

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: 675096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2025
NAME OF PROVIDER OR SUPPLIER Avir at Hillsboro		STREET ADDRESS, CITY, STATE, ZIP CODE 411 Old Brandon Rd Hillsboro, TX 76645	
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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, interviews, and record reviews , the facility failed to ensure no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span for 61 of 61 residents reviewed for meal frequency . The facility failed to ensure the timing/hours between the supper and breakfast meal was no more than 14 hours. The current schedule was for 14.25 hours between dinner and breakfast the following day. This failure could place all 61 residents who received meals served from the facility's only kitchen at risk of decreased intake and meal dissatisfaction. Findings included: Record review of the facility mealtimes undated and posted outside the facility kitchen revealed: Breakfast at 7:00 AM , Lunch at 11:45 AM, Dinner at 4:45 PM. In a confidential resident group meeting on an undisclosed date and time, it was revealed that residents did not help choose the mealtimes and that the ADM had given (on 12/04/2025) the RCP a piece of paper with new mealtimes to vote on. The residents stated they desired for dinner to be later than the posted time, but they were satisfied with the posted breakfast and lunch times. In an interview on 12/03/2025 at 4:00 a.m., the ADM stated she would get with the RCP to have the council vote on new dinner and breakfast times. She stated the mealtimes were set before she started a few months ago, and she would begin the change by the time the annual survey concluded. She stated there was only a list of residents who received snacks at bedtime, but not every resident who resided in the building. In an interview on 12/04/2025 at 11:02 a.m., the DM stated she was aware there should not be a lapse of more than 14 hours between dinner and breakfast. She stated she had a list of residents who received snacks at bedtime, but it was only the residents on the list, not all residents. She stated she would need to get with the ADM to change the mealtimes. In an interview on 12/05/2025 at 8:51 AM with the RD, she stated the last time she looked at the mealtimes, the facility was at the 14-hour requirement, and that snacks should be offered to residents who had an order for them. Review of the facility's Open Style Dining policy, dated 2023, revealed, Note: Federal nursing home tag F809 requires no more than 14 hours to elapse between a substantial evening meal and breakfast the following day. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a patient/resident group agrees to this span, and a nourishing snack is served.		

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 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 sanitation. The facility failed to keep a clean veggie/dessert/drink freezer. This failure could place residents at risk of foodborne illness due to unhygienic food storage. Findings included: In an observation of the kitchen on 12/03/2025 at 9:58 a.m., revealed a freezer labeled veggie, dessert, and drinks that contained a yellow sticky residue spilt on the bottom shelf underneath an ice cream tub and surrounding frozen packets of pancakes. In an interview on 12/03/2025 at 10:02 AM, the DM stated she had worked at the facility for two weeks. She stated that they were about to clean up the spill in the dessert freezer and that it must have happened overnight because the spill was not there yesterday. She stated her main goal when she started two weeks ago was to get the kitchen cleaned up. In an interview on 12/05/2025 at 11:00 a.m., the DM stated they used frozen ham to slice and make ham and cheese sandwiches. She stated that if residents did not like the posted menu items, they could choose an item off the alternate menu. She stated that some residents had an order for PB&J with lunch and dinner or as snacks. She confirmed that Resident #39 wanted to receive meat with every meal due to her desire to gain weight, but Resident #39 also made requests for different menu items and was served them upon request, to the DM's knowledge. She stated she was unsure why the resident would receive PB&J sandwiches, unless it was when the DM was not working. In an interview on 12/05/2025 at 12:50 p.m., CNA C stated the nursing staff were responsible for getting alternate food items for residents from the kitchen, but only picking up the items, not preparing them or ensuring it was what the resident wanted. She stated PB&J and ham and cheese sandwiches were go-tos for the kitchen to pass out as alternates. She stated she knew Resident #39 needed double portions for all meals, but the resident did not always get that. In an observation on 12/05/2025 at 11:35 a.m. of the kitchen, revealed a frozen ham in the freezer, canned soup in the pantry, and no alternate menu items (burgers or baked potatoes) prepared on the steam table. In an interview on 12/05/2025 at 4:12p.m., the ADM stated that when she started a few months ago, they started ordering bacon and salads, because residents had not been getting those items on a regular basis. The DON stated she had to explain to staff that a few residents needed menus available to them in their rooms so they could submit substitutions prior to the meal being served. The ADM stated that the DM planned to start having the always available menu items prepped in anticipation of residents requesting it.		

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. Based on observation, interview, and record review, the facility failed to establish procedures to ensure that enough water was available in the facility in the event of a loss of normal water supply for 1 of 1 facility. 1. The facility's emergency water supply consisted of 23 gallons (140, 16.9 fl oz water bottles and 1, 5-gallon jug) of water on hand for a census of 61 residents stored in the kitchen's pantry. 2. The facility failed to follow their water supply policy by not having enough water to service the facility's needs in case of a water outage. This failure could place residents at risk of not having water during an outage for bathing, cooking, and drinking. Findings included: In an observation of the kitchen on 12/04/2025 at 8:59 a.m. revealed, four packs of 35-16.9 fl oz water bottles, and 1-5-gallon jug of water. In an interview on 12/04/2025 at 9:05 a.m., the DM stated the water stored in the kitchen pantry was all the emergency supply water they had in the facility for use in case of a water outage. She stated that she could ask the ADM or maintenance if there was additional water stored elsewhere but she was not aware of them. She stated she was unsure how much water was needed per resident, but she did not think they currently had enough to supply all the residents in case of a water emergency. In an interview on 12/05/2025 at 4:12 p.m., the ADM stated the facility received water from [supplier] and that she would put orders in for the required water supply soon. She stated the water in the kitchen pantry was the only emergency supply in the building, and it was not enough to continue daily operations should a water emergency occur. She stated she previously had to get rid of emergency supply water due to it expiring and had not restocked the water yet. Review of a letter dated 01/01/2025, generated by the facility's food procurement servicer, revealed, Please be advised that, while (servicer) warehouses do stock various bottled waters, such inventory is based on regular ongoing customer demand unrelated to an unexpected event or disaster. We do not carry inventory to replace upon an emergency basis a complete loss of, or substantial reduction in, water ordinarily obtained by pipeline, or in truckload or other bulk quantities from municipal entities, utility companies, or other suppliers. We will make available water supply on hand on a pro-rata basis based on inventory not otherwise dedicated to a specific customer until regular water service is restored. For disaster planning purposes, we recommend that you establish disaster water service through a different company capable of fulfilling your particular quantity requirements during a disaster scenario. Review of an undated Emergency Preparedness Guidance policy revealed, We recommend maintaining on hand at least one gallon of bottled water per person per day x 3 days. This includes residents, staff, families of residents and families of staff who will be at the facility.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews, and record review, the facility failed to notify residents of how to file a grievance in an anonymous manner, for 6 confidential residents out of 6 residents interviewed for grievances. 1.The facility failed to notify Residents or their representatives either individually or through prominent postings throughout the facility on how to file a grievance or complaint in an anonymous manner. 