

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Athens		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Gibson Rd Athens, TX 75751	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure medications were available and administered for 1 of 6 residents (Resident #87) reviewed for medication administration. The facility failed to ensure that Resident #87's medications Clonazepam (a benzodiazepine medication that produces a calming effect, reducing anxiety) and Hydrocodone-Acetaminophen (an opioid medication that relieves pain) were available for 6 consecutive days following admission. This failure could place residents at an increased risk of and exacerbation of underlying medical conditions, avoidable discomfort, and a decline in physical or psychosocial well-being. A record review of an undated face sheet indicated Resident #87 was a [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses of encephalopathy (a group of conditions that cause brain dysfunction, leading to altered mental states and various neurological symptoms), hypothyroidism (a condition in which the thyroid gland does not produce enough hormones), hyperlipidemia (a condition of high cholesterol or fats in the blood), depression, Parkinsonism (a brain condition that causes slowed movements, rigidity, and tremors), and acute kidney failure. A record review of Resident #87's active medications included Acetaminophen Oral Tablet 325 MG, 2 tablets by mouth every 4 hours as needed; Clonazepam Oral Tablet 0.5 (a benzodiazepine medication that produces a calming effect, reducing anxiety), 1 tablet by mouth 2 times a day; Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (an opioid medication that relieves pain), 1 tablet by mouth 4 times a day; and Meloxicam Oral Tablet 15 MG (a nonsteroidal anti-inflammatory drug that helps relieve pain, inflammation, and stiffness), 1 tablet by mouth 1 time a day. A record review of Resident #87's medication administration record indicated that Resident #87 did not receive Clonazepam Oral Tablet 0.5 MG ranging from 02/13/2026 through 02/17/2026, resulting in a total of 9 missed doses. A record review of Resident #87's medication administration record indicated that Resident #87 did not receive Hydrocodone-Acetaminophen Oral Tablet 10-325 MG ranging from 02/13/2026 through 02/18/2026, resulting in a total of 19 missed doses. During an observation on 02/17/2026 at 1:26 PM, Resident #87 was observed listening to music in the living room area. Resident #87 smiled when she was spoken to, had her hair braided, and did not exhibit any facial grimacing to indicate that she was experiencing pain. During an interview and observation on 02/18/2026 at 9:17 AM, Resident #87 was observed sitting in a wheelchair in her room. Resident #87 appeared comfortable and did not exhibit any facial grimacing to indicate that she was experiencing pain. Resident #87 indicated that she felt some anxiety and pain, but indicated that it did not prevent her from participating in activities of daily living including eating, speaking, or participating in activities. During an interview on 02/18/2026 at 9:20 AM, LVN B indicated that Resident #87 had not received her ordered Clonazepam or Hydrocodone-Acetaminophen. LVN B indicated that she had gone to obtain these medications from the facility's automated medication dispensing machine on 02/16/2026 but was unable to as these medications required a triplicate prescription form from Resident #87's physician. LVN B indicated that she did not receive the notification that these medications were unavailable until after she had left for the day on 02/16/2026. LVN B indicated that she notified Resident #87's physician on (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/17/2026 at 9:50 AM that these medications required his authorization. During an interview on 02/18/2026 at 9:42 AM, MA D indicated that when a resident does not have their medications available on the medication cart she reports this information to the charge nurse who contacts the pharmacy or physician. MA D indicated she was aware Resident #87 did not receive her scheduled orders of Clonazepam and Hydrocodone-Acetaminophen on 02/15/2026 and that she notified the charge nurse at that time. During an interview on 02/18/2026 at 10:11 AM, LVN C indicated that he was working on 02/14/2026 assisting with medication administration. LVN C indicated that the facility did not have all of Resident #87's medications and that they were waiting on Resident #87's physician to send the triplicate prescription form to the pharmacy. LVN C indicated that he was told by the ADON that Resident #87's NP was aware of the issue. LVN C indicated that he should have contacted the NP or pharmacy to verify the triplicate prescription form was completed. LVN C indicated that the risk to Resident #87 of not being provided with these medications could include unmanaged pain control and resident safety. During an interview on 