STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455713	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at San Antonio	50 Briggs Ave. San Antonio, TX 78224

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. Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours for 1 of 1 provider investigation reports reviewed for freedom of abuse, neglect, and exploitation. The facility failed to report an alleged abuse incident within 2 hours of the incident occurring on 2/20/26. This failure could place residents at risk for abuse.The findings include: Record review of the provider investigation report dated 02/27/2026 revealed a resident-to-resident altercation that stated the incident occurred on 02/20/2026 at 9:30am and was reported to HHS on 02/20/2026 at 12:30pm. During an interview on 05/07/2026 at 6:07 p.m., the ADM stated they were in charge of reports made to HHS and that alleged abuse needs to be reported within 2 hours. The ADM confirmed they submitted the provider investigation report, regarding the resident-to-resident altercation, to the state after the 2-hour mark from when the incident occurred. The ADM stated there was no risk due to the facility had already taken care of the situation and that there was no immediate harm. Record review of the facilities policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed: 9. Investigate and report any allegations within timeframes required by federal requirements. Record review of long-term care regulation provider letter titled, Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC), issued on August 29, 2024, revealed: Do Report: abuse (with or without serious bodily injury.) When to report:Immediately, but not later than two hours after the incident occurs or is suspected.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 5 of 5 residents (Residents #1, #2, #3, #4, and #5) reviewed for care plans: The facility failed to develop a comprehensive care plan for Resident #1 and Resident #5.The facility failed to ensure Residents #2, #3, and #4 had a completed comprehensive care plan. This failure could place residents at risk of not receiving care and services needed to meet individualized needs.The findings included: Record review of Resident #1's Face Sheet dated 05/08/26 documented an [AGE] year-old male admitted to the facility 04/20/26. Diagnoses included sepsis, unspecified organism (a life-threatening emergency condition where the body has a severe systemic response to an infection, but the specific bacteria, fungus, or virus causing it has not been identified), chronic pain syndrome (a condition where pain persists for 3 to 6 months or longer), Type 2 Diabetes Mellitus without complications (elevated blook sugar levels without developing associated damage to organs or nerves), encephalopathy (a disease in which the functioning of the brain is affected by some agency or condition), chronic kidney disease, Stage 3, unspecified (moderate kidney damage with an estimated reduction in function of about 40%-70%) and chronic pancreatitis (a long-lasting, progressive, and irreversible inflammatory condition of the pancreas that causes persistent structural damage and loss of function, leading to chronic abdominal pain, malabsorption and diabetes). Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 1 indicating he was severely cognitively impaired. In Section GG - Functional Assistance, the MDS indicated Resident #1 required minimal to maximal assistance with various ADLs. Record review of Resident #1's medical record did not reveal the presence of a Comprehensive Care Plan which was due no later than 05/03/26.Record review of Resident #2's Face Sheet dated 05/08/26 documented a [AGE] year-old male initially admitted to the facility 03/21/26 with the most recent admission date of 04/12/26. Diagnoses included gangrene, not elsewhere classified (tissue death not caused by diabetes, infection, or specific vascular diseases), bipolar disorder, current episode depressed, severe, with psychotic features (a psychiatric emergency where a severe depressive episode includes hallucinations, delusions, or disorganized thinking), type 2 diabetes mellitus with diabetic neuropathy, unspecified (a condition where chronic high blood sugar damages peripheral nerves, causing numbness or pain), other schizophrenia (mental health condition with symptoms similar to schizophrenia, such as hallucinations or delusions, but which do not meet the full diagnostic criteria for schizophrenia, schizoaffective disorder, or bipolar disorder), and acquired absence of