2.The facility failed to ensure residents felt like they could complain about care without worrying someone would get back at them. These failures could affect resident's' ability to file a grievance without the fear of discrimination, reprisal, retribution, and their right to request a written decision regarding the resolution of their grievance.Findings Included: Observations on 12/03/2025 and 12/04/2025 throughout the annual survey revealed no blank grievance forms anywhere in the facility where residents or their representatives could obtain a grievance form and/or turn in grievance forms anonymously. No grievance official information was posted, and the only mention of filing complaints was on a posterboard at the beginning of a hall, adjacent from the nurses. In a confidential resident group interview at an undisclosed date and time with six residents revealed that the residents did not know how to file grievances anonymously due to having to obtain grievance forms from the activity director, who would then fill out the grievance form on their behalf. They stated there was not a place to obtain blank grievance forms by themselves or during weekends/holidays when department heads may not be available, and there was not a place to turn in any grievances. The residents stated that they did not know they had the right to file grievances/complaints anonymously. They also stated that in the past, they felt they could not file a grievance without the fear of retaliation due to word getting around about their grievance, they stated this was prior to the current administration. In an interview on 12/04/2025 at 4:09 PM with the AD, she stated that she handled resident grievances. She stated that during resident council she would write the grievance up for the resident. She stated she would also make room rounds in the morning and if a resident had a complaint, she would write the grievance for them. She stated that all department head staff had access to the blank grievance forms. She stated she was not aware of any blank grievance forms being available to residents or their family to make anonymous grievances. In an interview on 12/05/2025 at 4:25PM, the ADM and DON stated that it was an option to file an anonymous grievance, but the forms were not available unless they were requested from staff. The ADM stated that the AD could write up grievances during resident council meetings. The ADM stated that residents should have the right to privacy and confidentiality. The ADM stated that she could post a folder outside the SW office for residents' and their family groups to obtain and submit anonymous grievances. Review of an undated Resident Rights poster revealed, As a resident of a long-term care facility you have the right: to privacy and confidentiality. Review of the facility's policy titled; Grievances/Complaints, filing dated April 2017 revealed that: 2. Residents, family and resident representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal.5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure the residents were free from abuse, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms for 3 of 6 residents (Resident #22, #25 and #45) reviewed for abuse. The facility failed to ensure that Resident #22 and Resident #45 were free from abuse when Resident #73 physically struck the residents on 11/21/2025. The facility failed to ensure Resident #25 and Resident #73 were free from abuse when Resident #25 and Resident #73 were found in Resident #25's room without their clothes on attempting to engage in a sexual act on 12/4/2025. This failure placed the residents at risk of physical harm or injury. Findings included: Review of Resident #22's admission record dated 12/5/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Acute and Chronic Respiratory Failure with Hypoxia (condition which can occur suddenly in which the lungs fail to adequately exchange gases), acute conjunctivitis (pink eye), dementia without behavioral disturbance/vascular dementia (reduced blood flow to the brain causing cognitive decline and memory issues), and abnormal posture. The admission record reflected RP 1 to be the resident's responsible party, and medical and financial POA. Review of Resident #22's Quarterly MDS assessment dated [DATE] reflected that the resident rarely or never made herself understood or had the ability to understand others. Therefore, a BIMS was not conducted or scored. Review of Resident #25's admission record dated 12/4/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including unspecified Dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a mental disorder that affects memory, social abilities, and daily functioning), Alzheimer's Disease (a neurodegenerative condition that leads to the gradual decline of cognitive functions), and Delusional Disorders (serious mental illness characterized by persistent false beliefs that are not based in reality). The admission record reflected RP 2 to be the resident's responsible party. Review of Resident #25's comprehensive annual MDS assessment dated [DATE] reflected the resident's BIMS Summary Score to be 2, indicating severe cognitive impairment. Review of Resident #45's admission record dated 12/5/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Unspecified Dementia, Major Depressive Disorder, Single Episode, and Primary Insomnia (inability to sleep). The record shows the resident to be his own responsible party. Review of Resident #45's Quarterly MDS assessment dated [DATE] reflected the resident sometimes made himself understood and sometimes understood others. The resident's BIMS Summary Score reflected in the record was 0, indicating severe cognitive impairment. Review of Resident #73's admission record dated 12/4/2025 reflected a [AGE] year-old male admitted to the facility on [DATE], with an initial/original admission date of 11/14/2025, with diagnoses including Traumatic Subdural Hemorrhage with Loss of Consciousness, Major Depressive Disorder, Single Episode, Type 2 Diabetes, and Person Injured in Collision Between other Specified Motor Vehicles (Traffic), Subsequent Encounter. The record reflected that Resident #73 was his own responsible party. Review of Resident #73's Comprehensive assessment dated [DATE] reflected a BIMS Summary Score of 5, indicating severe cognitive impairment. The record indicated that Resident #73 experienced delusions and exhibited physical behavioral symptoms 1 to 3 days. The record revealed that the behavioral symptoms exhibited had no significant impact on the resident and did not put other residents at risk of physical injury. Review of Resident #73's Care Plan Report initiated on 11/17/2025 reflected Focus: I have episodes of adverse behavior(s): Verbally Aggressive: cursing, racial slurs, yelling/screaming; Physically Aggressive: hitting, pinching, kicking, throwing objects; Fabricates facts/unreliable historian/manipulates staff. Interventions/Tasks: (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer meds per order, monitor labs-report [abnormals] to MD, Maintain a calm environment. According to information reviewed, the resident's care plan appeared to have been followed. Review of the facility's investigation file and report dated 11/21/2025, for the incident involving Resident #22, Resident #45, and Resident #73, revealed the facility was unaware of any concerning behavior exhibited by Resident #73 prior to this incident. The incident reportedly occurred on 11/21/2025 at approximately 10:24 PM. The report stated that Resident #73 struck Resident #45 in the back several times. It was stated that neither resident suffered any injury. Resident #73 was placed on 1:1, psychological referrals were made for both residents, and no adverse outcomes were observed. The investigation file also indicated that the incident with Resident #45 happened after staff had already intervened in the incident that occurred between Resident #73 and Resident #22. It is stated that Resident #73 grabbed Resident #22 by the face and hair while trying to get her up and out of her wheelchair. Review of Resident #22's Progress Notes dated 11/24/2025 reflected the resident was seen for a Psychiatric Periodic Evaluation after an incident with another resident. The resident was observed to be in a calm state during the encounter. The practitioner noted that the resident was in a safe environment within the facility and had good medical support. The resident's monitoring would continue at her next appointment. Review of Resident #73's Progress Notes dated 11/24/2025 revealed the resident was seen for a Psychiatric Periodic Evaluation. Ongoing recommendations made and directive provided that 1:1 could be discontinued since the resident did not appear to be a danger to himself or others. The practitioner noted that the resident's status could change based on treatment outcomes/worsening medical condition, and psychosocial stressors. Review of Resident #45's Progress Notes dated 11/24/2025 revealed the resident was seen for Psychiatric Periodic Evaluation due to the physical encounter with Resident #73. Resident #45 described as pleasantly confused and unable to provide reliable feedback. The resident's mood was noted to be manageable with no behavioral concerns since the last encounter. Record review of the facility's in-service training reports revealed an in-service was provided to all staff regarding Resident-to-Resident Altercations, Resident Rights, Abuse and Neglect, Reporting and Investigating immediately following this incident. Review of the facility's policy on Resident-to-Resident Altercations revised in September 2022 details the appropriate actions, interventions and notifications that must be made if an incident of this type occurs. Review of Resident #22's Progress Notes dated 11/24/2025 reflected the resident was seen for a Psychiatric Periodic Evaluation after an incident with another resident. The resident was observed to be in a calm state during the encounter. The practitioner noted that the resident was in a safe environment within the facility and had good medical support. The resident's monitoring would continue at her next appointment. Review of the facility's investigation file and report regarding the