02/18/2026 at 10:25 AM, the ADON indicated she had been unaware that Resident #87 was not receiving her scheduled Clonazepam and Hydrocodone-Acetaminophen until 02/16/2026. The ADON indicated that she believed this medication was not provided to Resident #87 due to miscommunication between staff. The ADON indicated that despite the NP being contacted on 02/17/2026, Resident #87 was still not receiving these medications. The ADON indicated that she was ultimately responsible for ensuring that Resident #87 received her medications. The ADON indicated that the risk to Resident #87 for not receiving these medications could be a decline in her overall well-being. During a phone interview on 02/18/2026 at 11:05 AM, the NP indicated he sent the triplicate prescription form to the pharmacy on the afternoon of 02/17/2026. The NP indicated that he was notified of Resident #87 not receiving her Clonazepam and Hydrocodone-Acetaminophen on 02/15/2026 by LVN A and on 02/17/2026 by LVN B. The NP indicated that he needed further information on these medications from Resident #87's previous physicians and did not obtain this until 02/17/2026. The NP indicated that the risk to Resident #87 for not receiving these medications could be withdrawals if Resident #87 had been on them for a long time. During a phone interview on 02/18/2026 at 11:21 AM with a family member of Resident #87 indicated that Resident #87 had been taking medications for pain for at least the last 5 years. During a phone interview on 02/18/2026 at 1:43 PM, LVN E indicated she had worked on 02/15/2026 and that a staff member reported to her that Resident #87 did not have the medications Clonazepam and Hydrocodone-Acetaminophen. LVN E indicated that she sent a message to the NP on 02/15/2026 at 1:14 PM. During an interview on 02/18/2026 at 2:20 PM, the ADM indicated that the believed Resident #87 did not receive her medications of Clonazepam and Hydrocodone-Acetaminophen due to miscommunication between the admitting hospital, the facility, and the physician's office, though the nursing facility was ultimately responsible for ensuring Resident #87's medications were received. The ADM indicated that the risk to Resident #87 for not receiving these medications could be anxiety that could affect not only Resident #87 but other residents. A record review of 24 Hour Report/Change of Condition report from dates ranging 02/14/2026 to 02/18/2026 indicated Resident #87 was not experiencing any pain or discomfort. A record review of Resident #87's skilled nursing assessments on dates 02/13/2026 through 02/18/2026 did not indicate that Resident #87 was experiencing any pain. A record review of the facility's policy dated November 2014, updated February 2025 titled Physician Orders indicated the following: 11. admission orders - the licensed nurse will verify admission or readmission order with the physician or physician extender for all residents admitting or readmitting. A record review of the facility's policy dated July 2022 titled Psychotropic Medication Use indicated the following: 9. Use of psychotropic medications may be considered appropriate in specific circumstances, as specified in F605. These include: . c. new admissions where the resident is already on a psychotropic medication. Resident Evaluations Situations which may prompt an evaluation or re-evaluation of the resident include: admission or re-admission		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were complete and accurately documented for 3 of 5 residents (Residents #53, #59, #73) reviewed for medical records accuracy. The facility failed to ensure Resident #53's physician's orders included an order for oxygen use. The facility failed to ensure Resident #59's physician's orders included an order for a foley catheter. The facility failed to ensure resident #73's physician's orders included orders for diet and dialysis treatments. These failures could place residents at risk for errors in care and treatment. Findings included: 1. Record review of a face sheet dated 02/18/2026 indicated Resident #53 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included tracheostomy status (opening in the neck into the windpipe to facilitate breathing, traumatic hemorrhage of the cerebrum (the rupture of blood vessels within the brain due to head trauma), heart failure, post cardiac arrest, and gastrostomy status (tube inserted through an opening in the abdomen into the stomach for provision of liquid nutrition). Record review of a 5-day MDS assessment dated [DATE] noted Resident #53 had a BIMS score of 3, indicating his cognition was severely compromised. Further review of the MDS indicated Resident #53 had a tracheostomy and was receiving continuous oxygen. Record review of Resident #53's physician's orders dated 02/17/2026 indicated he did not have an order for oxygen therapy. During observations made on 02/16/2026 at 10:32 AM, on 02/17/2026 at 09:50 AM, and on 02/18/2026 at 10:00 AM, Resident #53 was noted receiving oxygen AT 3.5 LPM via a mask placed over his tracheostomy. During an interview on 02/18/2026 at 10:25 AM, RN F said Resident #53 had a physician's order for him to receive oxygen via his tracheostomy at 2-4 LPM to maintain his oxygen saturation at greater than 90%. When RN was unable to locate a physician's order for oxygen therapy, she said the nurses had been verbalizing Resident #53's oxygen use during change of shift report and she thought there was an order for it. RN F said it was important to have an order for oxygen therapy to ensure the rate of oxygen administration was at a rate beneficial to the resident. 