STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675035	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Burkburnett	406 E Seventh St Burkburnett, TX 76354

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 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 interviews and record review, the facility failed to develop a comprehensive person-centered care plan 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 of 6 residents (Resident #1) reviewed for care plans.The facility failed to ensure Resident #1's comprehensive care plan described the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being.The facility failed to ensure Resident #1's comprehensive care plan described any specialized services or specialized rehabilitative services the nursing facility will provide because of PASARR recommendations.The facility failed to ensure Resident #1's comprehensive care plan described the resident's goal for admission and desired outcomes.The facility failed to ensure Resident #1's comprehensive care plan described the resident's preference for future discharge.This failure could place the residents at risk of inadequate care and services.Findings included: Record review of Resident #1's face sheet revealed a [AGE] year-old male, admission date 11/26/2025, Diagnoses: Spastic Quadriplegic Cerebral Palsy (significant muscle stiffness and poor motor control in all four limbs due to damage to the brain), Spina Bifida (spine doesn't close completely affecting spine and nerves), Recurrent Depressive Disorders (multiple episodes of depression over time by persistent sadness, loss of interest), Protein-Calorie Malnutrition (insufficient intake of protein calories leading to poor growth). Record review of Resident #1's electronic health record revealed no evidence of a comprehensive care plan. Record review of Resident #1's comprehensive MDS dated [DATE], reflected Resident #1's PASARR conditions found were positive. BIMS of 11 (moderate cognitive impairment). In an interview on 01/04/26 at 2:12 p.m. with CNA A, she stated she was familiar with Resident #1's care because he can tell staff what he wants and needs and how he prefers things to be done. CNA A also stated that staff communicate across shifts through verbal reports to make sure the resident gets what he needs to be kept safe. CNA A was knowledgeable about Resident #1's care. In an interview on 01/04/26 at 5:59 p.m. with Resident #1, he revealed he was safe, and he had not gotten hurt while at the nursing facility. He stated that staff care for him the way he tells them to, and he did not have any issues with anything. Resident #1 stated he received his PASARR services and staff were following his plan of care. In an interview on 01/05/26 at 11:57 a.m. with the ADM, she stated that she did not locate a comprehensive care plan for Resident #1. In an interview on 01/05/26 at 12:18 p.m. with the DON, she stated the Baseline Care Plan dated 11/26/25 was the care plan for Resident #1 and no comprehensive care plan had been completed. In an interview on 01/05/26 at 12:30 p.m. with MDS, she stated that she was responsible for completing the care plans after the MDS assessment was completed. She stated that a new company took over the facility, and they have switched healthcare software. MDS stated she had to put in each individual resident's care plan into the software program, and she had not gotten to Resident #1's Care Plan (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675035	A. Building B. Wing	01/05/2026

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Avir at Burkburnett	406 E Seventh St Burkburnett, TX 76354

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yet. MDS stated staff are aware of Resident #1's needs and know how to care for him. MDS stated Resident #1 was receiving his services despite the care plan not being completed yet. She stated that the facility lost staff, and she was also helping with patient care as a floor nurse. MDS did not state negative effects to residents. In an interview on 01/05/26 at 1:13 p.m. with the ADM, she stated that it was the responsibility of the MDS nurse to complete the assessment and then do the care plan. The ADM stated with the new company transition, the MDS got bogged down. The ADM stated that Resident #1 was receiving his services. The LIDDA was taking him out weekly and they were working on finding him a group home in his preferred location, which is something discussed during his IDT meeting. The ADM stated that the care plan not being completed could negatively affect a resident by them not getting something they need but in Resident #1's case, that was not happening. In an interview on 01/05/26 at 2:15 p.m. with the ADON, she stated that it was the responsibility of MDS to complete the care plan after she does the assessment, and she does not think it is anyone but her is responsible, even if she gets busy. The ADON stated that staff communicate through verbal reports to provide care. The ADON stated if a care plan did not get completed, it could cause injury or an error if interventions were not used. Record Review of the Comprehensive Care Planning policy dated March 2022 reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. The policy further reflects, 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 of 6 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's comprehensive care plan was developed within 7 days after the MDS assessment was completed. This failure could result in the residents not receiving proper care and services.Record review of Resident #1's face sheet revealed a [AGE] year-old male, admission date 11/26/2025, Diagnoses: Spastic Quadriplegic Cerebral Palsy (significant muscle stiffness and poor motor control in all four limbs due to damage to the brain), Spina Bifida (spine doesn't close completely affecting spine and nerves), Recurrent Depressive Disorders (multiple episodes of depression over time by persistent sadness, loss of interest), Protein-Calorie Malnutrition (insufficient intake of protein calories leading to poor growth). Record review of Resident #1's comprehensive MDS dated [DATE] reflected this was a nursing home comprehensive assessment with PASARR positive and a BIMS of 11 (moderately cognitively impaired). In an interview on 01/05/26 at 12:30 p.m. with MDS, she stated that she was responsible for completing the care plans after the MDS assessment was completed. MDS stated she was aware the Comprehensive Care Plan was to be completed within 7 days of the MDS assessment being completed. She stated that a new company took over the facility, and they have switched healthcare software. MDS stated she had to put in each individual resident's care plan into the software program, and she had not gotten to Resident #1's Care Plan yet. MDS stated Resident #1 was receiving his services despite the care plan not being completed yet. MDS did not state negative effects to residents. In an interview on 01/05/26 at 1:13 p.m. with the ADM, she stated that it was the responsibility of the MDS nurse to complete the MDS assessment and then do the comprehensive care plan. The ADM stated she was aware the care plan was to be completed within 7 days of the assessment, and this did not usually happen but with the new company transition, the MDS got bogged down. The ADM stated that Resident #1 was receiving his services. The ADM stated that the care plan not being completed could negatively affect a resident by them not getting something they need but in Resident #1's case, that was not happening. In an interview on 01/05/26 at 2:15 p.m. with ADON, she stated that it was the responsibility of MDS to complete the care plan after she does the assessment, and she does not think it is anyone but her even if she gets busy. ADON stated that staff communicate through verbal reports to provide care. The ADON stated if a care plan did not get completed, it could cause injury or an error if interventions were not used. Record review of the Comprehensive Care Planning policy dated March 2022 reflected, 2. The comprehensive, person-centered care plan is to be developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.