

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: 455989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Avir at Borger		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 S Florida Borger, TX 79007	
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 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #14) of 12 residents reviewed for pain management. The facility failed to ensure Resident #14 did not have mouth pain from at least March of 2025 to August of 2025. This failure could place residents at risk of living for extended periods of time with unaddressed pain. Findings included: Record review of Resident #14's admission record dated 08/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, aggressive periodontitis localized moderate (severe, rapid periodontal disease affecting few teeth characterized by significant bone and attachment loss that progresses quickly, requires early and comprehensive treatment involving mechanical debridement, potentially systemic antibiotics, and periodontal surgery to halt destruction and prevent tooth loss), myelodysplastic syndrome (group of blood disorders characterized by abnormal production of blood cells in the bone marrow), and dental caries (cavities). The diagnosis date for aggressive periodontitis was 12/10/24. The diagnosis date for the myelodysplastic syndrome was 07/25/19. The diagnosis date for the dental caries was 02/28/22. Record review of Resident #14's annual MDS assessment completed on 08/25/25 revealed a BIMS score of 15 which indicated intact cognition. Section J Health Conditions revealed Resident had mild pain and received pain medication. The pain was coded as rarely interfering with sleep, therapy, and day to day activities. Section L Oral/Dental Status revealed Resident #14 was not coded as having Mouth or facial pain, discomfort or difficulty chewing. Record review of Resident #14's care plan completed 08/20/25 revealed no mention of mouth or dental pain/issues. The care plan stated Resident #14 had complaints of acute pain but did not specify where the pain was located. Record review of Resident #14's EHR under the MISC tab revealed the following: a letter dated 01/22/25 which indicated her dental assistance case had been reviewed and she was found to qualify for assistance. a dental visit report dated 02/25/25 revealed Resident #14 had two teeth extracted and had others that needed to be extracted. She was put on a round of amoxicillin 500 mg 3 times a day for 5 days. an encounter note from an oral and maxillofacial surgeon's office dated 07/07/25 revealed Resident #14 was evaluated for osteonecrosis of her jaw due to cancer treatment drugs she used to take. She was noted to have exposed bone in her right maxilla and mandible. She was noted to have been seen by oral surgeon and referred for further evaluation due to the extensive nature of her disease. Resident #14 was noted to have pain and an occasional foul taste in her right jaw upper and lower. The encounter note stated, Patient has a 2 cm exposed bone in her right maxilla as well as her right mandible which is necrotic. The oral and maxillofacial surgeon noted he would obtain x-rays from her dentist and call with a date for surgery which is usually excision of for quality bone with primary closure. Record review of Resident #14's progress notes revealed the following notes and corresponding dates: 03/20/25 a note from NP with an order for an oral numbing gel PRN which was to be kept at Resident #14's bedside. 03/23/25 a note which stated Resident #14 complained multiple times of tooth pain. [Resident #14] asked if I knew anything regarding her dentist appointment, I (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 0697 Level of Harm - Actual harm Residents Affected - Some	informed her I did not. She had a document with her from 01/22/25 regarding her tooth. I advised [Resident #14] had no information about any dental appointment for her but I would pass on her question to DON [first name of DON]. 06/26/25 Resident c/o pain radiating from right Nursing side of jaw to front of jaw. [NP] in facility and assessed resident. new orders to d/c chlorhexadine mouth wash d/t not for long term use. Clindamycin 300mg 1 capsule q8 hours x3 days and acidophilus capsule 1 capsule BID x3 days. 08/19/25 resident continues to c/o oral pain 8/1 O (8 out of 10) after PRN APAP administered as ordered, with significant halitosis noted, [NP] notified new order CBC BMP one time resident informed 08/26/25 at 02:57 AM Res complaining of oral pain of 4 APAP given to res.During an observation and interview on 08/25/25 at 07:40 AM Resident #14 stated she had bone and blood cancer. As she spoke her breath was foul and noticeable from 3 feet away. Resident #14 stated she was in pain all the time due to a pocket with pus and all that in her mouth. She stated she had x-rays in a nearby town and was told by that doctor that the only doctor who could handle her needed surgery was a doctor out of state. She stated the out of state doctor told her he would set a date for surgery, but it had not happened yet.During an observation and interview on 08/27/25 at 07:55 AM Resident #14 stated she regularly told staff about the pain she had in her mouth.During an interview on 08/27/25 at 08:54 AM CC stated Resident #14's mouth pain, has been an issue for a while. She stated an inaccurate care plan could potentially affect their (residents') care and treatment.During an interview on 08/27/25 at 10:46 AM CCM stated she did not know much about Resident #14's mouth pain. She stated, I know she had been having some.During an interview on 08/27/25 at 11:06 AM LVN F stated Resident #14's mouth pain has been for a very long time. This poor woman has been dragged through the ropes. We are just waiting on the surgeon to get it together.During an interview on 08/27/25 at 11:14 AM ADM stated she knew Resident #14 had mouth pain.During an interview on 08/27/25 at 01:04 PM DON stated she knew about Resident #14's mouth pain. She stated the pain had been going on for a minute. DON stated the facility took Resident #14 to a dentist and were told to take her to an oral surgeon who sent them to an out of state oral surgeon who took forever and a day to get her in and is now taking forever and a day to get her in for surgery.Record review of facility policy titled, Pain Management and dated 7-2025 revealed the following: . The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, new pain or an exacerbation of pain). Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal. 3. The interdisciplinary team and the resident and/or the resident's representative will collaborate to arrive at pertinent, realistic and measurable goals for treatment. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain. The following are general principles the facility will utilize for prescribing analgesics: a. Evaluate the resident's medical condition, current medication regimen, cause and severity of the pain and course of illness to determine the most appropriate analgesic therapy for pain. c. Consider administering (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food service safety. The facility failed to ensure stored food was properly labelled and dated. The facility failed to ensure dented cans were placed in the specified area to be returned. The facility failed to discard leftover food by use by date on the label. The facility failed to ensure the floor, walls, trashcan, and bathroom of the kitchen were clean and sanitized. The facility failed to ensure food was stored at least 6 inches off the floor. These failures could place residents at risk of food borne illness. Findings included: An observation on 08/25/25 at 05:35 AM revealed a meal trolley outside the door to the kitchen. It was full of dirty dishes and trays with two dirty trays and their dirty dishes sitting on top of the trolley. An observation on 08/25/25 at 05:36 AM revealed the sink next to the dishwasher was full of dirty dishes, pots, and pans and the three compartment sink on the other side of the dishwasher was full of dirty dishes, pots, and pans. An observation on 08/25/25 at 05:37 AM revealed three round, 5-gallon, opaque plastic, lidded containers stacked on top of one another on the floor of the kitchen next to the stand mixer. The bottom container was 1/4 full of yellow substance and labeled Cornmeal 07/17/25 use by 08/17/25. The middle container was 1/2 full of white substance and labeled Sugar 07/17/25 use by 08/17/25. The top container was 1/6 full of white powdery substance and had no label or date. An observation on 08/25/25 at 05:39 AM revealed the kitchen floor around the step-to-open trashcan was littered with white crumbs which were stuck to the floor but could be scraped off using the toe of this surveyor's shoe. The trash can did not have a liner and the inside of the trashcan is smeared. The bottom of the trash can contained crumbs, two individual ketchup packets, and one individual butter packet. An observation on 08/25/25 at 05:40 AM revealed the kitchen floor next to the stove, steam table, and prep table was littered with crumbs and black/brown streaks and smears that were sticky to the bottom of this surveyor's shoes. An observation on 08/25/25 at 05:42 AM of the counter next to the microwave revealed the following: two bags of circular fruit flavored breakfast cereal open to air a bag of cheese sauce mix open to air with no date a banana peeled 1/3 of the way down and open to air. An observation on 08/25/25 at 05:43 AM of the shelving under the microwave counter and the steam table revealed clean steam pans and a scattering of white crumbs. An observation on 08/25/25 at 05:46 AM of the walls next to and behind the oven revealed brown/orange substance splattered from about 6 feet high to the bottom of the walls. An observation on 08/25/25 at 05:48 AM of the prep table reveals a brown/grey smear approximately the size of a dessert plate that is sticky and greasy to touch on the end of the table closest to the serving door. An observation on 08/25/25 at 05:48 AM of the refrigerator and freezer temperature logs revealed the last entry was 08/20/25. An observation on 08/25/25 at 05:51 of the large freezer revealed the following: 1 zip topped plastic bag contained what appeared to be pancakes no label or date 1 zip topped plastic bag contained breaded meat patties no label or date 2 large plastic bags of what appeared to be fried shrimp no label or date 1 plastic bag labeled cookies open to air. An observation on 08/25/25 at 05:55 AM of the walk-in refrigerator revealed the following: 2 individual butter spread containers on the floor 1 unopened, clear plastic bag labeled coleslaw and dated 07/22/25 1 zip topped plastic bag labeled cucumber onion dated 08/21/25 use by 08/24/25 1 large opaque circular tub 1/3 full of what appears to be chopped carrots in liquid no label or date 1 plastic circular opaque tub 1/3 full labeled cream of chicken and dated 08/19/25 use by 08/22/25 1 rectangular, metal, lidded steam table pan 1/2 full of what appears to be oatmeal no label or date 1 zip topped plastic bag labeled Roast dated 08/20/25 use by 08/23/25 1 buffet ham in original packaging dated 07/29/25 1 package of what appears to be round luncheon meat with no label or date. 1 package of sliced ham no date 1 box of bacon open to air. An observation on 08/25/25 at 06:07 AM revealed a round, lidded, plastic tub of chocolate frosting with 1/6th used sitting on the counter (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	next to the coffee maker. Manufacturer's label stated, Refrigerate leftovers for up to 2 weeks. An observation on 08/25/25 at 06:08 AM of the pantry revealed the following: 1 can of apples dented on the side and top seam of the can 1 large bag of parboiled rice open to air 1 undated box of small macaroni noodles open to air 1 zip topped plastic bag with open cheese sauce package inside with no open date 1 zip topped plastic bag with open bag of potato chips inside with no open date 4 macaroni noodles and lots of crumbs and dirt on the floor behind the pantry door. An observation on 08/25/25 at 06:23 AM of the kitchen bathroom revealed the following: 1 wet spot under the sink the size of a sheet of letter paper, with dirty end of plunger resting in the wet spot toilet bowl was speckled with brown spots yellow stains on underside of toilet seat in a splatter pattern sink drain is broken and lying crookedly in the bottom of the sink sink was stained grey/brown along the top right side floor of bathroom was sticky and stained with brown/black smears walls of bathroom were dirty with grey/brown/black smudges light switch was stained greyish brown and sticky spiderwebs on the shelf above the toilet and on the ceiling An observation on 08/25/25 at 08:43 AM revealed cornmeal, sugar, and third unlabeled tubs still stacked on the floor of the kitchen next to the stand mixer. An observation on 08/25/25 at 08:43 AM of prep table revealed it still has same smear of grey/brown sticky, greasy substance on the end closest to the DR. An observation on 08/25/25 at 08:43 AM of kitchen floor revealed it was still littered with crumbs and black/brown sticky smears. An observation on 08/25/25 at 08:45 AM of the walk-in refrigerator revealed a pitcher of opaque plastic with red lid 1/3 full of white