incident that occurred on 12/4/2025 at 12:15 AM, involving Resident #25 and Resident #73 revealed Resident #73 was found on top of Resident #25 in her bed during the night shift. The residents were separated, and Resident #73 was put on 1:1 monitoring. Neither were sent out to the hospital or emergency room, neither required x-rays, and neither required follow-up medical appointments. The report stated that the physician, guardian and/or family were notified. In-service training was reportedly provided to staff on abuse and neglect and resident rights. Review of Witness Statement provided by CNA C on 12/4/2025, regarding the incident between Resident #25 and Resident #73 stated CNA C was walking a resident into his room to change him and Resident #73 was observed at this time at the end of the hall looking out the door. CNA C stated that she asked CNA D to help change the other resident. CNA C stated Resident #73 was in the same position at that time, looking out the door. CNA C stated when she and CNA D finished changing the other resident and exited that resident's room, she noticed a light on. CNA C said opened the door of Resident #25's room and found both Resident #25 and Resident #73 without their clothes on. Resident #73 was on top of Resident #25 rubbing back and forth. CNA C told Resident #73 to get off of Resident #45 but he became angry. CNA C instructed CNA D to get the nurse. LVN D came and was able to instruct Resident #73 off of Resident #25. Review of Witness Statement provided by CNA D on 12/4/2025, (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding the incident between Resident #25 and Resident #73, stated CNA D was asked to assist with another resident. At that time, she noticed Resident #73 looking out the back door. When they were finished, CNA C noticed a light on and she went to get it. CNA D stated this is when CNA C called to her and asked her to get the nurse. Review of Witness Statement provided by LVN D on 12/4/2025, regarding the incident between Resident #25 and Resident #73, stated a CNA reported observing Resident #73 in Resident #25's room laying on top of her with his pants down and her brief and pants off. The CNA reported that Resident #73 was very uncooperative and agitated when asked to leave the room. LNV D stated the residents were separated and assessed. Neither of the residents' vital signs were concerning, neither resident had any skin issues or signs or symptoms of emotional distress. LVN D stated that Resident #25 stated to her, I love him! The DON was made aware of the occurrence, the ADM was notified, the Primary Care Physician and RP's were notified. Resident #73's RP could not be reached so a message was left. Review of Progress Notes for Resident #25 dated 12/4/2025, reflected at 0236 AM an advanced skin check of Resident #25 was completed by DON that indicated 'Complete head to toe assessment completed, vaginal area examined by charge nurse and DON, slight redness noted to outer perineal area, no bruising, scratches, discoloration, or discharge noted. Resident denies any pain or discomfort in vaginal area. Review of Progress Notes for Resident #25 dated 12/4/2025 at 07:46 AM reflected the resident was assessed head to toe and no skin issues were noted. The resident denied pain and vital signs were within normal limits. Review of Resident #25's Care Plan Report on initiated on 12/4/2025, reflected Focus: I reside in the Secure/Memory Care unit and am at risk for injury from wandering in an unsafe environment related to Dementia diagnosis and impaired safety awareness. I am at risk for injury from others while residing in secure/memory unit due to altered cognition. Interventions/Tasks listed do not address monitoring or resident-to-resident altercations. Review of Safe Surveys conducted with residents on the secure unit on 12/4/2025, regarding abuse revealed no responses of concern and residents felt safe and treated with respect and dignity. Review of Staff abuse questionnaires completed on 12/4/2025, indicated staff were aware of reporting requirements regarding abuse. Observation of Resident #45 on 12/3/2025 at 11:18 AM in the secured unit of the facility revealed the resident to be quietly pacing around the perimeter of the unit continuously without interaction or regard for others. The resident was non-responsive when interaction attempted. The resident did not appear to be in distress or uncomfortable. The resident's physical appearance was not concerning for abuse or neglect. No injuries or obvious abnormalities noted. During this time, Resident #22 and #73 were all present in the common area of the secured unit in which they all reside. The residents sat fairly close to each other with no disturbances or behaviors observed. None of the residents observed on the unit displayed concerning behaviors or responses during observation period. Staff members were present and nearby monitoring the residents as well. Observation of Resident #73's room on 12/3/2025 at 11:18 AM revealed the resident was assigned the room closest to staff and the first room on the unobstructed hallway. The resident was the only occupant of the room. Observation of Resident #22 on 12/3/2025 at 11:31 AM revealed the resident sitting contently in the open sitting area of the secured unit with other residents around and nearby. Resident #22's daughter was visiting her and sitting with her. An attempt to interview the resident was unsuccessful due to her inability to understand or participate in the conversation. The resident appeared comfortable in the environment and in the presence of other staff. No bruising, injuries or signs of physical harm observed on the resident's face, cheeks, hands, or arms. No distress or signs of discomfort observed. Observation of Resident #73 on 12/3/2025 at 11:43 AM revealed the resident sitting in the open sitting area around or near other residents calmly and quietly. No distress or discontent observed. The resident responded to greetings but did not actively participate in conversation attempts. Resident #73 was observed interacting with staff and complying with staff's request to check his blood sugar. No concerns with the resident's appearance or disposition noted. Observation of Resident #25 on 12/3/2025 at 12:25 PM revealed the resident sitting in and then walking around the dining room of the secure unit with other residents around and (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nearby. Resident #25 was observed physically interacting with furniture and staff in that the resident was observed pushing a dining room chair around the dining room and then touching staff while trying to braid their hair. The resident was not aware of personal space or boundaries upon observation. The resident appeared content and pleasant with no distress noted. Observation of Resident #73 on 12/3/2025 at 12:25 PM revealed the resident walking the hallway. The resident attempted to push the unit door open, but the alarm sounded so he stopped and turned around. Observation of Resident #25 on 12/4/2025 at 10:26 AM revealed the resident in her bed resting. The resident appeared calm and content with no signs of harm, distress or injury observed. The resident was smiling and mumbled something that sounded as if she were asking to braid my hair. Observation of Resident #73 attempted on 12/4/2025 at 10:26 AM, however, the resident was receiving resident care behind closed doors so no observation conducted. Observation of 1:1 monitoring station outside Resident #73's room was conducted along with additional staff on the unit. In an interview on 12/3/2025 at 11:28 RN A she said she has been employed with the facility strictly on the secured unit for the last 4 months. RN A stated that she typically worked the day shift. She stated that she has not witnessed any incidents of abuse or neglect personally, but she would immediately report any such incidents to ADM if she did. RN A stated that management was supportive of staff and the residents, and she received the necessary orientation, training, education and in-service to do her job and do it well. She stated that staffing is not really a problem on the secure unit. RN A stated that she had no concerns for resident care and safety within the unit. She feels things are managed well. RN A said she has had no problems or issues with any resident on the unit acting out or being aggressive that she has observed. She stated that the residents are typically calm and easy to manage during her shift. RN A stated that she was not present during the incident between Resident #73, #22 and #45. RN A stated that she was surprised to hear that the resident had acted out in such a way. RN A stated that Resident #73 is easily redirected and manageable during her time with him. She stated that Resident #73 showed no signs of discontent or dislike for Resident #22 or Resident #45. RN A said all residents involved were screened and assessed and none were injured or suffered any immediate or ongoing negative effects as a result of the incident. RN A said Resident #73 was placed on 1:1 monitoring around the clock immediately and referred for psychological evaluation and services and to his doctor. The doctor changed the resident's medication and after a day or 2 the resident seemed happier and content. He showed no signs of concerning behavior and it was felt he could be managed without continuing 1:1 monitoring so that was discontinued. RN A stated that she thinks Resident #73 was confused when the incident happened because he was still new to the facility and confused as to where he was and why. RN A stated that she believed