STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675055	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Childress	1200 7th St NW Childress, TX 79201

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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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(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	**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 #1) of 5 residents observed for infection control practices. CNA B performed Resident #1's catheter care without placing a gown for EBP. This deficient practice could place residents at risk of cross-contamination and infections. Findings include: Record review of Resident #1's clinical record revealed an [AGE] year-old male resident admitted to the facility originally on 3/03/2022 and readmitted on [DATE] with diagnoses to include urinary tract infection with onset date of 9/17/2025, benign prostatic hyperplasia with lower urinary tract symptoms (non-cancerous enlargement of the prostate gland that causes urinary issues). Record review of Resident #1's clinical record revealed his last full MDS was a quarterly completed 9/01/25 listing him with a BIMS of 9 indicating he was moderately cognitively impaired, he had a functionality of requiring set-up/clean-up for most of his activities of daily living, and he did not require a catheter at that time. Record review of Resident #1's care plan with admission date of 9/17/25 revealed the following: Resident has a bladder disorder requiring foley catheter (a flexible tube inserted into the blader through the urethra to drain urine) and is at risk for UTI. During an observation on 11/25/2025 at 10:11 AM CNA B performed catheter care for Resident #1. CNA B was noted observing the sign posted on Resident #1's door for EBP while placing gloves before entering the resident's room. This surveyor noted a PPE station placed on top of the unoccupied roommate's dresser. CNA B proceeded to perform catheter care to include cleaning the urinary tube, the resident peri and rectal area, and placing a new brief before replacing Resident #1's shorts and covers and ensuring he was comfortable. She then performed her final hand hygiene, gathered the used supplies, and exited Resident #1's room. CNA B never placed a PPE gown to maintain EBP and prevent contamination. During an interview on 11/25/2025 at 10:25 AM CNA B reported that Resident #1 should be on EBP because he has a catheter and stated, That was my mistake. I am used to them having a PPE station outside their room and I just missed the sign on his door. CNA B reported she did not see the PPE station inside Resident #1's room. CNA B stated, I know better. CNA B reported that she had been trained on EBP by the ADON who was no longer the infection control officer and that she (CNA B) was not sure who the current infection control officer was because they have had several management changes recently. CNA B reported that if EBP was not followed then they could get urine on themselves and could spread infection. During an interview on 11/25/2025 at 10:58 AM the DON reported that the facility has a new ADON that was currently completing the infection control training, that the previous ADON was no longer available to do the training. The DON reported that she expects her staff to place the proper PPE like a mask and gown when EBP was needed such as with catheter care. The DON reported that if the proper PPE was not used with EBP, then cross contamination would occur, and staff could carry infection from one resident to another. During an interview on 11/25/2025 at 11:27 AM ADON A reported that she would be the infection control nurse and would train staff when she completes her training. ADON A reported that she would expect staff to wear gloves and gowns when performing care such as catheter care. ADON A reported if a staff member did not follow EBP, then they could carry an infection from one resident to another resulting in cross-contamination. Record review of the facility provided Enhance Barrier Precautions (EBP) educational posting placed in each resident's room that required Enhance Barrier Precautions (EBP) revealed the following information provided for visitors and staff: Enhanced Barrier Precautions.Providers and staff must also:Wear gloves and gowns for the following High Contact Resident Care Activities--Device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Record review of the facility provided policy titled, Enhanced Barrier Precautions date 2001, revealed the following: Policy Statement:Enhanced barrier precautions (EBP) are utilized to reduce the transmission of multi-drug-resistant organisms (MDRO's) to residents. Policy Interpretation and Implementation:3. Examples of high-contact resident care activities requiring the use of gown, and gloves for EBP's include:g. device care or use, (central ling, urinary catheter.