substance no label or date. An observation on 08/25/25 at 08:47 AM of locked freezer revealed the following: 4 cylindrical packages of what appears to be ground meat with no label or date 2 turkey breasts with no date box of bite-sized pieces of what appears to be meat with no label or date open to air. During an observation on 08/26/2025 at 07:32 AM DA B used her right index finger to stir apple juice into ground sausage patty as she prepared puree meal. During an observation on 08/26/2025 at 07:56 AM DA B finished using the blender for one pureed item and used water from the tap to rinse out the blender before reusing it for the next pureed item. During an observation on 08/26/2025 at 08:10 AM DA A used her gloved hand to pick up a half slice of toast and place it on a plate for a resident after touching trays, utensils, and the door handle to the walk-in refrigerator. During an interview on 08/25/2025 at 09:09 AM DA C stated he had worked for facility for 2 months. He stated all kitchen staff were responsible for cleaning pantry, kitchen floors, and kitchen bathroom. He stated there was a cleaning log and they communicate with one another to see who does what each shift. DA C stated the bathroom was cleaned at least 3 times a week. He stated all kitchen staff were responsible for labeling and dating food in pantry, freezer, and fridge. DA C stated they were flying by the seat of their pants while DM was out on medical leave. He stated he was not trained on labelling and dating food. DA C stated he managed a kitchen previously and all he needed to know was where the stickers to label and date were kept. During an interview on 08/25/2025 at 09:16 AM DA A stated she had worked for the facility for 3 years. She stated all kitchen staff were responsible for cleaning pantry and kitchen floors. DA A stated they did both things daily. She stated the kitchen bathroom was cleaned by kitchen staff at least 3 times a week. DA A stated she noticed the water under the sink in the kitchen bathroom yesterday. She stated it was often necessary to leave dirty dishes in the tray trolley and dirty dishes, pots, and pans in the sinks overnight due to needing to clock out at 06:00 PM after dinner was served at 05:30 PM. DA A stated whoever puts food in the fridge needs to label it with the day made and the use by date. She stated she was trained on labelling and dating food. During an interview on 08/26/25 at 03:22 PM RD stated residents could be negatively impacted if food was not labeled and dated properly. She stated, A lot of different things could go wrong with that if it is expired or out of date, you wouldn't know. During an interview on 08/27/25 at 10:27 AM DA A stated she had been trained on labeling and dating food at least 6 times in 3 years. She stated if food was not properly labeled and dated it could make residents sick. DA A stated she was trained on sorting canned goods for dented cans when the food truck arrives. She stated residents could be negatively impacted by eating food from dented cans. DA A stated she had been trained on cleaning the floors of (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policy titled Hand Washing and dated 10/01/18 revealed the following: . The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition and Foodservice employees will practice good hand washing practices in order to minimize the risk of infection and food borne illness. Hands should be washed after the following occurrences: . k. Touching un-sanitized equipment, work surfaces .Record review of facility policy titled General Kitchen Sanitation and dated 10/01/18 revealed the following: . All Nutrition and Foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. 1. Clean and sanitize all food preparation areas, food contact surfaces . 3. Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil. 6. Clean non-food contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles . 11. Check restrooms regularly throughout the shift .Record review of facility policy titled Food Preparation and Handling and dated 6/1/19 revealed the following: . To ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes . General Guidelines a. Use clean, sanitized surfaces, equipment . c. Prepare food with the least manual contact possible. Do not allow bare hands to touch raw food directly.Record review of facility policy titled Food Storage and dated 10/01/19 revealed the following: . To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes . Dry storage rooms d. All containers must be labeled and dated.h. Store all items at least 6 inches above the floor . Refrigerators . d. Date, label, and tightly seal all refrigerated foods . e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. h. Temperatures (of refrigerators) should be checked each morning and again on the PM shift. Record the temperatures on a log that is kept near the refrigerator. Freezers . e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.Record review of facility policy titled Handwashing Guidelines for Dietary Employees and dated 07/25/25 revealed the following: . Handwashing is necessary to prevent the spread of bacteria that may cause foodborne illnesses. Frequency of Handwashing . n. 3. After engaging in any activity that may contaminate the hands.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 3 (Resident #2, Resident #8, and Resident #14) of 12 residents reviewed for accuracy of assessment.1. The facility failed to accurately code Resident #2's oxygen therapy status.2. The facility failed to accurately code Resident #8's tobacco use status.3. The facility failed to accurately code Resident #14's dental status.These failures could place residents at risk of not receiving necessary care and/or consideration.Findings Included:1. Record review of Resident #2's admission record dated 08/25/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, generalized anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), shortness of breath, and acute chronic congestive heart failure (a type of progressive heart disease where both aspects of the heart's pumping mechanism are significantly impaired over a prolonged period resulting in shortness of breath, swelling, fatigue, wheezing, and confusion or forgetfulness).Record review of Resident #2's annual MDS with an ARD of 08/07/25 and completed 08/22/25 revealed a BIMS of 9 which indicated moderately impaired cognition. Resident #2 was not coded as receiving oxygen therapy.Record review of Resident #2's care plan completed on 08/20/25 revealed the following problem: Resident requires PRN oxygen therapy R/T heart failure. This problem area was initiated on 12/28/20. One of the approaches was, Administer oxygen at 2L via Nasal Cannula. Observe oxygen precautions. This approach was initiated on 12/28/20.Record review of Resident #2's active orders dated 08/27/25 revealed the following order with start date of 08/27/25: Nasal Cannula (Continuous): O2 @ 2 L/Min Every Shift Shift 1, Shift 2.Record review of Resident #2's oxygen saturation notes from 07/25/25, 07/31/25, 08/01/25, 08/02/25, 08/05/25 and 08/07/25 revealed she was receiving O2 via NC at 2 lpm.During an observation and attempted interview on 08/25/2025 at 6:28 AM Resident #2 was in bed sleeping wearing O2 via a N/C. Resident #2 was asleep and did not wake to knocking or introduction. During an observation on 08/27/2025 at 7:32 AM Resident #2 was in bed sleeping wearing O2 via a N/C. Resident #2 was asleep and did not wake to knocking or introduction.During an interview on 08/27/2025 at 10:32 AM CCM reviewed Resident #2 annual MDS assessment completed 8/07/25 and reported that Resident #2 was not marked for oxygen use. CCM reported that Resident #2 was not documented on her MAR for oxygen use and that is why she did not mark Resident #2 on her MDS for oxygen therapy. CCM reviewed Resident #2 O2 assessments per request by this surveyor and noted the resident was documented for oxygen therapy for the 7-day look back period for the 8/07/25 annual MDS and stated, I didn't see this. Resident #2 should have been marked for oxygen therapy. I do not know why it was not documented on her MAR's. CCM reported not addressing the residents' needs on an MDS such as respiratory therapy would affect the residents care plan and could affect the resident care and would also affect the facility's reimbursement for care provided which could eventually affect resident care indirectly. CCM reported that the facility used the RAI manual to complete all MDS assessments.2. Record review of Resident #8's admission record dated 08/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it, stroke), flaccid hemiplegia (a type of paralysis characterized by muscles that are weak, limp, and floppy due to a lack of nerve signals) affecting left non-dominant side, and nicotine dependence. The admission record indicated Resident #8 was diagnosed as nicotine dependent on 04/07/23.Record review of Resident #8's quarterly MDS completed 08/25/25 revealed a BIMS of 9 which indicated moderately impaired cognition.Record review of Resident #8's annual MDS completed 02/07/25 revealed he was coded as not using tobacco.Record review of Resident #8's care plan completed on 08/20/25 revealed the following: I (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	want to smoke. I am a safe smoker. This problem area was initiated on 05/26/25. The care plan made no mention of chewing tobacco. Record review of Resident #8's Smoking Risk form completed 04/28/23 revealed he was a safe smoker. The form revealed no mention of chewing tobacco. Record review of Resident #8's Smoking Evaluation completed 05/26/25 revealed he required supervision while smoking. The evaluation made no mention of chewing tobacco. Record review of the smoking list provided to surveyors on 05/25/25 by ADM revealed Resident #8 was not listed as a smoker. During an observation and interview on 08/27/25 Resident #8 was seated in his bed. He stated he smoked and chewed snuff (tobacco) quite a bit. He stated he started both habits after he was admitted to the facility but was not sure when. He stated he had not stopped smoking or chewing tobacco since he started. During an interview on 08/27/25 at 08:54 AM CN stated Resident #8 smoked once every week or two when he arrived at the facility. She stated she was not sure if he smoked any longer. During an interview on 08/27/25 at 10:46 AM CCM stated she was responsible for completing MDS assessments and she was not sure how long Resident #8 had been smoking or why his annual MDS did not code him as using tobacco. During an interview on 08/27/25 at 11:06 AM LVN F stated she had worked for the facility off and on and had been back working for the facility for a year. She stated Resident #8 had been smoking since before she met him. She stated, He prefers dip, but he hardly ever, ever has any to use. During an interview on 08/27/25 at 11:14 AM ADM stated Resident #8 very rarely asks to smoke. She stated she thought he was initially assessed as a smoker when he was admitted to the facility. During an interview on 08/27/25 at 01:04 PM DON stated she did not know how long Resident #8 had used tobacco. 3. Record review of Resident #14's admission record dated 08/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, aggressive periodontitis localized moderate (severe, rapid periodontal disease affecting few teeth characterized by significant bone and attachment loss that progresses quickly, requires early and comprehensive treatment involving mechanical debridement, potentially systemic antibiotics, and periodontal surgery to halt destruction and prevent tooth loss), myelodysplastic syndrome (group of blood disorders characterized by abnormal production of blood cells in the bone marrow), and dental caries (cavities). The diagnosis date for aggressive periodontitis was 12/10/24. The diagnosis date for the myelodysplastic syndrome was 07/25/19. The diagnosis date for the dental caries was 02/28/22. Record review of Resident #14's annual MDS assessment completed on 08/25/25 revealed a BIMS of 15 which indicated intact cognition. Section J Health Conditions revealed Resident had mild pain and received pain medication. The pain was coded as rarely interfering with sleep, therapy, and day to day activities. Section L Oral/Dental Status revealed Resident #14 was not coded as having Mouth or facial pain, discomfort or difficulty chewing. Record review of Resident #14's care plan completed 08/20/25 revealed no mention of mouth or dental pain/issues. The care plan stated Resident #14 had complaints of acute pain but did not specify where the pain was located. Record review of Resident #14's EHR under the MISC tab revealed the following: a letter dated 01/22/25 which indicated her dental assistance case had been reviewed and she was found to qualify for assistance. a dental visit report dated 02/25/25 revealed Resident #14 had two teeth extracted and had others that needed to be extracted. She was put on a round of amoxicillin 500 mg 3 times a day for 5 days. an encounter note from an oral and maxillofacial surgeon's office dated 07/07/25 revealed Resident #14 was evaluated for osteonecrosis of her jaw due to cancer treatment drugs she used to take. She was noted to have exposed bone in her right maxilla and mandible. She was noted to have been seen by oral surgeon and referred for further evaluation due to the extensive nature of her disease. Resident #14 was noted to have pain and an occasional foul taste in her right jaw upper and lower. The encounter note stated, Patient has a 2 cm exposed bone in her right maxilla as well as her right mandible which is necrotic. The oral and maxillofacial surgeon noted he would obtain x-rays from her dentist and call with a date for surgery which is usually excision of for quality bone with primary closure. Record review of Resident #14's progress notes revealed the following notes and corresponding dates: 03/20/25 a note from NP with an order (continued on next page)		