right leg below knee and acquired absence of left leg below knee. Record review of Resident #2's Quarterly MDS dated [DATE] documented a BIMS score of 14 indicating no cognitive impairment. Record review of Resident #2's Care Plan with the last revision date of 03/21/26 only had 1 focus of Wound Management with a goal of Wound will show signs of improvement and interventions that included Measure ulcer on at regular intervals; Monitor ulcer for signs of progression or declination, Notify provider if no signs of improvement on current wound regimen, and Provide wound care per treatment order. The Care Plan did not include instructions for mental health medications and treatment, ADL care, dietary needs or activities. During an observation and interview with Resident #2 on 05/06/26 at 10:55 am, resident stated his wounds were almost healed where his legs were amputated. Resident #2 stated he was now getting double portions but still had some problems getting snacks in the evening. Resident #2 stated he had to ask for them and sometimes was told either they had not been brought to the nourishment room yet or they did not have what he wanted. Resident #2 stated he could get himself to the bathroom and did not have to use his call light (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	much. Record review of Resident #3's Face Sheet dated 05/08/26 documented a [AGE] year-old male admitted to the facility 04/17/26. Diagnoses included leukemia, unspecified, in relapse (a cancer of the blood-forming tissues that returned after a period of remission), autoimmune hemolytic anemia, unspecified (a rare disorder where the immune system mistakenly destroys red blood cells faster than they can be replaced), Alzheimer's Disease with late onset (dementia, developing in individuals aged 65 or older, characterized by progressive memory loss, cognitive decline, and personality changes). Record review of Resident #3's admission MDS dated [DATE] with a completed date of 04/30/26, documented a BIMS score of 4 indicating severe cognitive impairment.Record review of Resident #3's undated Baseline Care Plan contained information on ADLs, communication, dietary orders, and therapy goals. A Comprehensive Care Plan with a date initiated on 05/06/26 just included a focus of Resident #3 gas exchange related to end state disease as evidenced by shortness of breath, a goal of Resident #3 will remain comfortable with reduced signs of respiratory distress while receiving oxygen therapy, and an intervention that included Administer oxygen as ordered and as tolerated. The other care plan components included a focus Resident is high risk for falls related to confusion with initiated date of 04/20/26 with a goal The resident will be free of falls through the review date with the target date of 07/06/26. The last focus area with a date initiated on 04/18/26 documented The resident has had an actual fall with no injury - poor balance, a goal of The resident will resume usual activities without further incident through the review date with a target date of 06/18/26 and interventions that included Keep bed in lowest position and Remind resident to lock rollator prior to sitting. Surveyor was informed that Resident #3 discharged to another nursing facility on 05/07/26. Record review of Resident #4's Face Sheet dated 05/06/26 documented a [AGE] year-old male initially admitted to the facility 01/28/26 with the most recent admission date of 04/16/26. The diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (a serious condition that causes paralysis or weakness on the right side of the body, often accompanied by language difficulties), aphasia following cerebral infarction (a language impairment that causes trouble speaking, understanding, reading, or writing, but does not affect intelligence), dysphagia following cerebral infection (difficulty or discomfort in swallowing), obstructive and reflux uropathy, unspecified (refers to a blockage or backward flow of urine anywhere in the urinary tract), altered mental status (a broad, non-specific symptom indicating a change in a person's baseline consciousness, cognition, or awareness, ranging from mild confusion to coma), and acquired absence of left leg above knee. Record review of Resident #4's Significant Change MDS dated [DATE] documented a Staff Assessment for Mental Status due to resident's inability to participate in the BIMS questions. The assessment indicated Resident #4 had short-term and long-term memory impairment and was severely impaired for daily decision making. Record review of an