| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455808 | A. Building<br>B. Wing | 06/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at Jacksboro | 211 E Jasper St<br>Jacksboro, TX 76458 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the residents were treated with respect and dignity and care 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 3 of 7 residents (Resident #2, Resident #3, Resident #4) reviewed for resident rights. The facility failed to ensure Resident #2, Resident #3, and Resident #4 were able to exercise his or her rights as a resident of the facility and as a citizen of the United States to be treated with dignity. The facility failed to ensure Resident #2, Resident #3, and Resident #4 exercised his or her rights without interference, coercion, discrimination, or reprisal from the facility staff. The facility failed to support Resident #3 in exercising her rights to have her personal property as required. This failure could place the residents at risk of inadequate care and services and/or unmet mental health needs.Findings included: Record review of Resident #2's Face Sheet reviewed on 6/01/2026 reflected a [AGE] year-old male, with an admission date of 5/31/2022. Resident #2 had diagnoses which included: encephalopathy (disease, damage or malfunction of the brain that alters its structure or function), Psychotic disorder with hallucinations due to known physiological condition (disconnect from reality seeing or hearing things not there), anxiety disorder (persistent worry or fear), dysphagia (impairment in the ability to produce and understand language), schizoaffective disorder ( affect the perception of reality with hallucinations, delusions, disorganized thoughts or speech), conduct disorder (persistent pattern of aggressive, destructive, and deceitful behaviors that violate social norms and the rights of others), muscle weakness (lack of physical strength). Resident #2 had a BIMS of 03 (severe cognitive impairment). In an observation on 5/31/2026 at 12:39 P.M., HA A stood over Resident #2 while providing feeding assistance. HA A mixed his food on his plate that was sitting on the table. Resident #2 sat in a large, padded medical recliner on wheels with a bib covering his clothes. HA A put food on a fork and handed him the fork. Resident #2 took the fork and fed himself. HA A took the fork from his hand, and he took a drink by himself. HA A put more food on the fork and handed him the fork and took his cup from his hand. Resident #2 paused and watched her put the cup down. HA A sat the cup down and Resident #2 took the fork and fed himself. Resident #2 tried to scoop food with the fork on his own and HA A reached to take the fork away from him and he pulled it back away from her. Resident #2 tried to reach towards the food with the fork, and HA A reached for the fork, and he pulled it away again. HA A reached for the fork again and he pulled away again. HA A picked up the spoon and put food on it and held it out towards Resident #2's mouth. He reached for the spoon, and she reached for the fork, and he let go of the fork and took the spoon and fed himself. HA A wiped his mouth with a napkin and put food on the fork and handed him the fork. Resident #2 took the fork and fed himself. In an interview on 5/31/2026 at 1:17 P.M. with Resident #2, he stated staff treat him with respect and he thought HA A did a good job at lunch. Resident #2 stated he had enough time and got enough to eat. In an interview on 5/31/2026 at 2:45 P.M. with HA A, she stated she had been trained in how to feed a resident. HA A did not answer when asked if she should sit in front of a resident during feeding and she did not answer when asked the procedure for feeding a resident. In an observation on 6/01/2026 (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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | at 12:41 P.M., Resident #2 sat in a large, padded medical recliner on wheels and fed himself with no assistance. In an interview on 6/01/2026 at 12:42 P.M. with LVN D, she stated Resident #2 decided how much assistance he got at mealtimes. She stated today he wanted to eat on his own with his hands, and we supervise and offer assistance if he needs or wants. LVN D stated Resident #2 is set up, supervise, and assist for meals. Record review of Resident #3's Face Sheet reviewed on 5/31/2026 reflected a [AGE] year-old female, with an admission date of 12/21/2023. Resident #3 had diagnoses which included: schizoaffective disorder, bipolar type (both schizophrenia and mood disorders that affect the perception of reality with hallucinations, delusions, disorganized thoughts or speech with bouts of mania and sometimes major depression), pleural effusion (fluid around your lungs), history of urinary tract infection (infections that happen when bacteria enter the urethra and infect the urinary tract), protein-calorie malnutrition (protein or calorie deficiency), history of dehydration (uses or loses more fluid than it takes in), bipolar disorder (mood disorder causing extreme highs and lows), major depressive disorder (persistent feelings of sadness and loss of interest), anxiety disorder (persistent feelings of worry or fear), obsessive compulsive disorder (pattern of unwanted thoughts and fears and uncontrollable and recurring thoughts), personality disorder (difficulty dealing with people due to being