/25 at 9:15 a.m. the right back burner pilot light was observed to be out again. Dietary Manager was observed to light burner with striker. She said the vent in the ceiling would blow toward the pilot light on the back burner and cause it to blow out. During an observation and interview on 07/22/25 at 10:30 a.m. a vent was observed in the ceiling directly in front of the stove. Air was felt blowing straight down. There was a large pot observed on the back burner of the stove. [NAME] moved the pot and pilot light was observed to be lit. Burner lit with no issues. Dietary manager was in kitchen and said she knew it could be dangerous for the pilot light to keep going out and having to light the burner with a striker. She said she had been at this facility on and off for about 14 years and it had been a constant issue. She said she did not know what the facility had tried in the past to avoid the air from the vent blowing the pilot light out. She said maintenance had been made aware, but she could not remember the last time she had reported it to him. She said she would report it again and get it taken care of. She said she knew it could be a fire hazard having to relight the burner with a striker. During an interview on 07/22/25 at 1:14 p.m. the Maintenance Director said he was aware the pilot light did go out at times. He said the gas would still be running if the pilot light was out and it could potentially be a fire hazard. He said he would look at the issue and see if he could possibly divert the air flow to prevent the pilot light from being blown out. During an interview on 07/22/25 at 8:30 a.m. the Administrator said they did not have a facility policy for maintaining equipment. During an interview on 07/23/25 at 8:20 a.m. the Administrator said he was an interim and had only been here for a couple of months. He said the risks of fire should be low on the stove because they have the exhaust fan running all the time, but it still would be fixed. He said he was going to look into ways to try and divert the airflow from the vent to try and prevent the pilot light from being blown out. He said going forward, he would expect the stove to work properly.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bedrooms measured at least 80 square feet per resident, in 3 of 11 resident rooms reviewed for required square footage. (Resident room #s 300, 309 and 310). The facility did not have at least 80 square feet per resident in resident room #s 300, 309, and 310. This failure could place residents at risk of having inadequate space for personal belongings, guests, and limit the resident's ability to move about in the room. Based on observation, interview, and record review, the facility failed to ensure bedrooms measured at least 80 square feet per resident, in 3 of 11 resident rooms reviewed for required square footage. (Resident room #s 300, 309 and 310). The facility did not have at least 80 square feet per resident in resident room #s 300, 309, and 310. This failure could place residents at risk of having inadequate space for personal belongings, guests, and limit the resident's ability to move about in the room. Findings included: During an observation on 07/21/25 from 10:00 am until 10:30 am, room [ROOM NUMBER] was used for maintenance, room [ROOM NUMBER] was used for an office and room [ROOM NUMBER] was used as a sitting area in the locked unit. The rooms measured approximately as follows: * room [ROOM NUMBER]- 6 x 4 feet at entry and the main area was 13.4 x 10.4 feet.* room [ROOM NUMBER]- 12 x 12.4 feet; and * room [ROOM NUMBER]- 12.8 x 12.3 feet.Record review of a bed classification worksheet, completed by the facility administrator, dated 07/22/2025 indicated there were 11 resident rooms on the secured unit, including Resident room #s 300, 309, and 310. (Hall 300) During an interview on 07/21/25 at 10:30 am, the Administrator said there had been no structural changes to the building and he knew there had been a waiver granted in the past for three rooms on the secured unit. The Administrator said he would complete HHSC form 3762 (room size waiver for facilities).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relays the call directly to a staff member or a centralized staff work area from toilet and bathing facilities for 1 of 4 residents reviewed for call lights. (Resident #11). The facility failed to ensure Resident #11's emergency call light in the bathroom would reach the floor. The call light cord for Resident #11 was three feet above the floor level.This failure could place residents at risk of not receiving timely assistance. Findings include: Record review of a face sheet dated 07/21/2025 indicated that Resident #11 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia (confusion due to aging with inability to remember), difficulty ambulating, and muscle wasting. Record review of a Quarterly MDS assessment dated [DATE] for Resident #11 indicated she had a BIMS score of 9, indicating that she had moderate cognitive impairment. The MDS indicated that the resident required supervision or touch assist of one person for toilet use and ambulated with a walker.Record review of a comprehensive care plan with a revision date 6/06/2025, revealed Resident #11 was at risk for injuries related to falls. During an interview and observation on 07/22/2025 09:15 AM Housekeeper A said the call light in Resident #11's bathroom was too short to be reached at floor level, the string was 3 feet from the floor. Housekeeper A said if Resident #11 had a fall she would not be able to reach the call light. She said if the resident fell, she could lay on the floor until someone heard her or when the next rounds were made by staff.During an interview on 07/22/25 at 10:00 AM, the Maintenance Director said the call lights in bathrooms needed to be accessible because if a resident were to fall, they needed to be able to reach the string to call for help. He said he would make a facility sweep to correct all strings to the required length. During an interview with the ADON on 07/22/2025 10:20 AM, the ADON said she would in-service staff to notify maintenance if the bathroom call strings did not reach floor level. The ADON said all staff members were responsible for ensuring call lights were in place. Residents could be at risk of not being able to call for help in an emergency, such as falls. Going forward, she would expect call lights to be checked every shift to make sure they are available. During an interview on 7/22/25 at 10:50 AM the Administrator said that the CNAs were responsible for ensuring that all call lights were in place and in working order and report to maintenance if there are no problems. He said that residents may not be able to call for help when needed if they can't reach their call light. Going forward, he would expect that all call lights be in place and functioning. Record review of a facility policy titled Call light - use of dated 12/2017 read .it is the policy of this home to ensure residents have a call light within reach and that they are physically able to access and that they have been instructed on its use .