

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2026
NAME OF PROVIDER OR SUPPLIER Avir at Western Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 512 Draper Dr Temple, TX 76504	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident was treated with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 2 residents (Resident # 1) reviewed for resident rights. The facility failed to ensure Resident #1 was treated with dignity and respect when her foley bag was uncovered and exposed, and was 1/4 full of urine. This failure could place residents at risk of lack of comfortability and respect, as well as a decline in self-worth. Findings include: Record review of Resident #1's face sheet, dated 05/27/26, reflected a [AGE] year-old female who was admitted to the facility 12/30/24. Resident #1 had diagnoses which included cerebral palsy (abnormal brain development), obstructive (blockage) and reflux (travels wrong way) uropathy (disease of urinary tract), unspecified, retention of urine, unspecified and presence of other specified devices (catheter). Record review of Resident #1's quarterly MDS, dated [DATE], reflected, Section GG. Functional Abilities: Toileting hygiene: 01. Dependent: Helper does all of the effort. Resident does none of the effort to complete the activity, or, the assistance of 2 or more helpers is required of the resident complete the activity; Toileting transfer: 88. Not attempted due to medical condition. Section H. Bladder and Bowel. Appliances A. Indwelling catheter. Urinary Toileting Program: 0. No. Urinary Continence: 9. Not rated, resident had a catheter (indwelling condom). Section I. Active Diagnoses: Obstructive Uropathy Record review of Resident #1's care plan, dated 04/03/26, reflected Focus: [Resident #1] has Foley Catheter related to Neurogenic Bladder Assoc with CP Retention. Goal: Resident #1 will be/remain free from catheter-related trauma through review date. [Resident #1] will show no s/sx of urinary infection through review date. Interventions/Tasks: Catheter: [Resident #1] has indwelling Foley Catheter, Position catheter bag and tubing below the level of the bladder and away from entrance room door. Record review of Resident #1's NMAR, dated 05/2026, reflected s/p catheter site: cleanse with soap and water, dry and apply t-sponge dressing daily and PRN at bedtime for s/p catheter; secure catheter with leg strap every shift Observation of Resident #1's room on 05/27/26 at 10:29 AM revealed a urine bag that was 1/4 full of yellow urine. The bag was uncovered and visible to passersby from the hallway. During an interview with CNA A on 05/27/26 at 01:15 PM, she stated foley bags had to be covered when residents were in their rooms. She also stated it was the responsibility of the CNA's to ensure they were covered. CNA A stated Resident #1's bag was uncovered because she was in her room. She stated an exposed urinary bag could negatively affect a resident's dignity or self-respect if visitors passed by the room and saw it. She stated there was a policy, but she could not recall it. During an interview with CNA B on 05/27/26 at 01:24 PM, he stated privacy bags were to be utilized at all times because it was a HIPAA violation. He stated all residents who had a urinary bag were supposed to have a privacy cover on them. CNA B stated resident dignity was affected by the bags not being covered. He stated all nursing staff were responsible for ensuring the bags were covered. He was asked why the bag was not covered, and he stated he did not know. During an interview with CNA C on 05/27/26 at 01:31 PM, she stated the facility policy was that (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455785
		If continuation sheet Page 1 of 2

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary privacy covers were to always be utilized on the foley bags, even when a resident was in their room. She stated there was no time when it was okay for a resident to have an exposed urinary bag. She stated all nursing staff/caregivers were responsible for making sure they were utilized at all times. During an interview with CNA D on 05/27/26 at 01:26 PM, she stated she did not recall her most recent training on catheter bags. She stated nursing staff had always known urinary bags were supposed to be covered with privacy bags. She stated there was a policy regarding this but added she could not quote it. During an interview with the DON on 05/27/26 at 01:45 PM, she stated the facility's expectation was for foley bags to be covered with a privacy bag because it was a dignity issue for residents. She stated staff were in-serviced on 05/26/26 about foley bags so they should have known to have them covered. She stated all members of the nursing department were responsible for ensuring privacy bags were in effect, and added ultimately, she was responsible for them all. Record review of the facility's policy Resident Rights, dated 02/2001, reflected Employees shall treat all residents with kindness, respect and dignity.		