Resident #73 moved Resident #45 who was standing in front of the secured unit doors in an attempt to get the door open. RN A stated that the incident with Resident #22 was minor with no injuries or negative impact to either. In an interview on 12/3/2025 at 11:30 AM, CNA A stated that she has not observed any further issues involving Resident #73. She stated there have been no further incidents or occurrences. In an interview on 12/3/2025 at 11:31 AM with RP 1, RP 1 confirmed she is the RP for Resident #22. She stated that the resident is her mother. She stated that the resident has been admitted at this facility for 2 years. RP 1 stated that she is very satisfied with the care and supervision provided by staff at the facility, specifically on the secured unit. She stated that her mother is happy and well cared for. RP 1 stated that she has never had any concerns for abuse or neglect of her mother or any of the residents at the facility. RP 1 stated that she visits often and is able to directly observe the circumstances and environment of the facility. RP 1 stated that she was immediately made aware of the incident involving her mother and Resident #73. She stated that staff are always inclusive and explain her mother's status and care effectively. RP 1 stated that her mother did not suffer any negative outcome as the result of the incident with Resident #73. RP 1 stated that she had concerns or hesitation allowing her mother to remain a resident at the facility as she does not feel her mother is in danger. RP 1 stated that her mother doesn't remember the incident that occurred and could not relay any details. RP 1 said her mother has been happy and (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no changes in behavior exhibited. In an interview with the ADM on 12/3/2025 at 2:25 PM, ADM stated that since the incident involving Resident #73 occurred, she has been reaching out to the family to discuss seeking placement for Resident #73 at another facility. ADM stated that she just doesn't think the resident is a good fit here. She stated that his injury and condition and circumstances are fairly new and this is likely part of the reason he got agitated. But ADM is concerned that his behaviors will not improve. ADM stated that the resident's family are slow to respond to her calls and messages, even when there is a serious concern or issue. ADM stated that she has actively been seeking alternative placements for the resident that can better service the resident and the family is in agreement but they will not assist. ADM stated that she was already in discussions with the appropriate persons and the family on seeking psychiatric care for the resident that was more intensive than they could provide in a more controlled environment. Family also agreed to this option but made no effort at getting the resident this type of care. ADM stated that they conducted an in-service training on resident-to-resident abuse/altercations, and she arranged for an outside provided to come in next week to give a more detailed presentation on the subject. ADM stated she would request the presenter to come sooner if possible. In an interview on 12/4/2025 at 10:15 AM, ADM revealed an incident occurred between Resident #25 and Resident #73 overnight. ADM stated that a self-report regarding abuse had been submitted and staff have been diligently assessing and monitoring the residents. ADM stated that no injuries occurred and no negative psychosocial impact to either resident detected. ADM stated that the proper notifications and interventions have been initiated and were continuing. ADM stated that Resident #73 will be removed from the facility asap as his family has agreed to provide respite care for the resident at home until another placement for the resident could be secured. ADM stated that it had been difficult to get in contact with Resident #73's family and at that time their responsiveness was inconsistent. ADM stated other measures were being considered including psychiatric commitment. ADM stated that Resident #25's RP and family were supportive and understanding. The family were aware of a similar incident in the past in which Resident #25 took on a romantic friend while residing on the regular unit. That incident was not sexual in nature, but involved the resident being affectionate with another resident. In an interview on 12/4/2025 at 10:15 AM, DON stated Resident #25 and Resident #73 suffered no physical trauma and there was no penetration of Resident #25's sexual organ by Resident #73. DON stated there appeared to be no emotional trauma suffered by either resident as well. She stated that Resident #25's family was not upset or angry and understood the incident would be reported. DON stated both residents were checked and neither sustained injuries. In an interview on 12/4/2025 at 10:52 AM, RN A revealed that Resident #73 had been on 1:1 monitoring since the most recent incident and this would continue indefinitely until an alternate placement for the resident could be obtained. RN A stated that she was surprised Resident #73 had another incident in that his behavior had been stable with no signs of agitation or distress. RN A stated that Resident #73 seemed to act out during the night shift because he was typically stable during the day shift. RN A said Resident #73 was acting fine at that time and that he had been resting and was being closely supervised. RN A said Resident #73 didn't remember the incident it seemed as the resident didn't mention it or ask for the other resident. In an interview on 12/5/2025 at approximately 10:00 A.M., ADM revealed that she was able to secure an emergency order for psychiatric care for Resident #73 on 12/4/2025. ADM stated that Resident #73 had been discharged, and he was transported to the psychiatric facility for intensive treatment and monitoring. In an interview on 12/6/2025 at 12:35 PM, RP 2 stated that he was made aware of the recent incident involving Resident #25. He stated that he was notified right away and the details of the incident were provided. RP 2 stated that he is satisfied with the care and supervision provided to Resident #25 by staff at the facility. RP 2 stated that he does not consider this to be an incident of abuse as neither resident are of sound mind. RP 2 did not believe that a lack of supervision or monitoring contributed to the incident in that it was something that just happened and could not necessarily be planned for. RP 2 stated that he does not feel Resident #25 suffered any ill effects (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the incident as her recollection is limited and he has not been made aware of any negative impacts. RP 2 stated that he feels the resident is safe and well cared for and she will remain a resident at the facility. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021, states, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: b. Other residents; 2. Develop and implement policies and protocols to prevent and identify: a. Abuse or mistreatment of residents; 8. Identify and investigate all possible incidents of abuse; 10. Protect residents from any further harm during investigations.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation , interview, and record review, the facility failed to ensure each resident was provided with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 (Resident #39) of 24 and multiple confidential residents reviewed that received food from the facility kitchen. 1. The facility failed to provide Resident #39 with a meat sandwich on multiple occasions when she requested them, or an alternative to the posted meal, when her meal tickets had Meat portions for all meals printed on them. 2. The facility failed to have a variety of breakfast meals available to residents. This failure could place residents at risk of weight loss, dissatisfaction with meal service, and interfered with their desire to gain weight. Findings included: Review of Resident #39's comprehensive MDS assessment, dated 10/08/2025, reflected an [AGE] year-old female admitted on [DATE]. Her diagnoses included: atrial fibrillation (irregular and often rapid heart rhythm), high blood pressure, arthritis (bone grinding on bone during movement), osteoporosis (low bone mass, and deterioration of bone tissue), malnutrition, Resident #39 had a BIMS score of 15, which indicated intact cognition. Review of Resident #39's comprehensive care plan, dated 11/18/2025, revealed Resident #39 was not care planned for her dietary preferences or desire to gain weight. Review of Resident #39's medical nutrition therapy assessment conducted by the RD and dated 10/07/2025 revealed Resident #39 was recommended by the RD to receive snacks, supplements, and her food preferences due to being at risk for severe malnutrition. Review of Resident #39's weights revealed she had not experienced weight loss since her admission to the facility on [DATE]. Review of the facility's weeks 2-4 Winter 2025-26 breakfast menus revealed, Week 2 Sunday, Tuesday, Thursday, Saturday: Monday, Wednesday, Friday: Assorted Juice Assorted Juice Cereal of Choice Cereal of Choice Bacon Sausage Patty Scrambled Eggs Scrambled Eggs Breakfast bread of choice Breakfast bread of choice Margarine Margarine Jelly Jelly Milk Milk Beverage Beverage Week 3 Sunday, Tuesday, Thursday, Saturday: Monday, Wednesday, Friday: Assorted Juice Assorted Juice Cereal of Choice Cereal of Choice Sausage Patty Bacon Scrambled Eggs Scrambled Eggs Breakfast bread of choice Breakfast bread of choice Margarine Margarine Jelly Jelly Milk Milk Beverage Beverage Week 4 Sunday, Tuesday, Thursday, Saturday: Monday, Wednesday, Friday: Assorted Juice Assorted Juice Cereal of Choice Cereal of Choice Bacon Sausage Patty Scrambled Eggs Scrambled Eggs Breakfast bread of choice Breakfast bread of choice Margarine Margarine Jelly Jelly Milk Milk Beverage Beverage In an interview and observation on 12/03/2025 at 10:45 a.m., Resident #39 stated if she complained about the meal and took it to the dining room the kitchen staff would offer her a PB&J, but it would be nice if she were given a meat sandwich. She stated sometimes they offered her a hamburger, if they had it. She stated it was usually just a PB&J sandwich they gave her when she asked for different food, and she was not aware of what the always available menu items were or if the facility had that. She stated the facility was aware she wanted/needed to gain weight, and she had previously communicated her preference of receiving meat for every meal. In an interview on 12/04/2025 at 11:02 a.m., the DM stated she told the ADM on 12/03/2025 that she wanted to do something different for breakfast since the menus all said the same options. She stated she wanted to incorporate different meals for the residents but she had only worked at the facility two weeks. In a confidential resident group meeting at an undisclosed time, it was revealed that residents who received meals in their rooms often received cold food, and that the cafe menu (always available) items were not always served when residents requested them. The residents stated they were given PB&J sandwiches if they requested something other than what was served. The residents also stated that they wanted a change in the breakfast menus due to the repetitiveness and some stated they skipped breakfast altogether because they could not stand to look at the same plate over and over again. In an interview on (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/05/2025 at 8:51 a.m., the RD stated she went to the facility once per week, and that she, nor the facility made the menu. The RD stated the menus were created by their food provider. She stated residents had a preference in boiled or scrambled eggs for breakfast, different varieties of bread, hot cereal or cold cereal, which created the variety in food options. She stated she was not invited to resident council to hear concerns. She stated she felt the residents' concerns and choices to skip breakfast due to the menu was disappointing and she would add it to her list of questions to ask residents when she visited with them. She stated she was not told about Resident #39 only getting PB&J sandwiches. She stated the kitchen should always have the always available items available upon resident request. She stated that the kitchen should offer an alternate protein source to Resident #39 since her meal tickets stated she needed meat with all meals. In an observation on 12/04/2025 at 1:47 p.m. of Resident #39's 12/04/25 lunch meal ticket revealed, Regular texture, regular diet, large protein/meat portions for all meals. In an observation of the dining room wall, near the kitchen, on 12/03/2025 at 9:40 AM, a framed paper titled Cafe Menu Available from 7am to 6pm revealed: HamburgerGrilled CheeseCold cerealBaked potatoSoup of the dayDeli SandwichPeanut Butter & Jelly Sandwich. Review of the facility's Food and Nutrition Services policy, dated October 2017 reflected: Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.1. The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization .4. Reasonable efforts will be made to accommodate resident choices and preferences.7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. Review of the facility's Open Style Dining policy dated 2023 revealed, 3. Nursing and/or food and nutrition services staff will offer food and beverage choices to the individual at the point of service and report an individual's food and beverage choices to the staff members responsible for serving the food. Food and nutrition services staff will serve food and beverage choices made with consideration given to any dietary restrictions and/or texture modifications.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide advance notice of change in services and charges not covered under Medicare for 1 of 3 residents (Residents #77) reviewed for Medicaid and Medicare Coverage Liability Notices. The facility failed to ensure Resident #77 was provided with a Notice of Medicare Non-coverage (NOMNC) when the resident discharged from Medicare Part A skilled services with benefit days remaining for that episode, or 2 days prior to the resident's planned discharge. This failure could place the residents, or their representatives, at risk of not being fully informed about services covered by Medicaid Part A and unknowingly being charged for skilled nursing services. Record review of Resident #77's admission record dated 12/6/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident's principal diagnosis was heart failure (a long-term condition that prevents the heart from pumping blood effectively throughout the body). The resident's discharge date was listed as 6/17/2025 at 1030 (10:30 AM), with the length of stay being 15 days, and the resident discharged home with home health. Record review of Resident #77's Nursing Home Discharge (ND) MDS, dated [DATE], indicated Resident #77 discharged to Home/Community on this date. The assessment showed Resident #77 had a BIMS Score of 15, which indicated normal cognitive function and intact cognitive response. Record review of the Beneficiary Notice worksheet reflected a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. The worksheet showed Resident #77 was discharged home from the facility on 6/17/2025. On 12/3/2025, Resident #77 was chosen at random from the list of residents provided for a Beneficiary Notification Review. Record review of Resident #77's SNF Beneficiary Protection Notification Review form on 12/4/2025 revealed Resident #77's Medicare Part A Skilled Services Episode Start Date was 6/2/2025 and the Last Covered day of Part A Services was 6/17/2025. The form revealed that the facility/provider initiated the resident's discharge from Medicare Part A services when benefit days were not exhausted because the resident Decided to go home per family. The form revealed a NOMNC was not provided to the resident. Facility staff did not choose a listed reason as to why the NOMNC was not provided to the resident. Instead, facility staff wrote, discharged to another facility. Record review conducted on 12/4/2025 of Resident #77's progress notes revealed LVN A made a late entry discharge summary note effective 6/17/2025 at 10:34 (10:34 AM). The entry stated Resident #77 discharged to home with personal items and meds. Condition stable at departure. LVN A's nurse's note made on 6/17/2025 at 11:16 (11:16 AM) stated, Patient discharged to home with personal items and medications. Meds reviewed with RP, patient condition stable at departure. Record review of Resident #77's routine physician follow-up visit after hospitalization dated 6/10/2025 indicated, The patient expresses a desire to return home. The visit notes also indicated that PT staff estimated the patient would be ready to return home in 7-10 days. Record review of Resident #77's physician's orders revealed no order for discharge at the time of the resident's departure from the facility; however, a verbal order was obtained on 6/18/2025 that stated, DC HOME WITH HOME HEALTH. In an interview on 12/6/2025 at 12:56 PM, ADM revealed Resident #77 was discharged from the facility with Medicare Part A days remaining. ADM stated that due to an unexpected loss of pertinent staff, she was unable to say for certain the circumstances under which the resident was discharged or locate any notices or forms issued to the resident. ADM stated that Resident #77 was discharged from the facility prior to ADM taking her position at the facility. ADM stated that she was not personally familiar with this resident or her discharge circumstances. ADM speculated that Resident #77 discharged AMA but provided other explanations on the SNF Beneficiary Protection Notification Review form. ADM revealed information regarding the resident's full discharge circumstances was missing and incomplete due to employee and record transitions. ADM stated the former BOM was responsible for issuing those notices and maintaining those records. The former BOM was not able or willing to further discuss facility matters after her termination. ADM stated that (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a new BOM will assume the position and responsibility soon and ADM will ensure the new BOM and existing staff are educated, training and cross-trained on the process to avoid this type of situation in the future. ADM stated that during the transition from one electronic medical health record system to another, staff were diligently working to ensure completeness of information and record audits will be ongoing. ADM stated that the expectation regarding the NOMNC was that staff would follow the appropriate Medicare guidelines. Record review of Form Instructions for 10123-NOMNC (Notice of Medicare Non-Coverage) revealed the following, in part: - The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. - Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. - The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Record review of the facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices revised September 2022, revealed, Residents are informed in advance when changes will occur to their bills. Notice of Medicare Non-Coverage (CMS form 10123) 1. If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before benefits end. 2. The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review by a Quality Improvement Organization.		