2. Record review of a face sheet dated 02/18/2026 indicated Resident #59 was a [AGE] year-old female who initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE] after a stay in the hospital. She had diagnoses on re-admission which included bullous pemphigoid (a rare, autoimmune, chronic skin disorder causing large, tense, itchy, fluid-filled blisters), chronic kidney disease, and Parkinson's disease. Record review of a significant change MDS dated [DATE] noted Resident #59 had a BIMS score of 9 indicating her cognition was moderately impaired. Record review of a significant change MDS dated [DATE] indicated Resident #59 had a foley catheter. Record review of Resident #59's physician's orders 02/17/2026 indicated she did not have an order for a foley catheter. During observations made on 02/16/2026 at 10:17 AM and on 02/17/2026 at 12:15 AM, Resident #59 was noted to have a foley catheter in place and draining urine to a closed collection bag suspended from her wheelchair. During an interview on 02/17/2026 at 01:05 PM, RN F said Resident #59 had a foley catheter due to skin issues on her buttocks. She said Resident #59 should have an order for the foley catheter in her chart to ensure she received the care needed for it. 3. Record review of a face sheet dated 02/18/2026 indicated Resident #73 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included diabetes and end-stage kidney disease requiring renal dialysis. Record review of an incomplete admission MDS indicated Resident #73 had a BIMS score of 15 indicating his cognition was intact. Record review of the Baseline Care Plan Indicated Resident #73 was on a renal diet and required dialysis treatments. Record review of Resident #73's physician's orders indicated he did not have an order for dialysis. Further review of the physician's orders indicated Resident #73 did not have a diet. During an interview on 02/16/2026 at 10:14 AM, Resident #73 said he went to the dialysis center three times a week on Tuesdays, Thursdays, and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saturdays. He said the facility provided transportation to and from the center. He said he had been receiving his meals in his room and said the food was good. During an interview on 02/18/2026 at 02:10 PM, RN F said Resident #73 was taken to the dialysis center on Tuesdays, Thursdays, and Saturdays. She said she could not find an order for dialysis nor a diet in the physician's orders. RN F said the DON usually transcribed the physician orders from the hospital to the facility's computer system during regular business hours and the charge nurses did it after hours. She said she was not sure who checked the orders to ensure the accuracy of transcribed orders. During an interview on 02/18/2026 at 02:55 PM, the ADON said the DON usually reviewed the admission orders from the hospital to ensure the accuracy of the facility's transcribed orders. She said the DON quit the previous Friday. The ADON said the accuracy of the physician's orders was important for ensuring the residents receive needed care and treatment. She said was responsible for ensuring the accuracy of the physician's orders since the DON left. During an interview on 02/18/2026 at 03:15 PM, the Administrator said he expected the physician's orders of all the residents to accurately reflect the residents' care and treatment needs. He said the DON and ADON were both responsible for ensuring the physician's orders were accurately transcribed on admission to the facility. A record review of the facility's policy updated February 2025 and titled Physician's Orders indicated the following: PurposeThe purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services.Supervision by a Physician 3. A current list of orders must be maintained in the electronic record of each resident. 5. Physician orders are essential for the comprehensive care of the residents. These orders encompass various aspects, including .medication and treatment regimen, . dietary plans . and any other orders as needed. Recording Orders 3. Oxygen Orders - When recording orders for oxygen, specify the rate of flow, route, and rationale. 6. Treatment Orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment. 8. Foley Catheter b. Specify the size and diagnosis/indication (i.e. Catheter Size (18French), catheter type, and indication:c. Catheter care-specify what is to be done or according to facility procedure. 