inflexible, rigid, and unable to respond to demands of life), kleptomania (repeatedly unable to resist urges to steal items), impulse disorder (difficult to control actions or reactions), extrapyramidal and movement disorder (drug induced movement disorders that primarily affect muscle tone, body posture, and involuntary movements). In an observation on 5/31/2026 at 11:48 A.M., Resident #3 walked to LVN C and asked for a coke. LVN C stated to Resident #3, We will have to see if you do good today staying away from other's drinks. LVN C asked her how much caffeine she had had today and Resident #3 stated there are non-caffeinated soda in there too. LVN C stated she did not believe there was any non-caffeinated soda. In an interview on 5/31/2026 at 11:48 A.M. with LVN C, she stated that if Resident #3 can stay out of other people's drinks, she can have a coke by the end of LVN C's shift but that she never really gets there. LVN C did not elaborate on what that meant. LVN C stated the coke is locked up in a storage room and Resident #3 had broken in so it was now padlocked because she would drink all of it. LVN C stated Resident #3 bought the coke in the storage room with her own money. LVN C stated Resident #3 is on caffeine restriction because she would run up and down the hallway yelling and screaming and get to wound up. LVN C was not able to answer what the restriction was or if it was a doctor's orders. LVN C stated Resident #3 is obsessed with drinking soda and tea and she asks everyone for some. LVN C further stated Resident #3 could have a soda if she is good and does not drink others. In an observation on 5/31/2026 at 11:48 A.M., LVN C gestured towards a brown door unmarked and secured with a padlock. In an interview on 5/31/2026 at 12:03 P.M. with CNA H, he stated that he had heard LVN C use Resident #3's soda as a reward and consequence system. He stated the soda belonged to Resident #3, but it was locked in a closet. CNA H stated he did not get the soda for her because he had to ask the nurse and eventually Resident #3 quit asking because the nurse decided if Resident #3 could have it. CNA H stated Resident #3 had water and tea and she got fluids during mealtimes and every time she goes to smoke. He stated he had seen Resident #3 with root beer bought by other staff, also. CNA H stated he did not know why Resident #3 was on caffeine restriction. Record Review of Resident #3's Physician Orders reviewed on 5/31/2026 lacked any order regarding fluid restrictions or caffeine restrictions. Record review of Resident #3's Care Plan undated revealed a focus that ?resident consumes more caffeine than preferred by family and resident will limit caffeine intake to one cup per day per family request' with interventions to educate the resident of the effects of caffeine and encourage hydration with non-caffeinated beverages and monitor intake. Further focus revealed that ?resident enters other residents' rooms and takes their snacks and or drinks' with interventions to collaborate with dietary staff to ensure the resident receives preferred snacks and drinks. In a follow up interview on 6/01/2026 at 10:18 A.M. with Resident #3, she stated she can have her coke if she does not take others and she had to be good to<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | get it. Resident #3 stated she bought her own soda. She stated she does not always get it when she asks because they don't want her to have it. Resident #3 stated she does not know why facility staff don't want her to have it. Resident #3's only issue was she wanted her Coke Zero. Record review of Resident #4's Face Sheet reviewed on 6/01/2026 reflected an [AGE] year-old male, with an admission date of 02/18/2026. Resident #4 had diagnoses which included: hepatic encephalopathy (brain dysfunction due to liver dysfunction), malignant neoplasm of brain (aggressive fast growing mass causing life-threatening pressure in the head), muscle weakness (lack of physical strength), Unspecified dementia (loss of memory, language, problem-solving, and other thinking abilities), vitamin deficiency (doesn't get or absorb essential micronutrients needed), polyneuropathy (damaged nerve in skin, muscle, organs), cognitive communication deficit (difficulty communicating because of injury to the brain). Record review of Resident #4's Care Plan undated revealed the resident had unexpected weight loss with interventions added to assist with ADL: ?Assist with utensils, meal set up and feeder assist'. In an observation on 5/31/2026 at 12:32 A.M., RN B was standing over Resident #4 feeding him from a plate on the table. Resident #4 sat in a geriatrics chair with a bib over his clothes. RN B provided a bite of food to Resident #4's mouth. RN B looked around and stood over him. Resident #4 watched her and looked around to see what she was looking at and then she gave him another bite. RN B bent over to talk to him and then spoke to him about what was in his bite she provided. In an interview on 5/31/26 at 1:23 P.M. with Resident #4, he stated he felt staff treat him with respect and it did not bother him when RN B stood over him and looked around the room. Resident #4 stated he got enough to eat and felt he had choices. Attempted interview with RN B and she did not respond prior to exit. In an interview on 6/01.2026 at 2:13 P.M. with ADON E, she stated Resident #3 did not have a fluid