undated Comprehensive Care Plan found for Resident #4 had a focus of Wound management dated 02/22/26, a goal of Wound will be free of signs or symptoms of infection with a date initiated 02/22/26 and a target date of 02/16/26. There were no interventions or tasks listed for this focus. No other focus items or goals were listed to indicate how staff would communicate with or care for Resident #4 to ensure his needs were met. Record review of Resident #5's admission sheet dated 05/052026 documented a [AGE] year-old female with a primary diagnosis of dislocation of internal left hip prosthesis, subsequent encounter. Record review of Resident #5's MDS assessment dated [DATE] documented a BIMS score of 13 of 15 indicated intact cognition. Record review of Resident #5's care plan report, no date, revealed no data found. During an interview on 05/07/2026 at 10:02 a.m., the MDS Coordinator stated they were responsible for care plans, and comprehensive care plans for new admissions should be completed 7 days after the initial MDS assessment is completed. The MDS Coordinator stated comprehensive care plans are uploaded to the resident's electronic health record. The MDS Coordinator stated Resident #5's comprehensive care plan should have been completed by now. The MDS Coord stated comprehensive care plans were used by staff to know how to care for the residents. During an interview on 05/07/2026 at 11:17 a.m., the DON stated comprehensive care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plans are completed upon admission and quarterly. The DON stated comprehensive care plans are used by staff to know how to care for the residents as well as how to address interventions. Record review of the facilities policy titled, Care Planning - Interdisciplinary Team, updated 12/2024, revealed:Policy Interpretation and ImplementationResident care plans are developed according to the timeframes and criteria established by S483.21. Record review of the code of federal regulations S483.21 Comprehensive person-centered care planning, dated October 4, 2016, revealed: b) Comprehensive care plans. (2) A comprehensive care plan must be-(i) Developed within 7 days after completion of the comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have the comprehensive care plan reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 5 residents (Resident #7) reviewed for comprehensive care plans. The facility failed to revise Resident #7's care plan after a change in behavior. This failure could place residents at risk of not receiving needed care and treatment.The findings include: Record review of Resident #7's admission sheet dated 05/05/2026 documented a [AGE] year-old male with a primary diagnosis of Alzheimer's disease with early onset (progressive memory loss, cognitive decline, and behavioral changes). Record review of Resident #7's MDS assessment dated [DATE] documented a BIMS score of 9 of 15 indicating moderate cognitive impairment. Record review of a provider investigation report dated 02/27/2026 revealed a resident-to-resident altercation involving Resident #7 that stated the incident occurred on 02/20/2026 at 9:30 a.m. Record review of Resident #7's care plan revised on 05/05/2026 revealed no mention of the resident-to-resident altercation on 02/20/2026. Record review of Resident #7's psychiatry progress note on 03/03/2026 revealed an order to discharge the medication Trazodone. Record review of Resident #7's behavior monitoring document following the altercation revealed monitoring for 72 hours to include 15-minute checks with no record of any behaviors during the period. During an interview on 05/07/2026 at 10:02 a.m., the MDS Coordinator stated they were in charge of care plans. The MDS Coordinator stated care plans should be revised when a resident has a change of condition or change in behavior. The MDS Coordinator stated Resident #7's care plans should have been updated after the resident-to-resident altercation they were involved in. The MDS Coordinator stated the risk of not revising the care plan could be staff not knowing how to care for the residents. During an interview on 05/07/2026 at 11:17 a.m., the DON stated care plans should be updated when there is a change with the resident. The DON stated Resident #7's care plans should have been updated after the resident-to-resident altercation they were involved in. The DON stated it was important to have the care plan updated to know how to care for the residents. At the time of exit no facility policy was given regarding revision of comprehensive care plans.