11. admission orders- the licensed nurse will verify admission or readmission order with the physician or physician extender for all residents admitting or re-admitting.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement baseline care plan within 48 hours of admission that includes the instructions needed to provide effective and person-centered care for 1 of 6 residents (Resident #87) reviewed for care plans. The facility failed to ensure that Resident #87 had a completed baseline care plan within 48 hours of admission. This failure could place residents at an increased risk of decline in physical or functional well-being, of not receiving necessary care or services, and of having personalized plans developed/implemented to address their needs. The findings included: A record review of an undated face sheet indicated Resident #87 was a [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses of encephalopathy (a group of conditions that cause brain dysfunction, leading to altered mental states and various neurological symptoms), hypothyroidism (a condition in which the thyroid gland does not produce enough hormones), hyperlipidemia (a condition of high cholesterol or fats in the blood), depression, Parkinsonism (a brain condition that causes slowed movements, rigidity, and tremors), and acute kidney failure. A record review on 02/17/2026 at 11:31 AM of Resident #87's baseline care plan indicated an undated, incomplete, and unsigned care plan. Completed information on Resident #87's baseline care plan included her identification information, modes of communication, vision and hearing, daily preferences, and advance directive. Resident #87's care plan did not include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, or any PASARR recommendations. During an interview on 02/18/2026 at 10:33 AM, the ADON confirmed baseline care plans were to be completed within 48 hours. The ADON indicated that usually the DON or MDS coordinator initiates the baseline care plan and the admitting nurse inputs the information required. The ADON indicated that she was unsure if Resident #87 had a completed baseline care plan. During an interview on 02/18/2026 at 10:41 AM, the MDS coordinator indicated that a registered nurse initiates the baseline care plan and the DON would ensure that it was completed and sign it. The MDS coordinator stated that she initiated Resident #87's baseline care plan and that typically the interdisciplinary team would complete it, then the DON would sign it as completed. The MDS coordinator denied that there was any one person that was ultimately responsible for ensuring that the baseline care plan was completed. The MDS coordinator indicated that the baseline care plan provides staff with an overall idea of what a resident's goals and outcomes could be, but denied that completing the baseline care plan would affect their overall health and well-being. During an interview on 02/18/2026 at 2:30 PM, the ADM indicated that the DON usually completes resident's baseline care plans. The ADM indicated that in the case of Resident #87, there was no DON on staff at the time of her admission. The ADM indicated that each member of the interdisciplinary team was responsible for completing their assigned sections of the baseline care plan. The ADM indicated that the MDS coordinator should have signed off on Resident #87's baseline care plan and ensured that it was completed. The ADM indicated that the risk to residents not having a complete baseline care plan would include no guide or direction to their care that would come from the baseline care plan. During an interview on 02/18/2026 at 2:35 PM, LVN A indicated she was the admitting nurse for Resident #87. LVN A indicated that when she completes her nursing assessment on admission that information is put into the baseline care plan. LVN A admitted that she was not sure if she completed her section of the baseline care plan and was unaware of the time frame in which it is to be completed. LVN A indicated that typically the DON or MDS coordinator are assigned to ensure the baseline care plan was completed and stated that the DON was no longer employed at the facility. LVN A indicated that the MDS coordinator was responsible for making sure the baseline care plan was completed. A record review of the facility's policy dated March 2022 titled Care Plans - Baseline indicated the following: Policy StatementA baseline plan of care to meet the resident's immediate health and safety needs is (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and ImplementationThe baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following:Initial goals based on admission orders and discussion with the resident/representative;Physician orders;Dietary orders;Therapy services; Social services; and PASARR recommendation, if applicable.		