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for an oral numbing gel PRN which was to be kept at Resident #14's bedside. 03/23/25 a note which stated Resident #14 complained multiple times of tooth pain. [Resident #14] asked if I knew anything regarding her dentist appointment, I informed her I did not. She had a document with her from 01/22/25 regarding her tooth. I advised [Resident #14] had no information about any dental appointment for her but I would pass on her question to DON [first name of DON]. 04/03/25 at 03:40 PM Made multiple attempts to contact the [name of foundation], which approved [Resident #14] for financial aid. The Dental provider they referred [Resident #14] to has reportedly not been working with the foundation for quite some time. The facility has obtained approval to pay for the dental consult at [name of local dentist], which is pending. 04/03/25 at 04:19 PM [Resident #14] has an appointment at 1 pm on April 8, 2025 at [name of local dentist]. 04/08/25 DON consulted on call facility provider for abt for dental abscess reported by dental provider this shift, new order received clindamycin 300mg PO TID x5 days as well as acidophilus BID x5 days resident aware initial dose given from stat safe at this time. office formulated plan of treatment to be entered into residents chart, new order received for chlorhexidine 0.12% mouth rinse take one capful and swish for 1 minute and expectorate. do not eat or drink for 30 min after swishing. 04/09/25 at 09:36 AM This nurse contacted [sic] [name of local oral and maxillofacial surgeon] per referral from [name of local dentist]. She stated they do not accept patients in this age group. 04/09/25 at 09:52 AM This nurse contacted oral surgeons in [names of larger cities near facility] area and none take adult medicaid [sic] at this time. 04/09/25 at 09:53 AM This nurse contacted superior Medicaid who stated that oral surgeons are not covered under her dental plan. 04/09/25 at 10:00 AM Spoke with [name of NP] regarding update on oral surgeon referral. She stated to speak to [MD] for suggestions for next steps. [MD] will be in facility today and will provide update. 04/09/25 at 02:47 PM This nurse left message with [name of doctor at oncology office]. This explained that dentist was wanted pocket that was in gums to be biopsied and that insurance did not cover oral surgeon and was inquiring to see if Oncologist would be comfortable performing biopsy and treating. awaiting a call back at this time. 04/09/25 05:07 PM Received a call back from [oncologist's] office and stated they can not perform biopsys [sic] of that nature. more information regarding dental situation. This nurse provided all requested information and nurse stated she would speak to the physician and give call back. 04/25/25 12:24 PM Received visit note from [local dentist] regarding patients visit. Follow up with [local dentist] as needed and refer to Dr. [oral and maxillofacial surgeon's name] in [city out of state]. 04/25/25 03:07 PM Message left with [out of state oral and maxillofacial surgeon's] office concerning referral. awaiting a call back at this time. 06/11/25 This social worker placed a call to [oral and maxillofacial surgeon's] office regarding a dental referral to him for a dental referral and a staff member from his office states that the office does not have a dental referral for resident. Social worker will let DON, that [oral and maxillofacial surgeon's] office does not have a dental referral on resident. regards to oral surgery for resident and the phone rang numerous times, but no one answered the phone from his office and there was no prompt to leave a message for the office. Social worker will try to call the office back after lunch and check for the referral to [oral and maxillofacial surgeon's name] for resident's dental needs. 06/18/25 This social worker called the office of [oral and maxillofacial surgeon] in [city out of state], and talked with a staff member regarding surgery on resident's mouth for an abscessed toot by [oral and maxillofacial surgeon]. The staff member told this social worker that [oral and maxillofacial surgeon] will be in the office at 3:30 pm and the staff member will talk with him to check if [oral and maxillofacial surgeon] can help resident with the surgery and if he is not able to assist resident then the staff member stated that he may know a dentist that can assist resident with oral surgery. The staff member states that she will call this social worker back after talking with [oral and maxillofacial surgeon] regarding possible assistance for surgery on resident. assistance on enrolling resident on a dental insurance plan and the representative stated that straight Medicare does not cover dental services and that resident would have to get on Medicare Advantage plan to receive any dental benefits or resident will have to enroll (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in a private dental insurance plan. The agent then gave the number to the phone number to Area On Aging to talk with a staff member over there regarding some assistance to enroll resident on a private dental insurance plan. This social worker then called the number for Area On Aging phone number and i was then transferred to the phone for a staff member named [name of staff member]. There was no answer at the phone for [name of staff member] and this social worker has left a message for [name of staff member] to call this social worker back on 6-16-25 to assist with dental insurance for resident. 06/25/25 This social worker did fax a doctor referral over to [oral and maxillofacial surgeon] for him to see resident for a dental intervention. in regards to if [oral and maxillofacial surgeon] can see resident for the oral surgery and the staff member did state that [oral and maxillofacial surgeon] can see resident if their office receives a referral from another provider. This social worker then called [local dentist] and asked for their office to send a referral to [oral and maxillofacial surgeon's] office so resident can be seen by [oral and maxillofacial surgeon]. The staff member from [local dentist] states that they can send the referral to [oral and maxillofacial surgeon's] office. This social worker then informed resident that [local dentist] will send a referral to [oral and maxillofacial surgeon's] office for him to see resident. 06/26/25 Resident c/o pain radiating from right Nursing side of jaw to front of jaw. [NP] in facility and assessed resident. new orders to d/c chlorhexadine mouth wash d/t not for long term use. Clindamycin 300mg 1 capsule q8 hours x3 days and acidophilus capsule 1 capsule BID x3 days. 06/30/25 This social worker has made a call to [oral and maxillofacial surgeon's] office to check if a referral has gotten to his office for resident to see [oral and maxillofacial surgeon] for oral surgery. A staff member from [oral and maxillofacial surgeon's] office has checked and states that the office has received the referral from our nursing home and has scheduled a consult for resident to see [oral and maxillofacial surgeon] on 7-7-2025 at 3:15 pm. This social worker has informed resident that she has an appointment on 7-7-2025 to see [oral and maxillofacial surgeon] for oral surgery. Resident voiced understanding. 07/02/25 This social worker called [oral and maxillofacial surgeon's] office and had the billing office run resident's insurance to check if the insurance will pay for the consultation with [oral and maxillofacial surgeon] when resident goes to his office on 7-7-25 for the consult. The staff member in [oral and maxillofacial surgeon's] office states that the insurance will pay for the consultation with [oral and maxillofacial surgeon]. 07/14/25 Social worker checked with resident to see if she saw [oral and maxillofacial surgeon] last Monday on 07-07-25 in [out of state city], for her consult with him in regards to oral surgery and resident states that she did see [oral and maxillofacial surgeon] in [out of state city], and she states that he thinks the problem in her mouth could be the cause of cancer and he is going to talk with the doctor that is following resident and then will schedule oral surgery on resident's mouth, according to resident. 08/06/25 This nurse spoke with [oral and maxillofacial surgeon's] office. Requested visit note again and stated they would fax over. Fax number provided. This nurse inquired about follow up and nurse at [oral and maxillofacial surgeon's] office stated that they are planning on surgery but nothing scheduled at this time. They are obtaining images from previous oral surgeon. 08/19/25 resident continues to c/o oral pain 8/1 O (8 out of 10) after PRN APAP administered as ordered, with significant halitosis noted. [NP] notified new order CBC BMP one time resident informed 08/22/25 Called [oral and maxillofacial surgeon's] office to inquire about scheduling procedure date for the resident. Spoke with a nurse who informed me that [oral and maxillofacial surgeon] was currently in the operating room and unavailable at the moment. Nurse stated she would send him a text message with the inquiry and follow up with me before the end of the day. Provided the nurse with the resident's full name and date of birth , as well as this nurse's personal cell phone number for a return call. Awaiting response. 08/26/25 at 02:57 AM Res complaining of oral pain of 4 APAP given to res. 08/26/25 at 02:29 PM Followed up with oral surgeon's office regarding patient's upcoming procedure. Spoke with nurse for [oral and maxillofacial surgeon], who stated there is currently no update on the procedure date. She reported that she has messaged the physician again and expects a response after he completes surgery, estimated to be (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	around 1600 (4 PM) today. Nurse provided a call-back number, and we are currently awaiting a return phone call from [oral and maxillofacial surgeon] or his office with further information. During an observation and interview on 08/25/25 at 07:40 AM Resident #14 stated she had bone and blood cancer. As she spoke her breath was foul and noticeable from 3 feet away. Resident #14 stated she was in pain all the time due to a pocket with pus and all that in her mouth. She stated she had x-rays in a nearby town and was told by that doctor that the only doctor who could handle her needed surgery was a doctor out of state. She stated the out of state doctor told her he would set a date for surgery, but it had not happened yet. During an observation and interview on 08/27/25 at 07:55 AM Resident #14 stated she regularly told staff about the pain she had in her mouth. During an interview on 08/27/25 at 08:54 AM CC stated Resident #14's mouth pain, has been an issue for a while. During an interview on 08/27/25 at 10:46 AM CCM stated she did not know much about Resident #14's mouth pain. She stated, I know she had been having some. She stated she was not sure why it was not coded on Resident #14's most recent MDS assessment. During an interview on 08/27/25 at 11:06 AM LVN F stated Resident #14's mouth pain has been for a very long time. This poor woman has been dragged through the ropes. We are just waiting on the surgeon to get it together. During an interview on 08/27/25 at 11:14 AM ADM stated she knew Resident #14 had mouth pain. During an interview on 08/27/25 at 01:04 PM DON stated she knew about Resident #14's mouth pain. She stated the pain had been going on for a minute. DON stated the facility took Resident #14 to a dentist and were told to take her to an oral surgeon who sent them to an out of state oral surgeon who took forever and a day to get her in and is now taking forever and a day to get her in for surgery. During an interview on 08/27/25 at 08:54 AM CC stated CCM was responsible for completing MDS assessments and an inaccurate MDS assessment could negatively affect the care and treatment of a resident. During an interview on 08/27/25 at 10:46 AM CCM stated an inaccurate MDS assessment could affect the way things are care planned. During an interview on 08/27/25 at 11:14 AM ADM stated CCM was responsible for completing MDS assessments and an inaccurate care plan could negatively impact the care the resident received. She stated, The MDS tells the full picture of care that should be provided for the resident and helps build the care plan for CNAs. We want it accurate and up to date. During an interview on 08/27/25 at 01:04 PM DON stated CCM was responsible for completing MDS assessments. She stated an inaccurate MDS assessment could cause residents to receive inaccurate care. Record review of facility policy titled Resident Smoking Policy and dated 2024 revealed the following: . 6. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed the following: . J: Health Conditions . Current Tobacco Use . 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. L: Oral/Dental Status . 1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort. Check L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort chewing. O: Special Treatments, Procedures, and Programs . Check all of the following treatments, procedures, and programs that were performed during the last 14 days . Respiratory Treatments C. Oxygen therapy .		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #29) of 12 residents reviewed for resident rights. Resident #29 was observed with her catheter bag not in a privacy bag. This failure could place resident at risk for feeling uncomfortable, disrespected, and embarrassed leading to isolation. Findings include: Record review of Resident #29's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and neuromuscular dysfunction of the bladder (the nerves and muscles of the bladder do not work well resulting in the bladder not filling or emptying well). Record review of Resident #29's was a new admission and did not require a MDS assessment to be completed at this time according to the RAI manual. Record review of the care plan with admission date of 8/22/25 for Resident #29 revealed the following: Problem start date: 8/25/25 Category: Indwelling Catheter. During an observation on 08/25/2025 at 06:33 AM Resident #29 was in her bed with the light on, her curtain pulled up against the wall, and the door open. Resident #29 could be observed with a shirt on and a sheet covering her midsection. Resident #29's lower thighs and legs were exposed. This surveyor observed Resident #29 attempting to move her catheter bag on the frame of her bed. The catheter bag was not in a privacy bag. The catheter bag was noted to be approximately half full of urine. During an observation from the hallway on 08/25/2025 at 9:08 AM Resident #29 continued to be in her bed with the light on, her curtain pulled up against the wall, and her door open with her catheter bag hanging from the bedframe with no privacy bag. This surveyor observed two residents pass Resident #29 room that could have observed the exposed catheter bag. During an interview on 08/26/2025 at 1:18 PM RN E (the nurse providing resident care this shift) reported all resident catheter bags should be stored in a privacy bag to prevent them from being viewed by visitors and other residents. RN E stated if the catheter bag was stored where it could be viewed it could result in humiliation and degradation for the resident with the catheter and could be gross or disgusting for anyone who viewed the exposed urine bag. During an interview on 08/27/2025 at 7:36 AM the DON reported a urinary catheter bag should be stored off the floor, attached to a bed below the resident's bladder, and in a privacy bag. The DON stated if a resident catheter bag was not stored in a privacy bag it would be a dignity issues. The DON stated, I would not want to walk around and let someone see my urine and I am sure others would not want to see it either. During an interview on 08/27/2025 at 8:45 AM the CN reported a catheter bag should be stored in a privacy bag, off the floor, secured, and below the bladder. The CN reported if the catheter bag was not stored in a privacy bag, then it was a dignity issue for the resident. The CN reported leaving the catheter bag exposed could result in a resident feeling bad about themselves. Record review of facility provided policy titled, Resident Rights Under Texas Law revised 2/22/22, revealed the following: You have the right:6. to privacy. Record review of facility provided policy titled, Promoting/Maintaining Resident Dignity date implemented 7-25, revealed the following: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity. Compliance Guidelines:12. Maintain resident privacy. Record review of facility provided policy titled, Catheter Care date implemented 7-24, revealed the following: Policy: It is the policy of this facility to ensure that resident with indwelling catheter receive appropriate catheter care and maintain their dignity and privacy. Policy Explanations:2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #10) of 12 residents reviewed for advanced directives. Resident #10 had a DNR in her record that was missing the date when the physician signed the form. The facility's failure could place residents a risk for not receiving healthcare as per their or their legal representatives wishes. Findings included: Record review of Resident #10's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), malnutrition (lack of proper nutrition), muscle wasting (the loss of muscle mass and strength due to disease, injury, or lack of use), anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and hypertension (a condition in which the force of the blood against the artery walls is too high). During an record review of Resident #10's last MDS was an annual assessment completed [DATE] listing her with a BIMS of 15 indicating she was cognitively intact, and she had a functionality of requiring partial/moderate assistance with most of her activities of daily living. Record review of During a record review of Resident #10's care plan with admission date of [DATE] revealed the following: Problem start date: [DATE]. Category: Code Status. I am a DNR. I do not wish to be resuscitated. Edited: [DATE]. Record review of the clinical record for Resident #10 revealed an Order Summary printed [DATE] with the following order: -Code Status: Do Not Resuscitate (DNR). Start Date: [DATE] Record review of the clinical record for Resident #10 revealed a DNR dated [DATE] (signed by Resident #10) with the following: Section - Physician's Statement: The physician signed the form, provided his printed name, and his license number. There was no date of when the physician signed the form. During an interview on [DATE] at 01:24 PM RN E reported the current DNR process for the facility was to check the daily printed list that gives each resident's code status, check the computer, and they can check the residents color coded door. RN E checked his printed sheet and verified that Resident #10 was currently a DNR, then checked the computer and verified again that Resident #10 was a DNR. RN E confirmed if Resident #10 was found without a heartbeat or breathing he would not start CPR. RN E reported that he would also review the DNR in the resident's chart just to be sure. RN E reviewed Resident #10 DNR in her electronic record and noted that the Physician did not date the DNR. When asked if Resident #10's DNR was valid RN E stated, to be honest, I don't know. During an interview on [DATE] at 7:40 AM the DON reported that a resident with a DNR that was not completed correctly would be an issue in that it could be a legal problem that would involve the resident and the family and if a resident died and the nurse could not follow the residents DNR wishes then that nurse would have to start CPR. The DON reported this would have a negative effect on the resident and the family. During an interview on [DATE] at 8:47 AM the CN reported a DNR that was not completed accurately would definitely be an issue and could possibly result in the improper or not coding of a resident which would affect them negatively. The CN reported that she and the DON were responsible for ensuring that the DNR's are accurately completed and they just missed this one. Record review of the facility provided policy titled Code Status Guidelines undated, revealed no information for completing a DNR accurately. Record review of the facility provided policy titled Advance Directives Available in Texas revised [DATE], revealed no information for completing a DNR accurately. Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following:- The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and clean environment for 1 (Resident #9) of 12 residents reviewed for environment. -Resident #9 had a dining tray left in his room for 18 hours. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept environment. Findings include: Record review of Resident #9's face sheet revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include bipolar disorder (a disorder associated with episode of mood swings ranging from depressive lows to manic highs), cognitive communication deficit (difficulty with thinking and how someone uses language), mild intellectual disabilities (a condition that affects a person's intellectual functioning and adaptive skills), mood disorder (any of a group of conditions of mental and behavioral disorder where the main underlying characteristic was a disturbance in a person mood), and vitamin D deficiency (a condition that occurs when the body does not have enough vitamin D which may resulting in bone pain, weakness, cramps, fatigue, and increased risk of falls). Record review of Resident #9's last MDS was a quarterly assessment completed 6/24/25 listing him with a BIMS of 15 indicating he was cognitively intact, and he had a functionality of being independent with most of his activities of daily living. Record review of Resident #9's care plan with admission date of 10/15/24 revealed the following: Problem start date: 8/20/25. Unintended weight gain related to increase access to food/snacks. Problem start date: 10/15/24. Nutritional Status Approach: Monitor meal % Record review of the clinical record for Resident #9 revealed an Order Summary printed 08/26/25 with the following order: Diet: Regular Diet. Start Dated 6/02/25 During an observation on 08/25/2025 at 7:50 AM Resident #9 was not in his room. Noted on Resident #9's bedside table was his lunch tray from 08/24/25 (Sun-Lunch was printed on the meal ticket left on the lunch tray) with approximately 50% of the food eaten. Noted Resident #9's lunch ticket and a cup placed on top of the plate with food exposed. During an observation and interview on 08/27/2025 at 7:30 AM Resident #9 was observed in his room laying on top of his bed dressed well for the day. Resident #9 did not have a food tray present but was able to verify a tray had been left in his room Monday morning (8/25/25) from the lunch meal delivered on Sunday 08/24/25. Resident #9 stated the staff sometime will leave his tray in his room overnight. When asked if this was an issue Resident #9 shrugged his shoulder and did not respond. During an interview on 08/25/2025 at 7:57 AM this surveyor asked the CN to enter Resident #9's room where she verified Resident #9's meal tray was in his room on his bedside table. The CN verified the meal tray was Resident #9's lunch tray from the previous day and it should not have been left out for Resident #9 to eat because it could be an infection control issue and it could make him sick if he ate any of it. The CN also reported if a confused resident wandered in the room, it could make them sick too. The CN reported floor staff were responsible for delivering hall trays to resident rooms. During an interview on 08/26/2025 at 1:23 PM RN E reported a food tray delivered to a resident's room should be picked up in a timely manner which in his opinion should be within one to two hours. RN E reported a tray left over one to two hours could grow something and place a resident at risk of getting sick if they were to eat it. When asked if a tray left in a resident's room for 18 hours would be considered too long RN E stated, that is much too long. RN E reported the resident in the room could eat something off the tray or a confused resident could enter the room and eat something off the tray and become ill. During an interview on 08/27/2025 at 7:38 AM the DON reported leaving a tray in a resident's room for a period of time was an issue especially if the resident ate it or a confused resident entered the room and ate it. The DON reported the facility had a couple of confused wanderers could possible do that. The DON reported leaving a tray out in a room could result in a food born illness. Record review of the facility provided policy titled, Food Safety Requirements date revised 7/23/25, revealed the following: Policy: Food will be stored, prepared, distributed, and served (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in accordance with professional standard for food service safety. Definitions:Food service safety - refers to handling, preparing, and storing food in ways that prevent foodborne illness.Foodborne illness - refers to an illness cause by the ingestion of contaminated for or beverages.Record review further revealed there were no instructions for when a residents meal tray was to be retrieved once the meal was completed. Record review of the facility provided in-service titled Hall Tray started 8/25/25 revealed the following training provided to 18 staff members: Topic: Hall TraysTimely pickup of hall trays after meals is an important aspect of providing quality care in the healthcare or long-term care setting		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a significant change assessment within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition for 1 (Resident #7) of 12 residents reviewed for timing of assessments. The facility failed to complete Resident #7's significant change MDS within 14 days of