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	06/04/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately to the appropriate State Agency, but no later than 2 hours after the allegation was made, for 1 of 5 Residents (Resident #2) reviewed for freedom from abuse and/or neglect.The facility failed to report Resident #2's allegation of verbal abuse by a staff member on 05/17/2026. The state agency was notified on 05/19/2026.This failure could result in placing residents at increased risk for further abuse, as well as not receiving a proper or thorough investigation.The findings included:Record review of Resident #2's face sheet, dated 06/04/2026, revealed a [AGE] year-old male with an admission date of 01/09/2026. Pertinent diagnoses included Type 2 Diabetes (a chronic condition which affects how your body metabolizes sugar [glucose], leading to high blood sugar levels and various health complications), and Morbid (severe) Obesity. Record review of Resident #2's care plan, initiated 01/26/2026 revealed a focus for ADL self-care performance deficit related to Dementia (a condition which affects memory, thinking, and the ability to perform daily activities) and Impaired Balance. Interventions included Bed Mobility: Resident #2 was dependent on staff, and Toilet Use: Resident #2 was dependent on staff.Record review of Resident #2's Quarterly MDS assessment, dated 04/16/2026, revealed BIMS score of 15, which indicated intact cognition. The MDS assessment also revealed Resident #2 frequently had urinary incontinence. Record review of Resident #2's progress note, dated 05/18/2026, revealed regarding events from the night before. Resident #2 was upset an aide came in and was rude to him by taking his urinal and slamming the bathroom door after emptying.Record review of the facility's internal investigation, reviewed 06/04/2026, revealed the facility first learned of the incident on 05/19/2026 at 11:45 AM. The narrative revealed Resident #2 reported a CNA may have called him an asshole while exiting the room and allegedly slammed the door. Internal investigation also revealed Resident #2 remained calm and cooperative during subsequent interview and did not express fear of returning staff or retaliation. An in-service regarding abuse and neglect prevention, appropriate communication, resident rights, professional conduct, and documentation expectations was provided. According to the Investigative Process: Resident #2 remained generally consistent he believed he overheard CNA call him an inappropriate name while leaving the room. In an interview on 06/04/2025 at 11:00 AM, the Administrator stated the incident with Resident #2 occurred on 05/17/2026, but she was not informed of the incident until 05/19/2026 in the morning stand-up meeting. The Administrator stated CNA-D was suspended for 2 days pending the investigation, but the investigation was unsubstantiated. She also stated CNA-D was counseled regarding the incident and all staff were in-serviced regarding reporting abuse and neglect immediately, call light response time, documentation, customer service, and resident rights. The Administrator stated Resident #2 admitted to being upset because CNA-D was mumbling under her breath and denied actually hearing what she had said. The Administrator also stated Resident #2 was very with it cognitively and had a BIMS score of 15. She stated he would be able to answer any questions asked of him. The Administrator stated abuse was supposed to be reported immediately, but no later than 2 hours, and the only reason (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was not reported in the expected time frame was because she was not made aware of it. In an interview on 06/04/2026 at 1:23 PM, Resident #2 stated he could not remember the exact date and time, but he remembered CNA-D calling him an asshole sometime late at night or early in the morning. He stated he should have handled the situation differently and felt like he should not have reported CNA-D (could not recall her name), but when CNA-D slammed the bathroom door and called him an asshole, it triggered his PTSD. Resident #2 stated he felt like maybe CNA-D was having a bad night, and he should have been more understanding. Resident #2 also stated the CNA was not mumbling under her breath because he had not had his hearing aids in, and if she were mumbling, he would not have been able to hear her. In an interview on 06/04/2026 at 2:48 PM, CNA-D stated it was before midnight when Resident #2 kept staying on the call light to empty his urinal. CNA-D stated she went in there the first 3 times, and then the other CNA went in afterward. The last time CNA-D was in the room she told Resident #2 she had just been in there 10 minutes prior, and he got upset immediately and started making comments. He made the comment aren't you just a delight, and she responded yes, I am, thank you very much. The other CNA went in after her to handle his call light. CNA-D stated she did not bother him or had not gone back into his room after the third time, but the other CNA went back in his room probably 4 or 5 more times. Around 5 minutes to 11:00 PM, the nurse went in Resident #2's room to discuss the situation with the Resident #2, and the resident went crazy and told the nurse he was calling 911 for elder abuse. The police showed up around midnight, spoke to the resident, and left. They were only in Resident #2's room approximately 10 minutes before they left. They never gave the staff any type of report. CNA-D stated she never called him a name and did not slam his door. CNA-D also stated abuse or neglect was supposed to be reported immediately to the Administrator and the charge nurse. Record review of the facility's Resident Rights policy, revised February 2021, revealed Policy Statement: Employees shall treat all residents with kindness, respect, and dignity.Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, revised April 2021, revealed Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms . Policy Interpretation and Implementation: 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to ensure a registered nurse served as the full time Director of Nursing for 1 of 1 facility reviewed for nursing services. The facility failed to designate a registered nurse to serve as the full time DON since 04/25/2026. This failure could place residents at risk of receiving inadequate care, as well as cause a lack of nursing oversight and higher level of care. The findings included: Record review of the DON timecard coverage report from 04/25/2026 through 06/04/2026 indicated there was no DON in facility. The timecard revealed the RNC had been in the facility three days per week (24 hours per week) since the previous DON's last day on 04/24/2026. Record review of the Clinical Staffing Schedules for May of 2026 revealed the DON spot was blank.In an observation on 06/03/2026 throughout the day, the RNC was not observed in the facility.In an observation on 06/04/2026, throughout the day, the RNC was observed rounding in the facility and speaking with the nursing staff throughout the day. In an interview on 06/03/2026 at 3:28 PM, RN-A stated she worked full time as the WCN. RN-A did not remember exactly when the DON's last day was, but it had been a while. She stated LVN-B, who was also the ADON and Infection Control Nurse had been covering for the DON. She stated the RNC came to the facility to help out. RN-A was unsure if or when they would be getting a new DON In an interview on 06/03/2026 at 4:00 PM, the ADON, who was also the IP, stated she was an LVN. She stated she did not remember exactly when the DON's last day was, but it had been a while. The ADON stated she was helping as much as she could, but the RNC had been filling in 2 or 3 days per week to assist until the position was filled. In an interview on 06/04/2026 at 9:47 AM, the SW stated the DON left her position approximately 4 weeks ago, but the ADON was the acting DON until the position was filled. The SW also stated the RNC came in a few days per week to help out. In an interview 06/04/2026 at 11:00 AM, the Administrator stated the RNC came in 3-4 times per week for 8 hours a day (counting her drive time, 8.5 hours per day). The Administrator stated she had been observing the WCN to determine if she would be a good fit for the DON position. She stated the DON position had been posted for a while, but she had not had any good candidates. In an interview on 06/04/2026 at 3:35 PM, the Administrator stated as long as they had an RN in the building for 8 hours of coverage each day the facility was in compliance, and they did not need DON coverage. In an interview on 06/04/2026 at 1:42 PM, the Administrator stated the facility did not have a policy which addressed the DON or DON coverage.

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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 all drugs and biologicals were labeled and stored appropriately for 1 of 4 medication carts (300 Hall Medication Cart) and 1 of 1 Emergency Crash Cart reviewed for pharmacy services. 1. The facility failed to ensure the 300 Hall Nurse Med-Cart was locked and secured.2. The facility failed to ensure the Emergency Crash Cart was locked and secured. These failures could place residents at risk of taking or ingesting medications and/or medical supplies which could have caused them harm.The findings included:An observation on 06/03/2026 at 11:49 AM of the 300 Hall Medication Cart, parked at the nurses' station, revealed an unlocked cart which was able to be accessed. The lock was popped out, and all drawers were able to be accessed except the narcotic drawer. There were staff behind the nurses' station on the computers, and residents in wheelchairs around the nurses' station. An observation on 06/03/2026 at 11:57 AM of the Emergency Crash Cart, parked in a cubby on the 200 hall, revealed it was unlocked and able to be accessed. There were staff and residents walking up and down the hall. In an interview on 06/04/2026 at 10:44 AM, LVN-B stated she worked on the 300-hall, and she was the one who left the 300-hall medication cart unlocked while she stepped away from it. LVN-B stated she was supposed to lock her medication cart anytime she walked away from it because residents could have accessed medications which did not belong to them and could have caused them harm or to have side effects and become ill. She stated she had been in-serviced over med-carts and med storage many times and knew not to leave the cart unlocked. In an interview on 06/04/2026 at 11:16 AM, LVN-C stated she worked as the staffing coordinator and filled in as the ADON and a floor nurse as needed. She stated she did the majority of the in-services in conjunction with the DON and ADON. She stated she had just recently in-serviced all of the nursing staff about locking their medication carts anytime they stepped away from them. LVN-C stated this was done for patient safety because if a resident ingested medication which did not belong to them, it could have caused them harm. LVN-C also stated if the Emergency Crash Cart contained sharps (needles) or medications, it should have been locked as well. Record review of the facility's Medication Labeling and Storage policy, revised February 2023, revealed Policy Heading: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys . 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 development and transmission of communicable diseases and infections for 1 of 5 residents (Residents #1) reviewed for infection control practices.1. The facility failed to ensure the IP, the WCN, and LVN-B knew the proper placement of the PPE cart for Resident #1.2. The facility failed to ensure the physician's order for EBP was obtained prior to placing Resident #1 on precautions. These failures could place residents at risk of cross contamination and/or infection.The findings included: Record review of Resident #1's face sheet, dated 06/03/2026, revealed a [AGE] year-old-male with an original admission date of 06/22/2025 and a current admission date of 03/19/2026. Pertinent diagnoses included Type 2 Diabetes Mellitus (a chronic disorder characterized by high blood sugar levels due to insufficient insulin [a crucial hormone which regulates blood sugar levels and plays a vital role in energy metabolism] production or ineffective use of insulin by the body) with Foot Ulcer.Record review of Resident #1's admission MDS assessment, dated 03/25/2026, revealed a BIMS score of 09, which indicated moderately impaired cognition. The MDS also revealed Resident #1 had a Diabetic Foot Ulcer and received applications of dressings to the feet.Record review of Resident #1's current care plan, initiated 03/30/2026, revealed a care plan focus for EBP with interventions to use gown and gloves during high-contact resident care activities. Gowns will be available outside of the room or in the room for staff to use when performing direct care with Resident #1.Record review of Resident #1's physician order summary, dated 06/03/2026, revealed no order for any type of precautions or isolation. Resident #1's previous orders reveal and order for EBP which was discontinued on 03/05/2026 (previous admission and discharge).During an observation on 06/03/2026 at 2:17 PM of Resident #1's door and the 200 hallway, there was a small EBP sign posted next to Resident #1's door, but there was no PPE cart posted on the outside of Resident #1's room. Upon further inspection, it was noted there was a PPE cart located further down the 200-hall next to another EBP room.In an interview on 06/03/2026 at 3:28 PM, RN-A stated she worked in the facility full time as the WCN. RN-A stated EBPs were utilized to protect both the residents and the staff and prevent cross-contamination and infection. She stated when a resident was on EBP they should have the EBP signage outside of the room, as well as PPE located outside of the room. She stated the EBP order and the PPE was placed by the ADON, who was also the Infection Control Nurse, or the IP.In an interview on 06/03/2026 at 4:00 PM, the ADON, who was also the IP, stated she had always been told or taught as long as there was PPE accessible on the hallway somewhere, then it sufficed for residents who were on EBP. She stated she never knew it had to be located immediately or right outside of the resident's room. The ADON stated she was not sure what the CDC recommendations for EBP-PPE were. She also stated it was either her or one of the floor nurses who typically obtained orders for EBP, as well as placed the PPE. The ADON stated it was just an error, and she must have overlooked obtaining the EBP order because she remembered to hang the sign and update the care plan. In an interview on 06/04/2026 at 10:44 AM, LVN-B stated either the floor nurses or ADON/IP typically obtained EBP orders and placed PPE on the hallways, and she was not sure how an EBP order could have been overlooked.Record review of CDC document: Long-Term Care Facilities: Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms, dated 04/02/2024, revealed the use of gown and gloves for high-contact resident care activities was indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves); For Enhanced Barrier Precautions, signage should also clearly indicate the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	high-contact resident care activities that required the use of gown and gloves; Make PPE, including gowns and gloves, available immediately outside of the resident room. Website reviewed on 03/19/25 at 4:35 PM: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html?CDC_AAref_Val=https://www.cdc.go review of the facility's Enhanced Barrier Precautions policy, revised February 2025, revealed Policy Statement: Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. 2. Gloves and gown are applied prior to performing the high contact resident care activity. 12. PPE for EBP's is available outside or inside of the resident rooms.