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure they did not employ an individual who was found guilty of a criminal offense barring employment by a court of law for 1 of 6 (Maintenance Director) employees reviewed for abuse and neglect. The facility did not disqualify the Maintenance Director from working when a criminal history record indicated a criminal conviction barring employment of credit or debit card abuse elderly: 32:31 (D) Felony -3rd degree in a nursing facility. The Maintenance Director had worked in the facility from 09/19/2025 through 12/05/2025. This failure could place residents at risk for possible abuse, neglect, or exploitation. Findings included: Record review of an undated personnel file for the Maintenance Director reflected a hire date of 09/19/2025. Further review revealed a national background check had been conducted on 09/19/2025. The background check reflected the Maintenance Director had an offense date of 09/04/2018 and disposition date of 7/29/2022 charged with credit or debit card abuse elderly: 32:31 (D) Felony -3rd degree (F3) with a final plea of guilty court confinement of 10 years and 5 years' probation sentence dated 09/12/2025 . In an interview on 12/05/2025 at 2:25pm the Maintenance Director stated he had been employed with the facility since October 2025. He stated that he was the Maintenance Director and has served in this role for the duration of his employment with the facility. The Maintenance Director stated that his direct supervisor was the Administrator. The Maintenance Director stated that the previous Administrator had hired him . In an interview on 12/05/2025 at 3:05pm HR A stated that 6 staff including the Maintenance Director on the employee file review list were employable. HR A stated that no staff on the list have any criminal histories that would bar them from employment. She stated that technically anyone that has something more than a misdemeanor on their background the ADM had to sign off on it. She stated that the Maintenance Director was approved by the previous ADM. HR A stated that now the facility had to send the personnel files to the [NAME] President of Operations, the ADM does not just have the authority to approve new hires. HR A stated that with the Maintenance Director, the facility did not want to go back and terminate him. HR A stated that there was an HR policy that outlined what the expectations are for hiring. HR A stated that she would be concerned if someone was hired into a position at a nursing home with a criminal history. In an interview on 12/06/2025 at 11:40 am the ADM stated that the criminal history report for the Maintenance Director was run prior to her employment. The ADM stated some things to her would seem to be automatically an unemployable offence. She stated she was going to get with HR and Cooperate for a full audit of employee files to ensure criminal history checks were reviewed. She stated based on policy and procedure the facility will make the necessary staffing adjustments accordingly. The ADM stated the risk for residents for having employees with conviction for elder abuse would be that it could open the residents up for potential abuse. The ADM stated the Maintenance Director was terminated as of 12/05/2025. Record review of the Employee Handbook dated April 2025 reflected: BACKGROUND AND CRIMINAL HISTORY SCREENS All newly hired employees will undergo a background and/or criminal history screen as required by the State of Texas and in accordance of the Health & Safety Code Section 250.006, Convictions Barring Employment. This will occur on a pre-employment basis. Unsatisfactory reports will result in rescinding the employment offer or termination of employment. Record review of the State of Texas, Health and Safety Code, Chapter 250, Section 250.006 Convictions Barring Employment revealed (Revision 24-1, Effective [DATE]): A person may not be employed in a position the duties of which involve direct contact with a consumer in a facility or may not be employed by an individual employer before the fifth anniversary of the date the person is convicted of: an offense under Section 31, theft, that is punishable as a felony. Record review of the facility's Abuse Prevention Program dated 2001 and revised November 2010 reflected: Our facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating (continued on next page)		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individuals. Screening: The facility will screen employees for a history of abuse, neglect, or mistreating residents by attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries.		

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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 interviews and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 2 of 10 (Resident #52 and Resident #61) reviewed for accuracy of assessments. The facility failed to ensure Resident #52's Quarterly MDS assessment dated [DATE] was accurately coded for the use and indication of high-risk medications, specifically anticoagulant and antiplatelet medication. The facility failed to ensure Resident #61's Quarterly MDS assessment dated [DATE] was accurately coded for the use and indication of high-risk medications, specifically anticoagulant and antiplatelet medication. This failure could place residents at risk of not receiving the appropriate care, treatment, and services due to inaccurate assessments. Review of Resident #52's admission record dated 12/6/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including other viral conjunctivitis (pink eye), repeated falls, weakness, traumatic subdural hemorrhage without loss of consciousness (bleeding between the brain and its protective layers), essential primary hypertension (high blood pressure), and gastro-esophageal reflux disease without bleeding (when stomach acid flows back up into the esophagus and causes heartburn). Review of Resident #52's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 4, indicating severe cognitive impairment. In Section N-Medications, N0415 High-Risk Drug Classes, Anticoagulant use and indication was marked , and Antiplatelet use and indication was not . Review of Resident #52's Care Plan Report revised as recently as 10/3/2025 did not reflect the use or indication of anticoagulants or antiplatelets, or monitoring for anticoagulant or antiplatelet use. Review of Resident #52's Order Summary Report dated 12/6/2025 reflected an order that stated : Anticoagulant Monitoring for Heparin/Lovenox/Coumadin/Plavix/Aggrenox/Xarelto/Pradaza/ASA/Plexal Monitoring: Bruising, nosebleeds, bleeding gums, prolonged bleeding from wound, IV, or surgical sites, blood in urine, feces or vomit; elevated PT/INR (test that measures how fast a blood sample forms a clot), low platelet count, every shift for indications of an adverse drug event. The order status was active upon review with an order date of 9/18/2025. Further review of the order summary reflected no anticoagulant medications ordered within the assessment period or currently. The order summary reflected an active order for Aspirin Oral Capsule 81 MG (Aspirin), an antiplatelet medication, started on 9/18/2025. Review of Resident #61's admission record dated 12/6/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including other Alzheimer's Disease (a type of dementia that affects memory, thinking, and behavior), urinary tract infection, fall, unsteadiness on feet, and Megaloblastic anemia (vitamin deficiency characterized by the production of abnormally large red blood cells). Review of Resident #61's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 00, indicating severe cognitive impairment. In Section N-Medications, N0415 High-Risk Drug Classes, Anticoagulant use and indication was marked and Antiplatelet use and indication was not. Review of Resident #61's Care Plan Report revised most recently on 9/24/2025 did not reflect the use or indication of anticoagulants or antiplatelets, or monitoring for anticoagulants or antiplatelet use. Review of Resident #61's Order Summary Report dated 12/6/2025 reflected an order that stated: Antiplatelet monitoring: monitor for signs and symptoms of adverse reaction: bruising, interocular hemorrhage, abdominal pain, flatulence, alopecia, rash, pruritus (itching), taste disturbance, tissue necrosis (death of body tissue), headache, lethargy, dizziness, hematuria, anemia, respiratory tract bleeding, hypersensitivity reaction, hemorrhage, bloody urine, fever every shift for antiplatelet medication monitoring. The order status was active upon review with an order date of 8/17/2025. Further review of the order summary reflected an active order for Aspirin 81 MG Chewable Tablet, an antiplatelet medication, started 4/11/2025. The order summary did not reflect any medication that would be classified as an anticoagulant. In an interview with ADM on 12/6/2025 at 12:56 PM, ADM stated that she expected staff to adhere to their assessment and care planning policies and (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 - Few	participate in ongoing education, updates and in-service offerings to ensure they are familiar with processes and outcomes. ADM stated that the accuracy of assessments and care plans is up to the entire clinical team. In an interview with the MDS Nurse on 12/6/2025 at 12:56 PM, the MDS Nurse stated that she was told and trained to code aspirin as an anticoagulant and that's why the assessments reflect the residents' use of anticoagulant medications. MDS Nurse said she refers to the RAI manual for coding of assessments. MDS Nurse stated their corporate office personnel monitor assessments for accuracy and will let them know when a correction or change is needed. MDS Nurse stated that she felt she had the experience, knowledge, education and support necessary to do her job and do it well. MDS Nurse stated staff were educated and in-serviced regularly on a variety of care related services, especially if there have been regulation changes. MDS Nurse said the negative effect of a mis-coded assessment would be that it's an inaccurate reflection of resident care and needs and would then create an inaccurate care plan. MDS said if she needs assistance with assessment coding, she refers to the RAI manual or she will contact their corporate office for assistance. Record review on 12/6/2025 of the facility's policy on Quarterly Assessments reflected, Quarterly MDS assessments are conducted to track the resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (Resident #15) of eight residents reviewed for bathing/showering. 