STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455808	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Jacksboro	211 E Jasper St 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 1 of 12 months (July 2025) reviewed for RN Coverage. The facility failed to ensure they had RN coverage 8 hours a day, 7 days a week for 6 of 31 days in July of 2025. This failure placed all residents at risk for inconsistency in care, services and decisions made that would have required an RN to make in the management of the residents' healthcare needs and in managing and monitoring the direct care staff.Findings include: In a record review and interview on 01/15/2026 at 05:45 PM, with the Administrator regarding RN week-end coverage, she stated she knew there were days or weekends that were not covered as required. The Administrator provided the staffing schedule and time sheets. Record review of Daily Staffing Hours vs. Daily Staffing Sign-in Sheets, regarding RN coverage presented by the Administrator revealed the following days did not have RN coverage for at least eight consecutive hours a day, seven days a week:July 5, 6, 12, 13, 26 and 27th of 2025. Totaling 6 days without an RN at least 8 hours a day, 7 days a week. In an interview on 01/15/2026 at 6:00 PM, the Corporate Nurse Consultant stated she knew RN coverage was supposed to be 7 days a week and 8 consecutive hours a day. She provided a copy of the facility policy named Staffing, Sufficient and Competent Nursing. She stated her expectation was to have coverage as required by law and that an adverse outcome could be a resident not assessed correctly and would be hard to run a code (Provide life saving measures)In an interview on 01/15/2026 at 6:15 PM, the Administrator stated the previous DON, that would help in covering weekends, had a stroke at the end of June and was unable to help provide coverage during these days. Stated her expectation was for an RN to be in the facility 8 consecutive hours a day, 7 days a week and an adverse outcome would be the resident not receiving care needed from an RN. Record review of the facility policy titled Staffing, Sufficient and Competent Nursing dated as revised August 2022 specified [in part]: Policy Statement:Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.Policy Interpretation and Implementation:Sufficient Staff:3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure proper sanitization of kitchen waste was kept in tightly closed trash cans.2. The facility failed to ensure that personnel change their gloves and wash their hands before serving and in between tasks. 3. The facility failed to ensure that food and nutrition services staff wear hair restraints. These failures placed the residents at risk of foodborne illness and being served food items that may be contaminated.The findings included: Observation on 01/13/2026 at 9:30 AM revealed the DM entered the kitchen and did not immediately wash her hands. She did not handle any food or food service equipment. During an observation and interview on 01/13/2026 at 9:39 AM, [NAME] O was not wearing a facial hair restraint or mask to cover his beard. [NAME] O reported he sometimes wore a facial hair mask and reported that his facial hair comes and goes depending on if he shaved his face. Observation on 01/13/2026 at 12:28 PM revealed [NAME] O was placing a dinner roll on each plate. He was handling the plates and did not change his gloves when he went in and out of the kitchen. He was observed using his cell phone and did not change his gloves. [NAME] O was observed taking the hall tray carts to each hallway with gloves on and did not change the gloves or wash his hands after re-entering the kitchen. He was not wearing a facial hair cover. In an interview on 01/13/2026 at 12:53 PM, [NAME] O reported his kitchen tasks included washing the dishes, placing plates and meal trays on the carts, and delivering the hall tray carts. He denied serving and handling food. When asked if he was placing the rolls on the plates at lunch today, [NAME] O responded, Well yeah, I guess. When asked if going in and out of the kitchen was his usual practice, [NAME] O responded yes because he delivered the meal tray carts to the halls. When asked if he was aware of how many times he had left the kitchen during the lunch meal service, [NAME] O responded, I don't know, maybe 4 or 5 times. When asked how many times he changed gloves and washed his hands after returning to the kitchen, [NAME] O responded, I don't know, every time. Then he changed his answer to I don't know, none I guess. When asked what the facility expectations were for hand washing, changing gloves and handling food, [NAME] O responded, I don't know. When asked what a negative outcome could be, [NAME] O responded, I wasn't trained right. I don't know. He then abruptly walked away and ended the interview. Observation on 01/13/2026 at 12:58 PM revealed signage for hand hygiene was posted by the hand-washing sink. Signage for hair/face covering was observed posted by the door inside the kitchen. In an interview on 01/13/2026 at 1:18 PM, the DM stated she expected the dietary staff to adhere to the facility policies and follow health guidelines for hand hygiene, infection control, and food distribution. DM reported that the staff were trained frequently on infection control. DM reported that proper hand