his admission to hospice care on 03/01/25. This failure could place residents at risk of not receiving necessary care/coordination of care. Findings Included: Record review of Resident #7's admission record dated 08/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), chronic viral hepatitis C (viral infection the body is no longer able to fight off that causes liver swelling and can lead to serious liver damage), chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue), and cirrhosis of the liver (impaired liver function caused by the formation of scar tissue). Resident #7's admission record noted his primary payer as Hospice and listed the name of the hospice company providing his services. Record review of Resident #7's quarterly MDS completed on 06/17/25 revealed he was receiving hospice care While a Resident. Record review of Resident #7's significant change MDS, documenting his change to hospice care, revealed a completion date of 03/21/25. Record review of Resident #7's care plan completed 06/04/25 revealed he was receiving terminal care from hospice. This problem area was initiated on 03/01/25 and the approaches for this area were initiated on 03/03/25. Record review of Resident #7's active physician's orders dated 08/27/25 revealed he was admitted to hospice care on 03/01/25 for COPD. During an interview on 08/27/25 at 08:54 AM CN stated CCM was responsible for completing MDS assessments. She stated a resident's care could be negatively impacted if a significant change MDS was not completed timely. During an interview on 08/27/25 at 10:46 AM CCM stated she was responsible for completing MDS assessments timely. She stated a resident's care could be negatively impacted if a significant change MDS was not completed within the 14 days allotted because the care plan for the resident was based on the MDS assessment. CCM stated she was not sure why Resident #7's significant change MDS was not completed within the 14-day time frame. During an interview on 08/27/25 at 11:14 AM ADM stated CCM and the interdisciplinary team were responsible for MDS assessments. She stated a resident's care could be negatively impacted if a significant change MDS was not completed timely. During an interview on 08/27/25 at 01:04 PM DON stated CCM was responsible for completing MDS assessments. She stated a resident might not get the correct care if their MDS was not completed timely. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed a chart on page 38 with the following: Assessment Type. Significant Change. MDS Completion Date. no later than 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). Significant Change in Status Assessment . Must be completed (item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #14) of 12 residents reviewed for comprehensive care plans.1. The facility failed to include Resident #14's mouth pain and need for oral surgery in her care plan.This failure could lead to residents not receiving needed care and/or receiving improper care/treatment.Findings Included:Record review of Resident #14's admission record dated 08/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, aggressive periodontitis localized moderate (severe, rapid periodontal disease affecting few teeth characterized by significant bone and attachment loss that progresses quickly, requires early and comprehensive treatment involving mechanical debridement, potentially systemic antibiotics, and periodontal surgery to halt destruction and prevent tooth loss), myelodysplastic syndrome (group of blood disorders characterized by abnormal production of blood cells in the bone marrow), and dental caries (cavities). The diagnosis date for aggressive periodontitis was 12/10/24. The diagnosis date for the myelodysplastic syndrome was 07/25/19. The diagnosis date for the dental caries was 02/28/22.Record review of Resident #14's annual MDS assessment completed on 08/25/25 revealed a BIMS of 15 which indicated intact cognition. Section J Health Conditions revealed Resident had mild pain and received pain medication. The pain was coded as rarely interfering with sleep, therapy, and day to day activities. Section L Oral/Dental Status revealed Resident #14 was not coded as having Mouth or facial pain, discomfort or difficulty chewing.Record review of Resident #14's care plan completed 08/20/25 revealed no mention of mouth or dental pain/issues. The care plan stated Resident #14 had complaints of acute pain but did not specify where the pain was located.Record review of Resident #14's EHR under the MISC tab revealed the following:a letter dated 01/22/25 which indicated her dental assistance case had been reviewed and she was found to qualify for assistance.a dental visit report dated 02/25/25 revealed Resident #14 had two teeth extracted and had others that needed to be extracted. She was put on a round of amoxicillin 500 mg 3 times a day for 5 days.an encounter note from an oral and maxillofacial surgeon's office dated 07/07/25 revealed Resident #14 was evaluated for osteonecrosis of her jaw due to cancer treatment drugs she used to take. She was a noted to have exposed bone in her right maxilla and mandible. She was noted to have been seen by oral surgeon and referred for further evaluation due to the extensive nature of her disease. Resident #14 was noted to have pain and an occasional foul taste in her right jaw upper and lower. The encounter note stated, Patient has a 2 cm exposed bone in her right maxilla as well as her right mandible which is necrotic. The oral and maxillofacial surgeon noted he would obtain x-rays from her dentist and call with a date for surgery which is usually excision of for quality bone with primary closure.Record review of Resident #14's progress notes revealed the following notes and corresponding dates: 03/20/25 a note from NP with an order for Orajel PRN which was to be kept at Resident #14's bedside. 03/23/25 a note which stated Resident #14 complained multiple times of tooth pain. [Resident #14] asked if I knew anything regarding her dentist appointment, I informed her I did not. She had a document with her from 01/22/25 regarding her tooth. I advised [Resident #14] had no information about any dental appointment for her but I would pass on her question to DON [first name of DON]. 04/03/25 at 03:40 PM Made multiple attempts to contact the [name of foundation], which approved [Resident #14] for financial aid. The Dental provider they referred [Resident #14] to has reportedly not been working with the foundation for quite some time. The facility has obtained approval to pay for the dental consult at [name of local dentist], which is pending. 04/03/25 at 04:19 PM [Resident #14] has an (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointment at 1 pm on April 8, 2025 at [name of local dentist]. 04/08/25 DON consulted on call facility provider for abt for dental abscess reported by dental provider this shift, new order received clindamycin 300mg PO TID x5 days as well as acidophilus BID x5 days resident aware initial dose given from stat safe at this time. office formulated plan of treatment to be entered into residents chart, new order received for chlorhexidine 0.12% mouth rinse take one capful and swish for 1 minute and expectorate. do not eat or drink for 30 min after swishing. 04/09/25 at 09:36 AM This nurse contacted [sic] [name of local oral and maxillofacial surgeon] per referral from [name of local dentist]. She stated they do not accept patients in this age group. 04/09/25 at 09:52 AM This nurse contacted oral surgeons in [names of larger cities near facility] area and none take adult medicaid [sic] at this time. 06/26/25 Resident c/o pain radiating from right Nursing side of jaw to front of jaw. [NP] in facility and assessed resident. new orders to d/c chlorhexadine mouth wash d/t not for long term use. Clindamycin 300mg 1 capsule q8 hours x3 days and acidophilus capsule 1 capsule BID x3 days. 08/26/25 at 02:57 AM Res complaining of oral pain of 4 APAP given to res. 08/26/25 at 02:29 PM Followed up with oral surgeon's office regarding patient's upcoming procedure. Spoke with nurse for [oral and maxillofacial surgeon], who stated there is currently no update on the procedure date. She reported that she has messaged the physician again and expects a response after he completes surgery, estimated to be around 1600 (4 PM) today. Nurse provided a call-back number, and we are currently awaiting a return phone call from [oral and maxillofacial surgeon] or his office with further information. During an observation and interview on 08/25/25 at 07:40 AM Resident #14 stated she had bone and blood cancer. As she spoke her breath was foul and noticeable from 3 feet away. Resident #14 stated she was in pain all the time due to a pocket with pus and all that in her mouth. She stated she had x-rays in a nearby town and was told by that doctor that the only doctor who could handle her needed surgery was a doctor out of state. She stated the out of state doctor told her he would set a date for surgery, but it had not happened yet. During an observation and interview on 08/27/25 at 07:55 AM Resident #14 stated she regularly told staff about the pain she had in her mouth. During an interview on 08/27/25 at 08:54 AM CC stated Resident #14's mouth pain, has been an issue for a while. She stated an inaccurate care plan could potentially affect their (residents') care and treatment. She stated CCM and DON were responsible for care plans. During an interview on 08/27/25 at 10:46 AM CCM stated she did not know much about Resident #14's mouth pain. She stated, I know she had been having some. She stated she was ultimately responsible for care plans. She stated an inaccurate care plan could negatively impact the care provided to the resident. During an interview on 08/27/25 at 11:06 AM LVN F stated Resident #14's mouth pain has been for a very long time. This poor woman has been dragged through the ropes. We are just waiting on the surgeon to get it together. She stated DON was responsible for care plans. She stated an inaccurate care plan could negatively impact a resident's care and treatment depending on what was inaccurate. During an interview on 08/27/25 at 11:14 AM ADM stated she knew Resident #14 had mouth pain. She stated DON and CCM were responsible for care plans. She stated an inaccurate care plan can have adverse outcomes if staff don't know specifically what the issues are and the correct interventions are regarding resident care and treatment. During an interview on 08/27/25 at 01:04 PM DON stated she knew about Resident #14's mouth pain. She stated the pain had been going on for a minute. DON stated the facility took Resident #14 to a dentist and were told to take her to an oral surgeon who sent them to an out of state oral surgeon who took forever and a day to get her in and is now taking forever and a day to get her in for surgery. She stated she and CCM were responsible for care plans. She stated an inaccurate care plan could place residents at risk of not receiving the care they need or how they need it. Record review of facility policy titled Comprehensive Care Plans and dated 7/2025 revealed the following: .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs . The care planning process will include an assessment of the resident's strengths and needs and will (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incorporate the resident's personal . preferences . The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. f. Resident specific interventions that reflect the resident's needs and preferences .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 2 (Resident #2 and #15) of 12 residents reviewed for respiratory care. -Resident #2 did not have orders for her oxygen therapy. -Resident #15 was not receiving oxygen at the correct dose. These failures could affect residents by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings include: Resident #2Record review of Resident #2's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include history of COVID-19, shortness of breath, diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), dementia (a group of thinking and social symptoms that interferes with daily functioning), myocardial infarction (heart attack), peripheral vascular disease (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs), and rheumatoid arthritis (autoimmune inflammation of the joints). Record review of Resident #2's clinical record revealed her last MDS was an annual completed 8/07/2025 listing her with a BIMS score of 9 indicating she was moderately cognitively impaired, and she had a functionality of being dependent on staff for most of her activities of daily living. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #2 was marked as not having oxygen While a Resident. Record review of Resident #2's Orders printed 8/27/25 revealed the following order:- O2 @ 2 L/Min. Start Date: 08/27/2025 Record review of Resident #2's Medication Administration Record printed 8/26/25 for 7/01/25 to 7/31/25 and 8/01/25 to 8/26/25 revealed no orders for oxygen administration or dosage and no documentation of oxygen administration. Record review of Resident #2's clinical record revealed a care plan with the admission date of 7/20/19, which revealed the following: Problem Start Date: 12/28/2020.Resident requires PRN Oxygen therapy R/T heart failure. During an observation on 08/25/2025 at 6:28 AM Resident #2 was in bed sleeping wearing O2 via a N/C. During an observation on 08/27/2025 at 7:32 AM Resident #2 was in bed sleeping wearing O2 via a N/C. Resident #2 did not wake to knocking or introduction. During an interview on 08/27/2025 at 7:34 AM the DON reviewed Resident #2 clinical records and stated, I can't find an order for her oxygen. I know there used to be one and I know she was on it, but I can't find one in her chart now. The DON reported if a resident was on a medication such as oxygen, then they need an order for the medication and if the resident did not have an order, it could affect the resident's treatment. During an interview on 08/27/2025 at 8:54 AM the CN reported oxygen was a medication, and any medication administered to a resident required a physician order. The CN reported administering a medication without an order can be a legal issue and can affect a resident's condition and their treatment. During an interview on 08/27/2025 at 10:12 AM the CN reported the oxygen order for Resident #2 was inadvertently discontinued due to it was a duplicate. The CN provided a General Order Summary revealing oxygen for Resident #2 was ordered on 9/10/2019 and dc'd on 11/15/2022. The CN stated, I don't know why it has been missed since then. During an interview on 08/27/2025 at 10:32 AM the CCM reviewed Resident #2 annual MDS assessment completed 8/07/25 and reported Resident #2 was not marked for oxygen use on her 7/25 and 8/25 MAR. The CCM reported because Resident #2 was not documented on her MAR for oxygen use, she did not mark Resident #2 on her on the MDS for oxygen therapy. Resident #15 Record review of Resident #15's admission record dated 08/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, COPD (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue). Record review of Resident #15's clinical record revealed her last MDS was an annual completed 8/21/25 listing her with a BIMS score of 07 indicating she was severely cognitively impaired, and she had a functionality (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of requiring substantial/maximal assistance with most of her activities of daily living. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #15 was marked as having oxygen While a Resident. Record review of Resident #15's active orders printed 8/27/25 revealed the following order with a start date of 12/27/24: O2 at 2 LPM via NC @ HS. Record review of Resident #15's care plan with admission date of 7/23/25 revealed the following: Problem Start Date: 7/23/25Resident requires oxygen therapy at times due to diagnoses of COPD. During an observation on 08/25/25 at 07:57 AM Resident #15 was lying in bed receiving O2 via NC at 3 lpm. During an observation and interview on 08/25/25 at 08:02 AM Resident #15 was sitting on the side of her bed eating breakfast and receiving O2 via NC at 3 lpm. She stated she was not sure how long she had been using O2. During an observation on 08/26/25 at 09:22 AM Resident #15 was lying in bed receiving O2 via NC at 3 lpm. During an observation on 08/26/25 at 03:32 PM Resident #15 was lying in bed receiving O2 via NC at 3 lpm. During an observation on 08/27/25 at 07:44 AM Resident #15 was lying in bed receiving O2 via NC at 2.75 lpm. During an interview on 08/27/25 at 08:54 AM the CN stated nurses were responsible for setting flow rates on O2 concentrators. The CN stated nurses knew what level to set the O2 flow rate by referring to physician's orders for that resident. The CN stated if a resident had a DX of COPD and received O2 at higher concentrations than ordered it could be a real issue. The CN stated the resident could go hypoxic or have a low blood oxygen saturation. During an interview on 08/27/25 at 10:46 AM the CCM stated nursing staff were responsible to set flow rates on O2 concentrators. The CCM stated, There should be an order to determine what flow rate to use. The CCM stated a resident could be negatively affected by receiving O2 at a different flow rate than ordered. During an interview on 08/27/25 at 10:57 AM CNA D stated nurses were responsible for setting flow rates on O2 concentrators. During an interview on 08/27/25 at 11:06 AM LVN F stated nurses were responsible for setting flow rates on O2 concentrators. LVN F stated the physician's order determined what flow rate to set. LVN F stated if a resident had COPD and received O2 at higher levels than ordered it could negatively affect their respiratory drive and they could stop breathing altogether. LVN F stated she did not know why Resident #15 was receiving O2 at higher rates than ordered. During an interview on 08/27/25 at 11:14 AM the ADM stated nurses were responsible for setting O2 flow rates and they referred to physician's orders to determine the rate. The ADM stated residents could be negatively impacted if they received O2 at different rates than ordered. During an interview on 08/27/25 at 01:04 PM the DON stated nurses were responsible for setting O2 flow rates and they were to set them according to the physician's order. The DON stated if a resident received O2 at higher rates than ordered it can suppress their respiratory drive. Record review of the facility provided policy titled, Oxygen Concentrator date implemented 7/25, revealed the following: Policy Explanation and Compliance Guidelines:2. Oxygen is administered under the orders of the attending physician.4. Use of a concentrator:a. The nurse shall verify physician's order for the rate of flow and route of administration of oxygen.		

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to provide or obtain from an outside resource, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services for 1 (Resident #14) of 12 residents reviewed for dental issues. The facility failed to obtain oral surgery for Resident #14 timely. This failure could place residents at risk of exacerbated dental issues and/or pain. Findings Included: Record review of Resident #14's admission record dated 08/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, aggressive periodontitis localized moderate (severe, rapid periodontal disease affecting few teeth characterized by significant bone and attachment loss that progresses quickly, requires early and comprehensive treatment involving mechanical debridement, potentially systemic antibiotics, and periodontal surgery to halt destruction and prevent tooth loss), myelodysplastic syndrome (group of blood disorders characterized by abnormal production of blood cells in the bone marrow), and dental caries (cavities). The diagnosis date for aggressive periodontitis was 12/10/24. The diagnosis date for the myelodysplastic syndrome was 07/25/19. The diagnosis date for the dental caries was 02/28/22. Record review of Resident #14's annual MDS assessment completed on 08/25/25 revealed a BIMS of 15 which indicated intact cognition. Section J Health Conditions revealed Resident had mild pain and received pain medication. The pain was coded as rarely interfering with sleep, therapy, and day to day activities. Section L Oral/Dental Status revealed Resident #14 was not coded as having Mouth or facial pain, discomfort or difficulty chewing. Record review of Resident #14's care plan completed 08/20/25 revealed no mention of mouth or dental pain/issues. The care plan stated Resident #14 had complaints of acute pain but did not specify where the pain was located. Record review of Resident #14's EHR under the MISC tab revealed the following: a letter dated 01/22/25 which indicated her dental assistance case had been reviewed and she was found to qualify for assistance. a dental visit report dated 02/25/25 revealed Resident #14 had two teeth extracted and had others that needed to be extracted. She was put on a round of amoxicillin 500 mg 3 times a day for 5 days. an encounter note from an oral and maxillofacial surgeon's office dated 07/07/25 revealed Resident #14 was evaluated for osteonecrosis of her jaw due to cancer treatment drugs she used to take. She was noted to have exposed bone in her right maxilla and mandible. She was noted to have been seen by oral surgeon and referred for further evaluation due to the extensive nature of her disease. Resident #14 was noted to have pain and an occasional foul taste in her right jaw upper and lower. The encounter note stated, Patient has a 2 cm exposed bone in her right maxilla as well as her right mandible which is necrotic. The oral and maxillofacial surgeon noted he would obtain x-rays from her dentist and call with a date for surgery which is usually excision of for quality bone with primary closure. Record review of Resident #14's progress notes revealed the following notes and corresponding dates: 03/20/25 a note from NP with an order for an oral numbing gel PRN which was to be kept at Resident #14's bedside. 03/23/25 a note which stated Resident #14 complained multiple times of tooth pain. [Resident #14] asked if I knew anything regarding her dentist appointment, I informed her I did not. She had a document with her from 01/22/25 regarding her tooth. I advised [Resident #14] had no information about any dental appointment for her but I would pass on her question to DON [first name of DON]. 04/03/25 at 03:40 PM Made multiple attempts to contact the [name of foundation], which approved [Resident #14] for financial aid. The Dental provider they referred [Resident #14] to has reportedly not been working with the foundation for quite some time. The facility has obtained approval to pay for the dental consult at [name of local dentist], which is pending. 04/03/25 at 04:19 PM [Resident #14] has an appointment at 1 pm on April 8, 2025 at [name of local dentist]. 04/08/25 DON consulted on call facility provider for abt for dental abscess reported by dental provider this shift, new order received clindamycin 300mg PO TID x5 days as well as (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acidophilus BID x5 days resident aware initial dose given from stat safe at this time. office formulated plan of treatment to be entered into residents chart, new order received for chlorhexidine 0.12% mouth rinse take one capful and swish for 1 minute and expectorate. do not eat or drink for 30 min after swishing. 04/09/25 at 09:36 AM This nurse contacted [sic] [name of local oral and maxillofacial surgeon] per referral from [name of local dentist]. She stated they do not accept patients in this age group. 04/09/25 at 09:52 AM This nurse contacted oral surgeons in [names of larger cities near facility] area and none take adult medicaid [sic] at this time. 04/09/25 at 09:53 AM This nurse contacted superior Medicaid who stated that oral surgeons are not covered under her dental plan. 04/09/25 at 10:00 AM Spoke with [name of NP] regarding update on oral surgeon referral. She stated to speak to [MD] for suggestions for next steps. [MD] will be in facility today and will provide update. 04/09/25 at 02:47 PM This nurse left message with [name of doctor at oncology office]. This explained that dentist was wanted pocket that was in gums to be biopsied and that insurance did not cover oral surgeon and was inquiring to see if Oncologist would be comfortable performing biopsy and treating. awaiting a call back at this time. 04/09/25 05:07 PM Received a call back from [oncologist's] office and stated they can not perform biopsys [sic] of that nature. more information regarding dental situation. This nurse provided all requested information and nurse stated she would speak to the physician and give call back. 04/25/25 12:24 PM Received visit note from [local dentist] regarding patients visit. Follow up with [local dentist] as needed and refer to Dr. [oral and maxillofacial surgeon's name] in [city out of state]. 04/25/25 03:07 PM Message left with [out of state oral and maxillofacial surgeon's] office concerning referral. awaiting a call back at this time. 06/11/25 This social worker placed a call to [oral and maxillofacial surgeon's] office regarding a dental referral to him for a dental referral and a staff member from his office states that the office does not have a dental referral for resident. Social worker will let DON, that [oral and maxillofacial surgeon's] office does not have a dental referral on resident. regards to oral surgery for resident and the phone rang numerous times, but no one answered the phone from his office and there was no prompt to leave a message for the office. Social worker will try to call the office back after lunch and check for the referral to [oral and maxillofacial surgeon's name] for resident's dental needs. 