1. The facility failed to provide showers to Resident #15 in compliance with his shower schedule. 2. The facility failed to have appropriate interventions in place when Resident #15 refused or was in too much pain to receive a bath. This deficient practice could place residents at risk of decline in skin integrity and overall health. Findings included: Review of Resident #15's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included: high blood pressure, kidney failure, high cholesterol, stroke, hemiplegia (complete paralysis on one side of the body), seizure disorder, depression, unspecified pain, generalized edema (swelling), constipation, and gout (sudden, severe attacks of pain, swelling, redness, and tenderness). Resident #15 was coded as being dependent on staff for shower/bathing. Resident #15 had a BIMS score of 13, which indicated intact cognition. Review of Resident #15's comprehensive care plan dated 11/05/2025 revealed Resident #15 would refuse showers, bed baths, ADL's, he would refuse to let staff perform incontinent and change his soiled linens, he would also curse at staff. The goal listed was for Resident #15 to be free from skin breakdown. The intervention listed for this area was for staff to encourage Resident #15 to take a bed bath or shower. He was also care planned for refusing to get out of bed, which increased the risk for skin breakdown, deconditioning, isolation, and complication of immobility. The goal listed was that Resident #15 would maintain skin integrity and physical function despite refusal behaviors. The intervention listed for this area was for staff to encourage resident to get out of bed. In an interview on 12/03/2025 at 2:11 PM with Resident #15, he stated that he was paralyzed on his left side, and that he was supposed to get showers on Tuesdays, Thursdays, and Saturdays, and the staff would get him into his shower chair and take him to the shower room, but recently they did not adhere to that schedule. He stated they could give him bed baths as well. He stated it had been a few months since he had a bed bath or shower, he stated that once in a great while he would refuse but mostly only if it was an agency staff would he refuse. He stated that the agency staff tended to be the staff he did not care for. Observation on 12/03/2025 at 2:11 PM of Resident #15's face, revealed dead skin flakes all over, his feet were also covered in dark (old) and fresh dead skin flakes, and on the bed, near his feet were large chunks of dead skin that had fallen off. In an interview on 12/05/2025 at 12:25 PM with CNA C, she stated she had been working at the facility for about 4 months. She stated that Resident #15 had a history of refusing brief changes too early in the morning or late at night, and that he had gotten to the point where his muscles could not move so he would not get out of bed anymore. She stated that Resident #15 only got bed baths, and that when she was responsible for bathing him, if he refused, she would offer a bed bath again later, and that she would report it to her charge nurse if he refused altogether. She stated that Resident #15 was vocal and would communicate to staff his needs. She stated she was not recently responsible for giving Resident #15 a bath. In an interview on 12/05/2025 at 1:15 PM with LVN A, she stated that Resident #15 would not allow the staff to touch his feet and legs due to pain. She stated that if they barely touched his legs he would scream out in pain. She stated that they had done x-rays and even gotten an order for fentanyl patches to control his pain, but he just did not like his feet or legs to be touched. She stated that it was very rare that he would request to be put in the shower, and he mostly received bed baths. She stated that the CNA's would report to her when any of their residents' refused showers/baths. She stated Resident #15 was cooperative when she went into his room, but that he would only allow certain staff to care for him. She stated that Resident #15 was given a bed bath on 12/4/25. In an additional observation and interview on 12/05/2025 at 1:25 PM of Resident #15's feet with LVN A, Resident #15's feet were observed to still be peeling and LVN A stated that (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would request an order from the MD for sodium lactate to resolve it. She stated that Resident #15 did not have any skin conditions that would contribute to the buildup of skin, and she relied on the CNA's to report skin conditions to her after showers. She stated that a negative outcome of not receiving adequate baths would be the buildup of dead skin, or potential skin breakdown on other areas of the body. In an interview on 12/05/2025 at 4:25 PM, the DON stated that the intervention listed on Resident #15's care plan was not adequate and that she would get with the nurses to update it. She stated that their corporate RN stated that the expectation was to shower/bathe residents 3x/weekly, and if the resident refused the CNAs should report it to the charge RN so the resident could be offered again. She stated that Resident #15 was verbally abusive toward some of her staff and would call them derogatory names. She stated that some staff were able to give him the care he needed. She stated that they would get something incorporated to prevent the dead skin buildup. Review of the facility's policy dated February 2025, titled Activities of Daily Living (ADL), Supporting reflected, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care)4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate.7. The resident's response to interventions will be monitored, evaluated and revised as appropriate.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 1 (Residents #4) of 8 residents reviewed for activities. The facility failed to ensure they provided in-room activities for Resident #4 who spent most of or all her time in her room. This failure placed residents at risk of boredom, depression, and diminished quality of life. Review of Resident #4's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included: heart failure, high blood pressure, diabetes mellitus (body's impaired ability to produce or respond to insulin), high cholesterol, anxiety, depression, schizophrenia, morbid obesity, urinary tract infection, constipation (inability to have a bowel movement. Resident #4 had a BIMS score of 07, which indicated severe cognitive impairment. Review of Resident #4's comprehensive care plan dated 11/06/2025 revealed Resident #4 did not like to attend activities, she enjoyed snack cart, reading books, watching television, and she enjoyed one on one visits. The intervention listed for this area was to encourage Resident #4 and assist her in attending and participating in activities. In an interview/observation on 12/04/2025 at 9:42 AM with Resident #4 she was observed lying in bed in a nightgown. She stated that in the past year she had to go to the hospital due to bad constipation and a UTI. She stated she would often get irritated because she resided in the NH, but it helped her mood to watch television and talk to the people at the facility. She stated she did not get out of her room because of her medical condition and that she required a mechanical lift and approximately 5 staff to help her out of bed and into her wheelchair. She stated that the Activity Director did not bring her any books, cards, or puzzles, and that she would enjoy doing puzzles. No puzzles, books, or other activities were observed in her room aside from her television. Review of Resident #4's EHR revealed no recent Resident Preference Assessment to determine what kind of activities she preferred. In an interview on 12/05/2025 at 1:07 PM with the AD, she stated that she started her position a couple months ago. She stated that she conducted Resident Preference Assessments when they came up in the computer as due. She stated that she knew which residents preferred individual activities by talking to the residents and asking them, she stated that she was able to pass out magazines, puzzles, or books when residents requested them. She stated that she ensured residents received individual activities by talking to residents in the mornings to see if there was anything they needed from her. She confirmed that she had not done a Resident Preference Assessment on Resident #4. Review of an undated Resident Rights poster revealed, As a resident of a long-term care facility you have the right: to choose your activities, both inside & outside the facility.		