hygiene instructions were posted by the sink. DM verbalized a negative outcome of not following the infection control and hand hygiene procedures may cause the residents to get sick, come in contact with something they might be allergic to, and most of all that it could cause death. Observation and interview on 01/15/2026 at 1:00 PM revealed [NAME] O was rolling the open top trash can from the kitchen through the dining room and down Hall B. [NAME] O stated he did not know where the lid was for the trash can. Observation revealed the trash can in the dining room near the drink station was also without a lid. In an interview on 01/15/2026 at 1:05 PM, the DM reported she was uncertain why the lids on the trash cans were not being utilized and she would correct this. The DM reported her expectation was that the staff would follow the policies for the kitchen. DM reported that not following the policy may result in spreading germs and odors around the facility. In an interview on 01/15/2026 at 5:00 PM, the Administrator stated her expectation for dietary employees was to use hand hygiene, use lids on trash cans, wear hair coverings and remove gloves between tasks. She stated her expectations included that the facility staff perform hand hygiene when going in and out of the kitchen and not to use their (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cell phones with gloves on. The Administrator stated the staff should also adhere to food preparation, sanitization and hygiene guidelines. She stated a negative outcome from not following these could result in foodborne illness and at worst death. Record review of the staff in-service training record for June 2025 with the topic of handwashing indicated [NAME] O was in attendance. The in-service included the policy for handwashing/hand hygiene. Review of the facility policy for Administrative Practices to Promote Hand Hygiene indicated [in part]: All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors. Record review of the facility policy for Sanitization, dated as revised November 2022, specified [in part]: #13 Kitchen wastes that are not disposed of by mechanical means are kept in clean, leakproof, nonabsorbent, tightly closed containers and disposed of daily. Record review of the facility policy for Food Preparation and Service, dated as revised November 2022, specified [in part]: Policy Interpretation and ImplementationFood distribution and service #5 Food and nutrition service staff, including nursing services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays. #7 Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. #8 Food and nutrition services staff wear hair restraints (hair net, hat, beard restraints, etc.) so that hair does not contact food.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 16 of 52 rooms (Room #s 3, 4, 6, 10, 12, 14, 22, 43, 44, 46, 47, 50, 51, 52, 53, and 54) observed for cleanliness and condition. 1. The doorway transition strips used to provide a smooth floor transition between the hallway and the room for the door thresholds were missing for resident Room #s 10, 12, 43, 44, 46, 47, 51, 52, and 54.2. Square vinyl floor tiles were broken and/or missing in Room #s 14, 22, 43, 44, 50, and by the nurse's desk in Hall C.3. The floors were soiled with a dark-colored build-up of dirt along the base of the toilets, cove-base (vinyl baseboard), and door frames in the restrooms for Room #s 3, 4, and 6.4. A fly paper glue strip was hanging on the wall above the head of Bed A in room [ROOM NUMBER].5. The floor in room [ROOM NUMBER] was soiled with chewing tobacco, and an open dresser drawer had a pizza box containing dried-up slices of pizza.6. A wash basin was positioned on the floor beneath the sink and the drain pipe was soiled with a dried brown colored substance in room [ROOM NUMBER].7. The restroom in room [ROOM NUMBER] had a urine odor on 1/14/2026. These failures placed the residents at risk for tripping and/or falling, illness, and decreased feelings of well-being within their living environment.The findings included: Observation on 1/13/2026 at 9:20 AM revealed room [ROOM NUMBER], used as a conference room, had square vinyl floor tiles with a worn and gray colored surface and an area of broken and missing tiles. Observation on 01/13/2026, between 9:30 AM and 10:00 AM revealed the following:room [ROOM NUMBER] was missing the doorway transition strip;room [ROOM NUMBER] was missing the doorway transition strip; room [ROOM NUMBER] had chipped floor tiles; room [ROOM NUMBER] was missing the doorway transition strip and had broken floor tiles;room [ROOM NUMBER] was missing the doorway transition strip and had missing floor tiles;room [ROOM NUMBER] was missing the doorway transition strip; room [ROOM NUMBER] was missing the doorway transition strip;room [ROOM NUMBER] had missing floor tiles;room [ROOM NUMBER] was missing the doorway transition strip; room [ROOM NUMBER] was missing the doorway transition strip;Floor tile was missing near the nurse's desk in Hall C. Observation on 1/13/2026 at 10:20 AM revealed the floor transition strip was missing from the doorway threshold to resident room [ROOM NUMBER]. In a confidential interview at an undisclosed date and time, a resident stated she had noticed, in the areas she visited within the facility, that the floors did not appear to be cleaned very well and there were