06/18/25 This social worker called the office of [oral and maxillofacial surgeon] in [city out of state], and talked with a staff member regarding surgery on resident's mouth for an abscessed toot by [oral and maxillofacial surgeon]. The staff member told this social worker that [oral and maxillofacial surgeon] will be in the office at 3:30 pm and the staff member will talk with him to check if [oral and maxillofacial surgeon] can help resident with the surgery and if he is not able to assist resident then the staff member stated that he may know a dentist that can assist resident with oral surgery. The staff member states that she will call this social worker back after talking with [oral and maxillofacial surgeon] regarding possible assistance for surgery on resident. assistance on enrolling resident on a dental insurance plan and the representative stated that straight Medicare does not cover dental services and that resident would have to get on Medicare Advantage plan to receive any dental benefits or resident will have to enroll in a private dental insurance plan. The agent then gave the number to the phone number to Area On Aging to talk with a staff member over there regarding some assistance to enroll resident on a private dental insurance plan. This social worker then called the number for Area On Aging phone number and i was then transferred to the phone for a staff member named [name of staff member]. There was no answer at the phone for [name of staff member] and this social worker has left a message for [name of staff member] to call this social worker back on 6-16-25 to assist with dental insurance for resident. 06/25/25 This social worker did fax a doctor referral over to [oral and maxillofacial surgeon] for him to see resident for a dental intervention. in regards to if [oral and maxillofacial surgeon] can see resident for the oral surgery and the staff member did state that [oral and maxillofacial surgeon] can see resident if their office receives a referral from another provider. This social worker then called [local dentist] and asked for their office to send a referral to [oral and maxillofacial surgeon's] office so resident can be seen by (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[oral and maxillofacial surgeon]. The staff member from [local dentist] states that they can send the referral to [oral and maxillofacial surgeon's] office. This social worker then informed resident that [local dentist] will send a referral to [oral and maxillofacial surgeon's] office for him to see resident. 06/26/25 Resident c/o pain radiating from right Nursing side of jaw to front of jaw. [NP] in facility and assessed resident. new orders to d/c chlorhexadine mouth wash d/t not for long term use. Clindamycin 300mg 1 capsule q8 hours x3 days and acidophilus capsule 1 capsule BID x3 days. 06/30/25 This social worker has made a call to [oral and maxillofacial surgeon's] office to check if a referral has gotten to his office for resident to see [oral and maxillofacial surgeon] for oral surgery. A staff member from [oral and maxillofacial surgeon's] office has checked and states that the office has received the referral from our nursing home and has scheduled a consult for resident to see [oral and maxillofacial surgeon] on 7-7-2025 at 3:15 pm. This social worker has informed resident that she has an appointment on 7-7-2025 to see [oral and maxillofacial surgeon] for oral surgery. Resident voiced understanding. 07/02/25 This social worker called [oral and maxillofacial surgeon's] office and had the billing office run resident's insurance to check if the insurance will pay for the consultation with [oral and maxillofacial surgeon] when resident goes to his office on 7-7-25 for the consult. The staff member in [oral and maxillofacial surgeon's] office states that the insurance will pay for the consultation with [oral and maxillofacial surgeon]. 07/14/25 Social worker checked with resident to see if she saw [oral and maxillofacial surgeon] last Monday on 07-07-25 in [out of state city], for her consult with him in regards to oral surgery and resident states that she did see [oral and maxillofacial surgeon] in [out of state city], and she states that he thinks the problem in her mouth could be the cause of cancer and he is going to talk with the doctor that is following resident and then will schedule oral surgery on resident's mouth, according to resident. 08/06/25 This nurse spoke with [oral and maxillofacial surgeon's] office. Requested visit note again and stated they would fax over. Fax number provided. This nurse inquired about follow up and nurse at [oral and maxillofacial surgeon's] office stated that they are planning on surgery but nothing scheduled at this time. They are obtaining images from previous oral surgeon. 08/19/25 resident continues to c/o oral pain 8/1 O (8 out of 10) after PRN APAP administered as ordered, with significant halitosis noted, [NP] notified new order CBC BMP one time resident informed 08/22/25 Called [oral and maxillofacial surgeon's] office to inquire about scheduling procedure date for the resident. Spoke with a nurse who informed me that [oral and maxillofacial surgeon] was currently in the operating room and unavailable at the moment. Nurse stated she would send him a text message with the inquiry and follow up with me before the end of the day. Provided the nurse with the resident's full name and date of birth , as well as this nurse's personal cell phone number for a return call. Awaiting response. 08/26/25 at 02:57 AM Res complaining of oral pain of 4 APAP given to res. 08/26/25 at 02:29 PM Followed up with oral surgeon's office regarding patient's upcoming procedure. Spoke with nurse for [oral and maxillofacial surgeon], who stated there is currently no update on the procedure date. She reported that she has messaged the physician again and expects a response after he completes surgery, estimated to be around 1600 (4 PM) today. Nurse provided a call-back number, and we are currently awaiting a return phone call from [oral and maxillofacial surgeon] or his office with further information. During an observation and interview on 08/25/25 at 07:40 AM Resident #14 stated she had bone and blood cancer. As she spoke her breath was foul and noticeable from 3 feet away. Resident #14 stated she was in pain all the time due to a pocket with pus and all that in her mouth. She stated she had x-rays in a nearby town and was told by that doctor that the only doctor who could handle her needed surgery was a doctor out of state. She stated the out of state doctor told her he would set a date for surgery, but it had not happened yet. During an observation and interview on 08/27/25 at 07:55 AM Resident #14 stated she regularly told staff about the pain she had in her mouth. During an interview on 08/27/25 at 08:54 AM CC stated Resident #14's mouth pain, has been an issue for a while. During an interview on 08/27/25 at 10:46 AM CCM stated she did not know much about Resident #14's mouth pain. She stated, I know she had been having some. She stated she was not sure why it was not (continued on next page)		

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

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

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coded on Resident #14's most recent MDS assessment. During an interview on 08/27/25 at 11:06 AM LVN F stated Resident #14's mouth pain has been for a very long time. This poor woman has been dragged through the ropes. We are just waiting on the surgeon to get it together. During an interview on 08/27/25 at 11:14 AM ADM stated she knew Resident #14 had mouth pain. During an interview on 08/27/25 at 01:04 PM DON stated she knew about Resident #14's mouth pain. She stated the pain had been going on for a minute. DON stated the facility took Resident #14 to a dentist and were told to take her to an oral surgeon who sent them to an out of state oral surgeon who took forever and a day to get her in and is now taking forever and a day to get her in for surgery. Record review of facility policy titled Dental Services and dated 7-2025 revealed the following: . It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. ?Emergency dental services' includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. 1. The dental needs of each resident are identified through the physical assessment and MDS assessment processes, and are addressed in each resident's plan of care. Oral/dental status shall be documented according to assessment findings. Oral care and denture care shall be provided in accordance with identified needs and as specified in the plan of care. Referrals to . or dental provider shall be made as appropriate. 9. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. Record review of an undated facility policy titled Dental Services Referral and Approval Policy revealed only information related to contracted dental services occurring in the facility and nothing related to dental surgery.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received food prepared in a form designed to meet individual needs for 1 (Resident #13) of 12 residents reviewed for dietary needs. The facility failed to prepare Resident #13's pureed diet appropriately. This failure could place residents at risk of aspiration, choking, and/or weight loss. Findings Included: Record Review of Resident #13's admission record dated 08/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia severe (a group of thinking and social symptoms that interferes with daily functioning), unspecified protein-calorie malnutrition (state of inadequate intake of food), dysphagia oropharyngeal phase (swallowing disorder that makes it difficult or unsafe to move food from the mouth to the esophagus), and other dietary vitamin B12 deficiency anemia (a form of anemia that occurs when the body lacks sufficient vitamin B12 due to an inadequate intake of natural sources, such as meat and dairy, or fortified foods). Record review of Resident #13's quarterly MDS completed 08/22/25 revealed no BIMS score as Resident #13 was rarely to never understood. The staff assessment revealed her cognition was severely impaired. Section GG Functional Abilities revealed Resident #13 was dependent across all ADLs except for eating where she required substantial/maximal assistance. Section K Swallowing/Nutritional Status revealed she received a mechanically altered diet while a resident. Record review of Resident #13's care plan completed 08/20/25 revealed the following: Nutrition: . physician/NP diet orders, functional assistance level with eating, swallowing precautions as needed will be maintained until further nutritional evaluation is completed. Resident #13 was noted to have impaired functional abilities r/t severe dementia. One of the approaches to address this problem area was Eating: usual performance: dependent Staff assistance: X 1 Assistive device, if applicable: food separated into bowls. Resident #13 was noted to have a regular puree diet order. The goal for this problem area was I will be offered an appetizing meal . help me avoid choking on food that I cannot eat over the next 90 days. This goal was edited on 08/11/25. One of the approaches regarding this goal was My texture is puree. Record review of Resident #13's active orders as of 08/27/25 revealed the following order: Order start date of 06/05/25 Diet: regular diet Texture: PUREE . Special Instructions: Serve food in bowls During an observation on 08/25/25 at 8:07 AM Resident #13 was seated in the dining room being fed by a CNA from bowls on the table in front of her. During an observation and interview on 08/26/25 at 07:26 AM DA B was taking temps of breakfast foods on the steam table. The breakfast was scrambled eggs, oatmeal, sausage patties, and toast. There were two bowls in a steam pan. One bowl contained a brown, dry, crumbly substance and the other contained a yellow substance that appeared to be the texture of cottage cheese. DA B stated the bowls were the puree diet and she had not added the gravy to the bowls yet. During an observation on 08/26/25 at 07:28 AM DA B asked DA A what liquid to add to the puree. DA A told DA B to add apple juice to the pureed sausage and eggs. During an observation on 08/26/25 at 07:32 AM DA B opened a small plastic, single serve container of apple juice and poured half of it into the bowl of ground eggs and half (approximately 1/4 cup) of it into the bowl of ground sausage. She then heated each bowl in the microwave. During an observation on 08/26/25 at 07:37 AM this surveyor tasted the pureed eggs and found them to be sweet from the addition of the applesauce. The flavor was not appetizing, and the texture was watery with small lumps of egg. This surveyor then tasted the pureed sausage patty. The sausage tasted better than the eggs but was still on the sweet side. The sausage texture was watery with grainy lumps and larger lumps. There was no pureed bread. During an observation on 08/26/25 at 07:49 AM The bowls of pureed food for Resident #13 were placed by DA A on the wrong tray and delivered to the wrong resident. During an observation on 08/26/25 at 07:53 AM DA B began to remake the puree. She placed a serving of eggs in the blender with approximately 1/4 cup of apple juice. DA B (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ran the blender for about 30 seconds and poured the egg mixture into a bowl. During an observation on 08/26/25 at 07:56 AM DA B rinsed the blender and added a sausage patty and approximately 1/4 cup of apple juice. She ran the blender for about 30 seconds and poured the sausage mixture into a bowl. During an observation on 08/26/25 at 07:58 AM DA B scooped oatmeal from the pan on the stove, added it to a bowl and placed the bowl of oatmeal, pureed eggs, and pureed sausage on a tray to be delivered to Resident #13. During an interview on 08/26/25 at 11:33 AM RD stated pureed food needed to be the consistency of thick pudding or mashed potatoes. She stated correctly pureed food should