STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Avir at Childress		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to receive written or verbal notice of a room change before the change was made for 1 of 6 residents (Resident #2) reviewed for resident rights. The facility failed to ensure Resident #2's Responsible Party (RP) received verbal or written notice prior to a room change. This failure could place residents at risk for being displaced without notice and/or reason in order to accommodate other individuals.Findings included: Record review of Resident #2's admission record, dated 01/28/26 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the following diagnoses: hemiplegia and hemiparesis following a cerebrovascular disease (paralysis), peripheral vascular disease (poor circulation) and major depressive disorder (mood disorder). Record review of Resident #2's annual MDS dated [DATE] reflected Resident #2 had a BIMS score of 04 indicating severe cognitive impairment. Record review of Resident #2's progress note, dated 12/11/25 written by LVN A stated, .resident moved to [a room] for contact isolation precautions. Resident aware. Awaiting new orders from physician. During a phone interview on 01/28/26 at 2:32 PM, LVN A stated she was the nurse who moved Resident #2 to an isolation room back in December 2025. LVN A stated she did not remember contacting the family regarding the room change. LVN A stated the DON had stated she would contact the family, but she did not. LVN A stated it was ultimately her responsibility to contact the family regarding the room change. LVN A stated a potential negative outcome to the residents with moving rooms and not notifying family was the resident was at a higher risk for falls. During a phone interview on 01/28/26 at 3:45 PM, Resident #2's RP stated she did not receive a call from the facility notifying her of a room change back in December 2025. The RP stated she was not aware of a room change for Resident #2 until the family went to visit Resident #2 and she was in a different room. During an interview on 01/28/26 at 4:42 PM, the DON stated she expected family or a resident who was cognitively intact to be notified of a room change right away if it was an unexpected room change. The DON stated the nurses were trained to notify the residents RP for room changes and stated the nurse who changed the resident's room should have contacted the family. The DON stated she did not know why the family was not notified regarding Resident #2's room change. The DON stated the family would think there were risks to the residents' changing rooms but did not give an exact answer. During an interview on 01/28/26 at 4:53 PM, the Interim ADM stated the nurses were trained to contact the residents' RP when changing rooms. The Interim ADM stated he did not know why Resident #2's family was not contacted prior to her moving rooms back in December 2025. The Interim ADM stated a potential negative outcome to the residents was that the residents gets used to another room and may get confused or the family may go to the facility and not be able to find their loved one. Record review of the facility's policy titled, Change in Resident's Condition or Status, with a revised date of April 2025, reflected the following: Policy Statement: Our facility promptly notifies the resident, his (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
	675055	A. Building B. Wing	01/28/2026

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (.resident rights.)Policy Interpretation and Implementation:.4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:.c. there is a need to change the resident's room assignment.

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	01/28/2026

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 an assessment accurately reflected a resident's status for 1 of 6 residents (Resident #1) reviewed for accuracy of MDS assessments. -The facility failed to accurately assess Resident #1 for oral/dental status on his annual MDS assessment. This failure could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Findings include: Record review of Resident #1's admission record, dated 01/28/26, revealed a [AGE] year-old male resident who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Guillain-Barre syndrome (a rare, serious, but usually temporary condition where your immune system mistakenly attacks your own nerves, often after a viral or bacterial infection), lack of coordination and need for assistance with personal care. Record review of Resident #1's annual MDS assessment dated [DATE] revealed she had a BIMS of 12 indicating he was cognitively intact. Section L Oral/Dental Status revealed none of the above were present was checked off. Record review of Resident #1's comprehensive care plan, undated, revealed there was not a focus area for dental care. During an observation and interview on 01/28/26 at 2:45 PM Resident #1 was talking with the surveyor and the surveyor noted brown/discolored teeth. Resident #1 stated it had been a while since he had seen the dentist, and he probably needs to be put back on a list to see the dentist due to some pain in his mouth. During a phone interview on 01/28/26 at 4:10 PM, the MDS Nurse stated she had completed the annual MDS for Resident #1. The MDS Nurse stated Resident #1 had told her he did not have any pain in his mouth and did not need anything, but he would not let the MDS Nurse look in his mouth. The MDS Nurse stated she must have been in a hurry, but she should have checked off the box that stated, Unable to examine. The MDS nurse stated checking off unable to examine in Section L would have triggered a care plan decision to be made by other staff to do a care plan in Section V. The MDS nurse stated a potential negative outcome to the resident was he could have an infection [in his mouth]. During an interview on 01/28/26 at 4:53 PM, the Interim ADM stated he did not think the MDS nurse marked the MDS incorrectly for Resident #1's dental status. The Interim ADM stated he understands that she was not able to see any issues with Resident #1's dental status so she marked no issues. The Interim ADM stated he would look into it as he could see both sides and was not sure exactly how the MDS should have been marked. The Interim ADM stated a potential negative outcome was a care are not being added to a care plan. During an interview on 01/28/26 at 5:38 PM, the Interim ADM stated after discussion, he does think the MDS nurse marked the dental status for Resident #1 incorrectly. The Interim ADM stated the facility did not have a policy regarding the MDS assessment and stated the facility follows the RAI guidelines from CMS. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025 revealed the following: Section L: Oral/Dental StatusL0200:Dental:Item Rationale - Health-related Quality of Life-Poor oral health has a negative impact on:Quality of life, overall health, and nutritional status.-assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.Steps for Assessment -.6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues.Coding Instructions:.-Check.unable to examine: if the resident's mouth cannot be examined.