restriction, but her mother and doctor wanted the facility to limit her caffeine intake because she became agitated and anxious. ADON E stated if Resident #3 wanted her Coke, they had to give it to her. She stated they attempt to sway her with Root Beer, but they have to give her Coke if that is what she wanted. ADON E stated the facility did not condone keeping Resident #3's Coke from her. They are hers and she can have them. ADON E stated RN B and HA A had both been trained in feeding assistance. ADON E stated they should sit in a chair in front of the residents and feed them that way. ADON E stated negative effects that could happen could be a dignity issue or make the residents feel less than or feel bad. In an interview on 6/1/2026 at 3:10 P.M. with DON G, she stated she was made aware of LVN C actions, and LVN C was now fully aware Resident #3's drinks cannot be withheld. DON G stated the reward system is not appropriate. DON G stated Resident #3 did get her drinks because DON G buys her soda and Resident #3 goes to the business office to get money to buy soda. DON G stated Resident #3 is offered non-caffeinated beverages and she would get Root Beer a lot of the time. DON G stated staff should be sat down having one on one with residents during feeding assistance. She stated if the residents wanted to feed themselves, they should. DON G stated Resident #2 can usually feed himself. She stated RN B and HA A should know the procedure but felt they were nervous. DON G stated the negative effects would be a dignity issue. Record review of LNV C's employee file reviewed on 6/1/2026 revealed she had been trained on Resident Rights on 7/1/2025. Record review of RN B's employee file reviewed 6/1/2026 revealed she had completed Assisting the Resident with Dining Competency dated 3/11/2026. Procedure for Assisting the Resident with Dining revealed 7. Sit facing the resident if possible.12. Include socialization, conversation during meal service. Record review of HA A's employee file reviewed 6/1/2026 revealed she had completed Assisting the Resident with Dining Competency dated 4/27/2026. Procedure for Assisting the Resident with Dining revealed 7. Sit facing the resident if possible.12. Include socialization, conversation during meal service. Record review of the facility's Resident Rights policy dated 2001 revealed Employee shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: a. a dignified existence; b. be treated with respect, kindness, and dignity.e. self-determination.g. exercise his or her rights as a resident of the facility and as a resident or citizen<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of the United States; h. be supported by the facility in exercising his or her rights; i. Without interference, coercion, discrimination, or reprisal from the facility. Record review of the facility's Activities of Daily Living (ADL), Supporting policy dated 2001 revealed Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable.2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene.d. dining (meals and snacks);. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 7 residents (Resident #3, Resident #4, Resident #5) reviewed for care plans.The facility failed to ensure the staff developed the comprehensive care plan goals and interventions from the comprehensive assessment for Resident #3, Resident #4 and Resident #5. The facility failed to ensure the comprehensive care plans for Resident #3, Resident #4 and Resident #5 described the resident's goals for admission and desired outcomes. The facility failed to ensure the comprehensive care plan for Resident #3, Resident #4 and Resident #5 described the resident's preference and potential for future discharge. The facility failed to ensure the comprehensive care plan Resident #3, Resident #4 and Resident #5 documented a desire to return to the community was assessed. This failure could place the residents at risk of inadequate care and services.Findings included: Record review of Resident #3's Face Sheet reviewed on 5/31/2026 reflected a [AGE] year-old female, with an admission date of 12/21/2023. Resident #3 had diagnoses which included: schizoaffective disorder, bipolar type (both schizophrenia and mood disorders that affect the perception of reality with hallucinations, delusions, disorganized thoughts or speech with bouts of mania and sometimes major depression), pleural effusion (fluid around your lungs), history of urinary tract infection (infections that happen when bacteria enter the urethra and infect the urinary tract), protein-calorie malnutrition (protein or calorie deficiency), history of dehydration (uses or loses more fluid than it takes in), bipolar disorder (mood disorder causing extreme highs and lows), major depressive disorder (persistent feelings of sadness and loss of interest), anxiety disorder (persistent feelings of worry or fear), obsessive compulsive disorder (pattern of unwanted thoughts and fears and uncontrollable and recurring thoughts), personality disorder (difficulty dealing with people due to being inflexible, rigid, and unable to respond to demands of life), kleptomania (repeatedly unable to resist urges to steal items), impulse disorder (difficult to control actions or reactions), extrapyramidal and movement disorder (drug induced movement disorders that primarily affect muscle tone, body posture, and involuntary movements). Resident #3's BIMS is 11 (moderate cognitive impairment). Record review of Resident #3's MDS dated [DATE] reflected dehydration was marked as a health condition, she was at risk of developing pressure ulcers, and antipsychotics were received on a routine basis. Record review of Resident #3's CAA dated 12/03/2025 reflected dehydration/fluid maintenance, pressure ulcers, and psychotropic medications were triggered and indicated a new care plan, revision, or continuation of care plan is necessary to address the identified area. It further reflected the care planning decision must be completed within 7 days. Record review of Resident #3's Care plan undated lacked documentation/goals for dehydration/fluid maintenance, pressure ulcers, and psychotropic medications. The Care Plan lacked documentation of Resident #3's preference and potential for future discharge or if her desire to return to the community was assessed In an interview on 5/31/2026 at 11:36 A.M. with Resident #3, she stated she takes medication and it helped. Resident #3 stated she gets fluids and does not have any sores. She stated her needs are met by the facility. The only issue was she wanted her Coke Zero. Record review of Resident #4's Face Sheet reviewed on 6/01/2026 reflected an [AGE] year-old male, with an admission date of 02/18/2026. Resident #4 had diagnoses which included: hepatic encephalopathy (brain dysfunction due to liver dysfunction), malignant neoplasm of brain (aggressive fast growing mass causing life-threatening pressure in the head), muscle weakness (lack of physical strength), Unspecified dementia (loss of memory, language, problem-solving, and other thinking abilities), vitamin deficiency (doesn't get or absorb essential micronutrients needed), polyneuropathy (damaged nerve in skin, muscle, organs), cognitive<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | communication deficit (difficulty communicating because of injury to the brain). Record review of Resident #4's MDS dated [DATE] reflected a BIMS of 12, moderate cognitive impairment. Resident #4's MDS revealed he had upper extremity impairment on both sides requiring functional ability assistance and was frequently incontinent. Record review of Resident #4's CAA dated 4/06/2026 reflected cognitive loss, functional ability, urinary incontinence, and pressure ulcer were triggered and indicated a new care plan, revision, or continuation of care plan is necessary to address the identified area. It further reflected the care planning decision must be completed within 7 days. Record review of Resident #4's Care plan undated lacked documentation/goals for cognitive loss, functional ability, urinary incontinence, and pressure ulcer. The Care Plan lacked documentation of Resident #4's preference and potential for future discharge or if her desire to return to the community was assessed. In an interview on 5/31/2026 at 1:23 P.M. with Resident #4, he stated staff take care of him and he has no concerns with his care. Record review of Resident #5's Face sheet reviewed on 6/01/26 reflected a [AGE] year-old male, with an admission date of 2/18/2026. Resident #5 had diagnoses which included: hepatic encephalopathy (brain dysfunction due to liver dysfunction), pancytopenia (blood disorder characterized by a dangerous decrease in all three types of blood cells), vitamin deficiency. Record review of Resident #5's MDS dated [DATE] reflected a BIMS score of 11, moderate cognitive impairment, and functional abilities requiring setup or cleanup assistance. Record review of Resident #5's CAA dated 3/02/2026 reflected cognitive loss and functional abilities were triggered and indicated a new care plan, revision, or continuation of care plan is necessary to address the identified area. It further reflected the care planning decision must be completed within 7 days. Record review of Resident #5's Care plan undated lacked documentation/goals for cognitive loss and functional abilities. The Care Plan lacked documentation of Resident #5's preference and potential for future discharge or if her desire to return to the community was assessed. In an interview on 5/31/2026 at 1:06 P.M. with Resident #5, he stated he does not live at the facility and only staying there for the moment, and he has no concerns with his care. In an interview on 6/01/2026 at 2:13 P.M. with ADON E, she stated ADON F is responsible for MDS assessments and care plans from the assessment. ADON E stated Resident #3's needs are being met and does not plan to discharge. She stated Resident #4's needs are being met, and he can voice his wants and needs. ADON E stated Resident #5's needs are being met, and he can also voice his wants and needs to staff. Resident #5 plans to discharge back to the community when he can. In an interview on 6/01/2026 at 2:52 P.M. with ADON F, she stated she was responsible for the MDS and care plan after that. She stated when the CAA triggers and the column for it to be added to the care plan is checked, it should be added to the care plan. ADON F stated the negative effects that could occur if the CAA areas are not in the care plan could be skin breakdown or set up for failure if not assessed for discharge.Record review of Care Plans, Comprehensive Person-Centered policy dated 2001 reflected, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.c. includes the residents stated goals upon admission and desired outcomes. |