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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 provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 (Resident #6) reviewed for medications and pharmacy services, in that: The facility failed to ensure Resident #6 did not have medication in their room. These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health.The findings include: Record review of Resident #6's admission sheet dated 05/05/2026 documented a [AGE] year-old female with diagnoses including major depressive disorder, recurrent unspecified (mood disorder characterized by repeated episodes of depression without specifying severity or particular features). Record review of Resident #6's MDS assessment dated [DATE] documented a BIMS score of 15 indicating intact cognition. Record review of Resident #6's care plan documented Risk for Harm: Self Directed or other-directed anxiety and depression with revision date 03/11/2026 with a goal Administer medications as prescribed with revision date 03/11/2026. During an observation and interview on 05/06/2026 at 2:06 p.m., a cup with 2 pills were on Resident #6's bedside table. Resident #6 stated the pills in the cup were her medications that she was still needing to take. Resident #6 stated the mediation aide did not usually leave them in the room, but when they came in the resident was busy and asked for the medication aid to set them down. During an interview on 05/06/2026 at 4:35 p.m., LVN B stated when medication was given to residents' staff should have watched the resident take all of their medication before leaving the room. LVN B stated staff should not be leaving medication in a resident's room due to the resident could have possibly overdosed, not taken it, or the roommate could have possibly taken it. During an interview on 05/06/2026 at 5:07 p.m., CMA C stated they gave medication to Resident #6. CMA C stated they did leave the medication in Resident #6's room because the resident was being transferred and they asked for another staff member to ensure Resident #6 took her medication. CMA C stated they were supposed to watch Resident #6 take the medication. CMA C stated the risk of not having watched a resident take their medication could be someone or the roommate grabbing the medication and taking it themselves. During an interview on 05/06/2026 at 5:55 p.m., the DON stated the nurse or medication aide who gave the resident their medication should have watched the resident take their medication. The DON stated there was a risk to leaving medication in a resident's room and the risk depended on the medication. Record review of the facilities policy titled, 1.0 Medication Preparation for Administering, undated, revealed:J. Medication Administration:8. Ensure that the customer swallows all the medication(s).

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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 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 disease and infection for 1 of 4 residents reviewed (Resident #6) for infection control. The facility failed to ensure Resident #6's indwelling urinary catheter bag and tubing were not touching the floor These failures could place residents at risk for cross contamination and infection.The findings include: Record review of Resident #6's admission sheet dated 05/05/2026 documented a [AGE] year-old female with diagnoses including major depressive disorder, recurrent unspecified (mood disorder characterized by repeated episodes of depression without specifying severity or particular features). Record review of Resident #6's MDS assessment dated [DATE] documented a BIMS score of 15 indicating intact cognition and revealed Resident #6 had an indwelling catheter. Record review of Resident #6's care plan documented The resident has indwelling FC Catheter. with revision date 03/11/2026 with a goal Catheter: The resident has indwelling FC. Position catheter bag and tubing below the level of the bladder and away from entrance room door with revision date 03/11/2026. Record review of Resident #6's order summary dated 05/05/2026 revealed an order check foley catheter tubing secure device placement every shift, every shift for placement may use leg strap to secure foley in place with a start date of 03/11/2026. During an observation and interview on 05/06/2026 at 2:06 p.m., Resident #6's catheter bag and tubing were on the floor under the bed. Resident #6 stated that the catheter bag and tubing were not normally on the floor, but that staff were in the room earlier and transferred her to her bed and it could have occurred then. During an interview on 05/06/2026 at 3:12 p.m., CNA A stated the catheter bag should be attached to the left or right side of the bed and the tubing and catheter bag should not be touching the floor. CNA A stated the catheter or tubing touching the floor could be a contamination issue. During an interview on 05/06/2026 at 4:35 p.m., LVN B stated the catheter bag should be below the bladder and the catheter bag and tubing should not be touching the floor. LVN B stated the catheter bag or tubing being on the floor could lead to a risk of contamination. During an interview on 05/06/2026 at 5:55 p.m., the DON stated the catheter bag should be hanging from the bed, below the bladder, and that the catheter bag and tubing should never be touching the floor. The DON stated the risk of the catheter bag or tubing touching the floor could be infection control. Record review of the facilities policy titled, Catheter Care, Urinary, updated July 2024, revealed:Infection controlMaintain clean technique when handling or manipulating the catheter, tubing, or drainage bag/b. Be sure the catheter tubing and drainage bag or kept off the floor.