

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

Printed: 08/27/2026
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 06/11/2026
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. During Observation, interview, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; for 1 of 6 residents (Resident #1) reviewed for quality of care.-The facility failed to ensure the ADON did not leave Resident #1 without providing incontinent care, when the resident had an BM on 06/11/2026 at 2:35 pm.This failure could result in skin breakdown, infection, and a significant decline in Resident #1's health.Findings included:Record review of Resident #1's face sheet revealed she is a forty-three-year-old woman with a diagnosis of cerebral palsy, aphasia, dysphagia, muscle weakness, muscle wasting and atrophy, epilepsy, and quadriplegia.Record review of Resident #1's care plan revealed she is dependent on staff etc. for meeting emotional, intellectual, physical, and social needs r/t Disease process (cerebral palsy), Immobility, Physical Limitations. Resident #1 is at high risk for falls related to Cerebral Palsy, muscle weakness, Quadriplegia, Epilepsy, lack of coordination, medication use and incontinence. (Resident #1) I am unable to voice my needs.On 6/11/26 at 2:35pm an observation/interview with the ADON (no other staff or family present) revealed the ADON checking Resident #1 for skin breakdown on her buttock. Skin was pink and blanchable with white cream visible on skin. Resident #1's brief was soiled with a fresh BM. She said she would tell an aide. She said it could cause skin breakdown leaving someone sitting in a soiled brief, but it didn't look like Resident #1 was done with the BM and an aide would be there shortly, so Resident #1 will be ok.On 6/11/26 at 3:30pm an interview/observation with Resident #1's family revealed Resident #1 had not had her brief changed and was still sitting in a soiled brief from earlier observation with the ADON. Resident #1's brief, bedding and clothing were wet. Resident #1's family was upset and stated that she frequently comes into visit and finds the resident in this condition. She pointed out that the call light was on prior to me entering the room and nobody had come in to check on the resident.In an observation on 6/11/26 at 3:55pm at the nurses' station for the 200 and 300 hall the call light was heard buzzing, and 2 lights were lit up. The MA was seen standing at the medication cart talking to another staff member. The ADMIN walked up to nurses' station standing right in front of the call light and started talking to MA. Both the MA and the ADMIN walked off in opposite directions. Neither of them checking on the residents whose call lights were going off including Resident #1. In an interview on 6/11/26 at 4:00pm, the MA stated they are always short-staffed but reported today they have 4 nurses, 3 aids, 2 trainees, and 1 MA on 200 and 300 halls. She said call light turnaround time was long because they did not have enough staff. She stated it can take 40-60 minutes sometimes to get to a call light. She said it is everyone's responsibility ensuring incontinence care is provided. She said the ADON did not tell anyone Resident #1 needed to be changed prior to her leaving for the day that she knew of.In an observation on 6/11/26 at 4:05 pm LVN was seen entering Resident #1's room and the call light went off.In an interview on 6/11/26 at 4:10pm, LVN stated the facility does seem to be short-staffed and call lights do tend to linger for a bit but everyone helped out and answered them as quickly as possible. She stated the ADON did tell her Resident #1 needed to be changed. She said she told her aide, but she did not know where that aid was, what her name was, or if she went in there to change Resident #1. She said she assumed that she did not go since Resident #1's family stated she had to (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change Resident #1 by herself. She said it was everyone's responsibility to ensure incontinence care was provided. In an interview on 6/11/26 at 5:15pm, the ADMIN stated it was the facility's fault that Resident #1 was not changed in a timely manner. He said he could not specify a time frame of what timely manner meant. He stated he was disappointed with the communication failure that led to Resident #1 not being changed in a timely manner. The facility did not have a policy that specified when a resident should be changed, who was responsible for changing a resident, or a time frame for answering call lights.		