not fall through and fork and should fall off a spoon in one lump. She stated grainy or watery texture was not correct. RD stated regular oatmeal was not suitable for a pureed diet as it had lumps. She stated the liquid used to puree eggs should be milk or gravy. She stated the liquid used to puree sausage should be broth or gravy. RD stated apple juice was not an appropriate liquid to puree eggs or sausage. She stated water was never an appropriate liquid. During an interview on 08/26/25 at 03:22 AM RD stated if a pureed diet was not the correct texture it could be a choking hazard. During an interview on 08/27/25 at 07:26 AM CNA D stated she fed Resident #13 her breakfast yesterday and Resident #13 ate one hundred percent of her breakfast. CNA D stated Resident #13 did not seem to have any trouble swallowing her breakfast. During an observation on 08/27/25 at 07:42 AM Resident #13 was seated at a table in the DR. CNA D was stirring a sugar packet into the bowls of what appeared to be eggs and sausage in front of Resident #13. The pureed eggs appear to be watery and grainy. The pureed sausage appears to be watery and grainy. The liquid seems to have separated from the eggs and from the sausage. Resident #13 had a bowl of regular oatmeal as well and it appears to be lumpy. Resident #13 did not have pureed bread, though the other residents observed eating in the dining room did have toast with their eggs, sausage, and oatmeal. During an interview on 08/27/25 at 08:54 AM CC stated if a resident with a dietary order of pureed received food that was watery, grainy, or lumpy it could lead to aspiration. During an interview on 08/27/25 at 10:27 AM DA A stated she had worked for the facility as a DA for 3 years. She stated her dining manager was out on medical leave. DA A stated ADM had been in charge of the kitchen operation during his absence. She stated the facility had only 2 residents with pureed diets and one of them was currently in the hospital. She stated she was trained by her first boss on making pureed meals. She stated she was trained to use milk or water as the liquid added to pureed food. DA A stated she was trained more recently to use apple juice or water as the liquid added to pureed food. She stated if a pureed food was not the correct consistency a resident could choke. DA A stated pureed food was supposed to be the consistency of pudding. She stated she trained DA B to use water and apple juice when making pureed food. During an interview on 08/27/25 at 10:37 AM DA B stated she has been working for the facility for 3 weeks. She stated she was not trained to make pureed meals by this facility. DA B stated at her previous job she was trained to use water and a breakfast gravy as the liquid to puree breakfast food and a brown gravy as the liquid to puree lunch or dinner items. She stated pureed food was supposed to be smooth, no chunks. DA B stated pureed food that was not the correct consistency was a choking hazard and might lead to aspiration. During an interview on 08/27/25 at 10:46 AM CCM stated if a resident with a dietary order of pureed received food that was watery, grainy, or lumpy they could choke or get pneumonia, or it could cause an obstruction and/or death. During an interview on 08/27/25 at 11:06 AM LVN F stated a resident with a pureed diet order who received watery, grainy food would not have any issues unless they were ordered to have thickened liquids. She stated if a resident with a pureed diet order was given food with lumps it could cause choking or aspiration. During an interview on 08/27/25 at 11:14 AM ADM stated a resident with a pureed diet order who received food that was not the correct consistency could aspirate. She stated pureed food should be good and smooth like a baby food like texture. ADM stated she did not know why dietary staff did not make pureed bread for Resident #13 as they have bags of puree bread mix and puree pancake mix in the pantry. During an interview on 08/27/25 at 01:04 PM DON stated if a resident with a pureed diet order received watery, grainy, or lumpy food they could choke or (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Avir at Borger		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 S Florida Borger, TX 79007	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aspirate. Record review of an in-service training titled F812 Kitchen Sanitation, Cook/Aide Responsibilities, Cleaning Schedules, RD Inspection, Food Storage, Infection Control, Dish Room provided to DA A and DA C by ADM and HR on 07/16/25 revealed the following: . Meal Service . Follow the recipe. Using incorrect ingredient measurements or changing/omitting ingredients can affect the overall quality or nutritive value of the food . Record review of an in-service provided to DA A and DA B by ADM on 08/27/25 revealed the following: . Employees will have knowledge and understanding on how to blend and prepare items for pureed ordered diets to include portions, consistency, acceptable liquids, and required temperatures. Pureed diet-is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be a smooth and moist consistency (mashed potato, pudding) and able to hold its shape. Pureed recipes are found in the recipe book. The recipe includes the type of liquid and additional ingredients to be used. It is important to pay attention to the type and amount of liquid. This helps ensure the puree food is the correct consistency and provides the appropriate nutrition. Examples of liquids: Milk, broth, gravy, apple juice. Water is typically not used because it will dilute flavors and nutrients in the food. Scrambled eggs do need to be pureed. Puree items on low until a paste consistency and then add the recipe'd [sic] fluid gradually until a smooth pudding consistency is achieved. If a pureed item is too thick, thickeners can be used . Pureed foods need to be served on a dinner plate for dignity and on in bowls or divided plate. Pureed foods should not be running together on the plate. If this is the case, then it is not the correct consistency. Taste the pureed food. Is it smooth? Does it taste like the regular food item? Record review of facility recipe for pureed pork breakfast sausage patty dated 08/26/25 revealed the following: . Ingredients 1 Sausage Pork Bkft (breakfast) Patty . 1 Tbsp Milk or appropriate liquid . Pureed foods should be soft and smooth without any lumps or visible particles. Liquids should not separate from the solids. Recipe liquid and thickener amounts, if needed, are an estimate only. NOTE: Cooking liquid, broth, gravy or other suitable liquid may be substituted for liquid in recipe with pureeing this food for PU4. Pureed Usually eaten with a spoon (a fork is possible) * Cannot be drunk from a cup because it does not flow easily * Cannot be sucked through a straw * Does not require chewing * Can be piped, layered or molded because it retains its shape . Shows some very slow movement under gravity but cannot be poured * Falls off spoon in a single spoonful when tilted and continues to hold its shape on a plate * No lumps * . Liquid must not separate from solid . Record review of facility recipe titled PU4 Milk or Appropriate Liquid (Milk or Other Appropriate Liquid) and dated 08/26/25 revealed the following: . Entrees - Broth or other appropriate sauce/gravy from menu . Record review of facility recipe for pureed scrambled eggs dated 08/26/25 revealed the following: . Ingredients 1 Tbsp Milk or Appropriate Liquid 1/4 Cup Egg Scrambled . NOTE: Cooking liquid, broth, gravy or other suitable liquid may be substituted for liquid in recipe with pureeing this food for PU4. NOTE: As this food item contains a high percentage of fluid, additional fluid may not be needed. Drain well before pureeing, and once the items in pureed, add additional liquid only if necessary. Thickener may also be needed to achieve the proper consistency for PU4. Record review of facility recipe for pureed oatmeal dated 08/26/25 revealed the following: . Ingredients 1/2 cup Cereal Oatmeal f/Quick Oats 1 Tbsp Milk or Appropriate Liquid . Drain any excess liquid from food. Place prepared recipe portion into a blender or food processor. Blend until smooth. Additional liquid and/or thickener may be needed to ensure puree is smooth, moist and appropriate for PU4. Record review of facility policy titled Puree Food Preparation and dated 08/01/25 revealed the following: . It is the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance. ?Puree' means that all food has been ground, pressed and/or strained to a consistency of a soft, smooth, thick paste similar to a thick pudding. 1. The facility should provide each resident food that is prepared by methods that conserve nutritive value, flavor, and appearance. 2. Puree foods should be prepared to prevent lumps or chunks. The goal is a smooth, soft, homogenous consistency similar to soft mashed potatoes. 3. If the food item requires chewing, it should be excluded from the puree diet and prepared in a way that preserved (continued on next page)		

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

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

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NAME OF PROVIDER OR SUPPLIER Avir at Borger		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 S Florida Borger, TX 79007	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vitamins and a minimum loss of nutrients. 5. Follow the recipe to prepare puree foods. 7. Examples of items to use to puree foods: . Meats: broth or gravy .		

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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 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 observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #5) of 3 residents observed for infection control practices. The DON did not wear a gown when performing wound care for Resident #5. This failure could place residents at risk of cross-contamination and infections. Findings include: Record review of Resident #5's clinical record revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include stage 4 pressure ulcer of the sacral region (a sever, full-thickness skin and tissue injury that extends into the muscle, tendo, and ligament, or bone at the base of the spine, below the lumbar vertebrae and above the coccyx (tailbone) and dysphagia (difficulty or discomfort in swallowing). Record review of Resident #5's clinical record revealed his last MDS was a quarterly completed 7/25/25 listing him with a BIMS of 15 indicating he was cognitively intact, he had a functionality of requiring supervision for most of his activities of daily living, and he had an unhealed stage 4 pressure ulcer. Record review of Resident #5's care plan with admission date of 11/06/24 revealed the following: Problem Start Date: 06/05/2025 Category: General require enhanced barrier precautions due to the following: I am at increased risk of a MDRO acquisition due to having a wound. Approach Start Date: 06/05/2025 PPE will be available (including gowns/gloves/face shield or goggles) will be available right outside my room, in the shower room. Problem Start Date: 06/05/2025 Category: General require enhanced barrier precautions due to the following: pressure ulcer and colostomy. Approach Start Date: 06/05/2025 Staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type requiring a dressing, device care or use. Problem Start Date: 05/29/2025 I have a colostomy R/T chronic wound infection to buttocks. Record Review of Resident #5's Orders printed 8/26/25 revealed the following order: -Enhanced Barrier Precautions - I have a pressure ulcer and colostomy. Start Date: 6/05/25. During an observation on 08/26/2025 at 09:42 AM the DON performed Resident #5's wound care to his Stage 4 Pressure Ulcer on his coccyx. The DON did not put on a gown at any time during the care. During an interview on 08/26/2025 at 9:56 AM the DON verified she did not put on a gown during the wound care for Resident #5's pressure ulcer on his coccyx. The DON reported this did violate EBP precautions because he had a wound and he had a colostomy. The DON reported not following EBP would result in violating infection control. During an interview on 08/26/2025 at 1:20 PM RN E reported any resident on EBP was on that process to maintain infection control. Anyone with a catheter, wound, or something similar to that should be on EBP which means they should have a station placed outside their room with gowns, gloves, and googles if needed. RN E reported EBP was done to prevent the spread of infection. During an interview on 08/27/2025 at 8:52 AM the CN reported EBP should be utilized with any resident that has a catheter, wound, ostomy, PICC line, of something like that. The CN reported she expects staff to wear the appropriate PPE with any of these procedures. The CN reported if staff do not follow EBP then they violate infection control and can spread infections. Record review of the facility provided policy titled, Enhanced Barrier Precautions date implemented 6/25, revealed the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of multidrug-resistant organisms. 3. Implementation of Enhance Barrier Precautions: b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. 4. High-contact care activities include: h. Wound care: any skin opening requiring a dressing.		