

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

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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 07/16/2026
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 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 observations, interviews and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections for 1of 3 residents (Resident #64) reviewed for infection control. MA failed to disinfect the blood pressure cuff between use on Resident #79 and Resident #64 while performing medication administration. This failure places residents at risk for cross contamination and development of infections. Findings include: 1. Record Review of Resident #79's updated face sheet reflected she was an [AGE] year old female admitted to the facility on [DATE] with diagnosis of Hypertension (high blood pressure). 2. Record Review of Resident #64's updated face sheet reflected she was an [AGE] year old female admitted to the facility on [DATE] with diagnosis of Acute Posthemorrhagic anemia (sudden drop in red blood cells), Dementia, Iron Deficiency, Duodenal ulcer (Ulceration in the intestines), Polyp in colon (growth in intestine), Lesion of Sciatic Nerve of Left leg. In observation of medication administration on 7/15/2026 at 8:20 AM MA utilized the automatic blood pressure cuff on Resident #70 and Resident #64 and failed to disinfect the blood pressure cuff between residents. In an interview on 7/15/2026 at 8:58AM with MAA she stated that she was frequently in serviced on infection control. She stated that it was policy to disinfect the blood pressure cuff between each use. She stated that she did not know why she did not clean the cuff. She stated that by not cleaning the blood pressure cuff between residents they could get a rash or something could spread from another resident. In an interview on 7/16/2026 at 1:20 PM with ADM he stated that staff are frequently in-serviced on infection control. He stated this training included the disinfection of reusable medical equipment between residents. He stated that he expects staff to clean the blood pressure cuff between residents. He stated if the cuff is not cleaned it could spread infections to the residents. In an interview on 7/16/2026 with DON and RNC they stated that staff are frequently in-serviced on infection control. They stated that the policy included the disinfection of reusable medical equipment between residents. The DON stated she expected her staff to clean the blood pressure cuff between each resident to prevent the spread of germs. Record review of facility provided policy Standard Precautions Revised September 2022 reflected, policy statements: Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. The section titles Resident-Care Equipment stated, Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed.		

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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