STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455697	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Corpus Christi	202 Fortune Dr Corpus Christi, TX 78405

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 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 record review and interview, the facility failed to maintain clinical records in accordance with accepted professional standards of practice, that were complete and accurately documented, for one resident (Resident #1) of three residents reviewed for personal inventory log. When Resident #1 was admitted on [DATE], LVN A failed to complete an accurate inventory log for Resident #1's belongings. This failure could jeopardize a resident from having their valuables properly recorded, which in turn could result in a resident's valuables being misplaced and/or not returning home with the correct resident. The findings included: Record review of Resident #1's admission record dated 07/15/2025, revealed Resident #1 was a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE] and later discharged [DATE] to home with hospice. Resident #1's primary stay was for Respite Hospice. Resident #1 had diagnoses of acute diastolic (congestive) heart failure, and type 2 diabetes (sugar irregularity). Record review of Resident #1's Discharge MDS dated [DATE] revealed Resident #1 had a BIMS score of 4 which meant she had severe cognitive impairment and additionally was independent for ADLs. Record review of Resident #1's Care Plan date initiated 06/15/2025 revealed the resident has an ADL self-care performance deficit. Goal: The resident will maintain current level of function through review date. Interventions: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. DRESSING: Assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self. Record review of the facility provider investigation report date of incident 06/18/2025 revealed On Wednesday 6/18/25 resident [Resident #1] was bathed by [hospice agency] C.N.A. Hospice C.N.A left [facility], later in the day [ADON A] received a phone call from [hospice agency], to inform us that the C.N.A who bathed [Resident #1] verbalized resident [Resident #1]'s gold chain with Crucifix pendant was not on her. [ADON A] and [Social Worker] went to speak to [Resident #1] about the jewelry in question. [Resident #1] verbalized she isn't sure what happened to it. [Social Worker] questioned [Resident #1] if resident recalls anyone taking it off of her or taking it in general. [Resident #1] verbalized No, no one took it off of me. [Social Worker] and [ADON A] looked in the resident room, around [facility] nursing facility and the assisted living side, since resident was noted going over to assisted living area and enjoying spending time there. The jewelry was unable to be located on the day it was noted to be missing. [Resident #1] 's [family member] was informed [facility] nursing staff were unable to locate jewelry, but staff will continue to look for it. At this time there were no allegations of theft and [facility] team members continued to look for jewelry in laundry and throughout the nursing home. During an interview on 07/12/2025 at 3:57PM, LVN A stated she recalled admitting Resident #1 into the facility on [DATE]. LVN A stated she recalled Resident #1 wearing a necklace, alongside a matching purple sweater, pants, and shoe attire. LVN A stated typically when admitting a resident, she would fill out all admission documents which included several types of assessments and a personal inventory log of all belongings. LVN A stated on the day of 06/15/2025 there were multiple residents being admitted and during the commotion of the day, she forgot to complete Resident #1's inventory log. LVN A reiterated she recalled seeing a necklace but could not recall the specific details of what the necklace looked like. LVN A stated although filling out the inventory log was a collaborative effort amongst the clinical staff, all personnel were busy on 06/15/2025 and therefore the inventory log was forgotten. LVN A stated filling out Resident #1's inventory was important, as it aided in ensuring Resident #1's belongings returned with her when she returned home. LVN A stated by not filling out Resident #1's inventory log, it jeopardized accurate monitoring of Resident #1's belongings and furthermore resulted in Resident #1 returning home without her sentimental valuables. LVN A stated she should have filled out Resident #1's inventory log but reiterated that day she had multiple admissions and forgot to complete Resident #1's inventory log. LVN A stated after the incident, she ensured to procedurally conduct the admission process which included filling out residents' inventory log of belongings. During an interview on 07/15/2025 at 5:15PM, the DON stated LVN A should have completed Resident #1's inventory log of personal belongings. The DON stated the importance of filling out an inventory log was to ensure a resident's belongings are itemized and accounted for during the resident's stay. Furthermore, once a resident is discharged the inventory log would ensure that the resident's belongings are all returned accurately. The DON reiterated LVN A should have completed Resident #1's inventory log but was not completed due to LVN A having multiple admissions on 06/15/2025. The DON stated Resident #1's well-being could have been negatively affected as the necklace held