

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Avir at Jacksonville		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Bonita St Jacksonville, TX 75766	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions in 1 of 1 facility kitchen in that: There were open to air items stored in a facility freezer. There were open to air items and unlabeled items stored in a facility refrigerator. These failures could place residents at risk for food borne illness. Findings included: During an observation on 6/22/26 at 9:46 a.m. a facility refrigerator revealed an open bag of shredded cheese stored with no date or labeling, the item was stored open to air. During an observation on 6/22/26 at 9:48 a.m. a facility freezer revealed an open bag of frozen pork patties, the item was stored open to air with date received labeling During an observation on 6/22/26 at 9:55 a.m. a facility freezer revealed an open box containing an open bag of frozen cookies, an open box containing an open bag of frozen mangoes, an open bag of pepperoni, and an open and expired bag of cinnamon rolls. The items were stored open to air with date received labeling. The cinnamon rolls included a use-by date of 12/13/25 which was expired. During an interview on 06/23/26 at 4:00 p.m., [NAME] B said she was unsure if there was a specific person assigned to check for and remove mislabeled or expired food from the refrigerators and freezers. [NAME] B said she typically checked for such items and removed them once per shift, at the start of her shift. [NAME] B said she checked for food that was either expired or not properly labeled and removed items. During an interview on 6/23/26 at 4:03 p.m. [NAME] C said she normally checked the refrigerators and freezers for mislabeled or expired food daily, once per shift at the start of her shift, as well as spot checking while working. [NAME] C said it was all kitchen staff's responsibility to check for and remove mislabeled or expired items. [NAME] C said risks to residents from being served mislabeled or expired food could be salmonella or other food-borne illnesses. During an interview on 6/23/26 at 4:00 p.m., the DM said all kitchen staff were responsible for ensuring food in the refrigerator was properly labeled and dated and expired food was removed. The DM said she usually cooks breakfast and always checks the refrigerator and freezers in the morning for any mislabeled or expired food. The DM said all staff were responsible for receiving items from delivery truck and properly dating them with the date received and date opened labels. The DM said correct labeling included the date received and date opened. The DM said risks to residents from being served expired or mislabeled food items included food poisoning. During an interview on 6/23/26 at 10:32 a.m., the ADM said she was responsible for supervision of all staff in the facility and the DM was responsible for supervision of the kitchen staff. The ADM said it was her expectation that kitchen staff checked for and removed mislabeled or expired items in the refrigerators and freezers at least daily, preferably twice, once at the beginning of their shift and again at the end. The ADM said going forward she planned to implement periodic auditing by inspecting the kitchen facilities herself in addition to the DM checking for expired or mislabeled food items daily. Review of a facility policy titled Food Receiving and Storage indicated .All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and 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 of 6 residents (Resident #5) and 2 of 6 staff (CNA A and DON) reviewed for infection control. The facility failed to ensure the DON and CNA A followed EBP and proper hand hygiene when providing direct care to Resident #5 on 6/22/2026. This failure could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings include: Record review of Resident #5's facility face sheet, dated 6/23/2026, indicated Resident #5 was a [AGE] year-old female, readmitted [DATE], with diagnosis of sepsis (infection throughout the body). Record review of Resident #5's admission MDS assessment, dated 5/11/2026, revealed a BIMS of 09 that indicated Resident #5 had moderately impaired cognition. She required assistance with her ADL's, had an indwelling catheter and a pressure ulcer. Record review of Resident #5's comprehensive care plan, dated 5/12/2026, indicated Resident #5 had a pressure ulcer and an indwelling catheter and required EBP. Staff must use a gown and gloves during high contact care activities and staff were to wash or sanitize their hands before entering and exiting the residents room. Record review of Resident #5's order summary report, dated 6/23/2026, indicated Resident #5 had an order for EBP effective 5/27/2026. During an observation on 6/22/2026 at 10:00 am Resident #5 had an EBP sign and PPE outside her room. During an observation on 6/22/2025 at 11:30 am Resident #5 was sitting in a wheelchair in the dining room and she had a catheter bag attached to her wheelchair. During an observation on 6/22/2026 at 11:53 am the DON and CNA A assisted Resident #5 to her room to adjust her position in her wheelchair. The DON and CNA A did not apply PPE and transferred Resident #5 that resulted in prolonged direct contact. Both the DON and CNA touched and repositioned Resident #5's catheter bag without any gloves in place. Resident #5 was transferred, the DON left the room without completing hand hygiene. CNA A remained in the room assisting Resident #5 with her clothing and hair. During an observation on 6/22/2025 at 12:03 pm Resident #5 asked to be placed back into bed. The DON entered the room with gloves on and CNA A did not apply any PPE. Resident #5 was transferred by a mechanical lift into the bed and both the DON and CNA A adjusted her position, removed the sling pad and adjusted her linens. The DON removed her gloves and left the room without hand hygiene and CNA A sanitized her hands and left the room. During an interview on 6/22/2026 at 12:11 pm CNA A said she had been trained on EBP and a gown and gloves should be applied before any direct care. She said that the positioning and transferring of a resident would be considered direct care and she should have put on a gown and gloves before providing care to Resident #5. She said by not following EBP infections could spread. During an interview on 6/22/2026 at 12:22 pm the DON said that the infection prevention nurse was the ADON but she was also trained on infection prevention. She said that a resident that required EBP, the staff should apply a gown and gloves before providing direct care. She said positioning and transferring were direct care and she and the CNA should have applied a gown and gloves before giving Resident #5 any care. She said that after care hands should be washed or sanitized before leaving the room and she failed to do so. She said not following EBP and proper hand hygiene infections could spread. During an interview on 06/24/2026 at 9:30 AM the ADON said she was the infection preventionist, and she provided the training for the infection control program. She said all staff were trained in EBP and hand hygiene on hire and at least annually, but she did random checks quarterly to see that staff were following the guidelines. She said she expected the staff to follow the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP program and wear gowns and gloves when giving direct care and to always wash or sanitize their hands before leaving any room. She said that not following infection control measures could spread infections. During an interview on 06/24/2026 at 10:01 AM the Administrator said that the ADON and DON were responsible for the infection control program. She said all staff were trained in infection control including EBP and hand hygiene on hire and annually with the competency evaluations. She said she expected all infection control measures were followed daily to prevent the spread of infections in the facility. Record review of a facility policy titled Enhanced Barrier Precautions, dated February 2025, indicated, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. 1. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 2. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing) . Record review of a facility policy titled Handwashing/Hand Hygiene, dated October 2023, indicated, .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. 1. Hand hygiene is indicated: immediately before touching a resident; before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching the resident's environment; before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal. 5. The use of gloves does not replace hand washing/hand hygiene .		