parts of floor tiles that were broken. Observation on 1/13/2026 at 10:45 AM revealed a fly paper glue strip had been hung on the wall above the head of the bed for the resident in Bed A in room [ROOM NUMBER]. The paper glue strip had a few dead flies stuck to it. There was an accumulation of yellow colored glue from previous strips staining the wall. During an observation and interview on 01/14/2026 at 12:04 PM, the resident in room [ROOM NUMBER] stated his room had not yet been cleaned today. Dark colored clumps of chewing tobacco were observed on the floor in the middle of the room. The resident stated he had dropped the tobacco. The restroom floor had dark colored build-up at the bottom of the wall along the cove-base (vinyl baseboard) and around the base of the toilet, and a brown colored dirt build-up was at the base of the door frame. A pizza box containing 8 squares of sliced pizza was in the open third drawer of the resident's dresser. The box was a holiday season box, with holiday figures in red decorating the box. The pizza was dried and curled up at the edges. The resident stated the pizza had been in the drawer for at least a week. He said he thought his family member had brought it to him. The resident stated the pizza needed to be thrown away. During an observation and interview on 01/14/2026 at 10:26 AM, a resident in room [ROOM NUMBER] stated one of the housekeepers did not empty the trash. She stated the housekeepers cleaned the room daily and had not yet been in the room today to clean. Observation of the restroom revealed the floor around the base of the toilet and along the cove base (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was soiled with a dark colored build-up of dirt, and the floor around the base of the door frame was soiled with a brown colored dirt build-up. A wash basin was positioned on the floor beneath the sink, and the drainpipe was soiled with a dried brown colored substance. Observation on 01/14/2026 at 1:08 PM revealed the restroom in room [ROOM NUMBER] had a urine odor, the floor tile had dark colored stains behind the base of the toilet, and the floor was soiled with dirt build-up along the base of the door frame. In an interview on 1/15/2026 at 11:25 AM, the Housekeeping Director stated the housekeeping staff cleaned all the rooms every day and deep cleaned one resident room per hall a day, which included moving the bed and dresser to clean under them. She stated that they also cleaned the windows during a deep clean. The Housekeeping Director stated the Maintenance Director was responsible for the floors that need repaired. The Housekeeping Director stated the expectation was for all resident rooms to be cleaned. She was not sure what a negative outcome would be from not cleaning the residents' rooms. In an interview on 1/15/2026 at 2:15 PM, the Maintenance Director stated the housekeeping staff deep cleaned one room on each hall per day. She stated that included baseboards, windows, windowsills, and bathrooms. The Maintenance Director stated she had heard about the dirty bathrooms and doorways. She stated the daily sweeping and mopping of the bathrooms and doorways should clean the dirt and stuff that was found. The Maintenance Director stated she repaired floors with missing pieces of tile with new tiles if she had the supplies, but if not she had been applying concrete to areas of the floor to make them flush so not to be a trip hazard. The Maintenance Director stated she had been in contact with the corporate office regarding the transition strips for the room thresholds and was working on getting bids to have them replaced. She stated she was not aware of any resident falls that were caused by the flooring or thresholds. The Maintenance Director stated her expectation was that all resident rooms, including the bathrooms, were deep cleaned once a month. She stated a negative outcome could be making the resident sick, or the floor, depending on where the floor was missing tiles or had been built up with concrete, could be a trip hazard. In an interview on 1/15/2026 at 5:00 PM, the Administrator stated it was her expectation that the floors were cleaned daily to include sweeping, mopping, scrubbing, and using the proper tools to clean the floors. She stated all rooms were deep cleaned once a month, including windows. The Administrator stated for floors that were damaged with missing and/or broken tiles, the staff should put a request into the software used for reporting items that needed repair and it should be done as soon as possible. She stated a negative outcome could be trip hazards for the residents. Record review of the facility policy for Homelike Environment, dated as revised February 2021, specified [in part]: Policy StatementResidents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and ImplementationStaff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: ˆ a. clean, sanitary and orderly environment. Record review of the facility policy for Falls and Fall Risk, Managing, dated as revised March 2018, specified [in part]: Policy headingBased on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Policy Interpretation and ImplementationFall Risk Factors:Environmental factors that contribute to the risk of falls include: ˆˆd. obstacles in the footpath. [The policy did not include additional information that pertained to flooring.]