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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 observations, interviews, and record reviews, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 6 Residents (Resident #17) reviewed for respiratory care. The facility failed to place Resident #17's oxygen tubing in a bag when not in use and failed to keep her concentrator filter clean. This failure could place residents at risk of not receiving appropriate air flow resulting in shortness of breath respiratory infections. The findings were: Record review of Resident #17's undated face sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of Unspecified Dementia (a decline in memory, thinking, daily problem solving), Heart Failure, Hyperlipidemia (elevated cholesterol), and Hypertension (elevated blood pressure). Record review of Resident #17's care plan dated 03/31/2022 reflected Resident requires supplemental oxygen to maintain adequate oxygen saturation levels. Date Initiated: 11/10/2025 Interventions included to administer oxygen as ordered. Record review of Resident #17's admission MDS dated [DATE] reflected short term and long-term memory problems indicating she was cognitively impaired. The MDS reflected Resident #17 required Oxygen. Resident #17 was indicated to have shortness of breath both with exertion and when lying flat. Record review of Resident #17's physicians' orders summary dated 12/03/2025 reflected an order to Change oxygen tubing/water every week and PRN (as needed) every night shift every Sun for Oxygen, and Oxygen at 2 liters/minute via nasal cannula every shift. every shift for Oxygen Parameters. In an observation on 12/03/2025 10:35 AM Resident #17 was lying in bed, eyes closed, appeared to be sleeping. She had oxygen in place at 2 lpm through a nasal cannula (a tube that rests on the nostril). The nasal cannula was not dated and the filter on the oxygen concentrator was packed with white lintlike substance, dust, and debris. Resident #17 had portable oxygen tank on a wheelchair with oxygen tubing observed rolled up on armrest, open not bagged. In an observation on 12/05/2025 at 10:54 AM reflected Resident #17 was not in the room. Oxygen tubing was undated and wound up around the dirty concentrator. The Oxygen filter remained dirty with dust and debris. During an attempt to interview LVN D on 12/05/2025 at 11:19 AM she stated to the Administrator she was not speaking to surveyor because it disturbed her peace and resigned. In an interview on 12/05/2025 at 11:31 AM the DON stated the oxygen concentrator and filter in Resident #17's room were dirty. The concentrator and filter should be cleaned routinely. The tubing was to be changed weekly and should have a date on it. The DON stated the tubing should be bagged when not in use. There were no set dates or days for filters to be checked and cleaned. She stated the nurses were responsible for ensuring concentrators, filters, and tubing were changed, dated, and cleaned. She stated the risk to the residents for having dirty filters and tubing on their oxygen concentrators would be respiratory infection or compromised airflow from the concentrator. 4. Record review of facility policy titled Standard Precautions dated 2001 and updated September 2022 reflected: Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. (6) Environmental Control. Environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces are appropriately cleaned. Surveyor was not provided when requested on 12/4/2025 a policy on Respiratory Equipment / oxygen use.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review , the facility failed to ensure residents' drug regimen was adequately monitored and free from unnecessary drugs for 1 of 6 (Resident #10) residents reviewed for pharmacy services. The facility failed to obtain a stop date for Resident #10's Amoxicillin-Pot Clavulanate (an antibiotic used to treat an acute infection) started on 11/27/2025. This failure could place residents at risk of side effects (gastrointestinal upset, multiple drug-resistant infections) related to long term antibiotic use. Findings included: Record review of Resident #10's undated face sheet reflected an admission date of 08/01/2025 with diagnoses of diverticulosis of the small intestine (inflammation of pouches within the small intestine), diabetes type 2 (elevated blood sugar), chronic kidney disease, and cellulitis (an infection within the skin). Record review of Resident #10's care plan, dated 05/01/2025, reflected, (Resident #10) am at risk for frequent infections, pressure/venous/stasis ulcers, vision impairment, hyper/hypoglycemia, renal failure, cognitive/ physical impairment/ skin desensitized to pain or pressure, slow healing process related to diagnosis of diabetes mellitus. Interventions included, Monitor skin for changes: redness, circulatory problem, breakdown- report to Medical doctor and responsible party. Record review of Resident #10's annual MDS, dated [DATE], reflected a BIMS score of 10 indicating moderate cognitive impairment. Resident #10 had lower body impairment and was dependent on staff for upper and lower body dressing. Record Review of Resident #10's Hospital Discharge Medication List, dated 11/26/2025, reflected an order for Amoxicillin-Pot Clavulanate 500mg-125mg oral tablet one tablet twice a day for cellulitis. Record review of the progress notes for Resident #10 , dated 12/05/2025, reflected, The patient is on Day 9/10, Augmentin 500-125 for the diagnosis of Cellulitis. Patient remains on Tramadol q6 routine along with Gabapentin 900mg q6 hours routine for pain management. Will monitor for effectiveness., signed by LVN C. Record review of Resident #10's Physicians order summary, dated 12/05/2025, reflected an order for Amoxicillin-Pot Clavulanate Oral Tablet 500-125 MG Give one tablet by mouth two times a day for Cellulitis, dated and started 11/27/2025 . Record review of Resident #10's Medication Administration Record for the months of November 2025 and December 2025 reflected the resident received Amoxicillin-Pot Clavulanate Oral Tablet 500-125 MG (Amoxicillin & Pot Clavulanate) for nine days from dates of 11/27/2025 through 12/05/2025. During an interview on 12/05/2025 at 11:19 a.m., LVN B, charge nurse, stated to the administrator she was not speaking to the surveyor because it disturbed her peace and resigned. In an interview on 12/05/25 at 11:31 a.m., the DON stated all antibiotics should have a stop date. The DON stated the charge nurses were responsible for obtaining a stop date. The nurses would do this by contacting the ordering physician and clarifying the order to include a stop date. She stated she was responsible for monitoring the nursing orders for accuracy. She stated the negative effects for the residents taking prolonged antibiotics could include drug resistance and upset stomach. Record review of facility policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, dated 2021, reflected, All resident antibiotic regimens will be documented. The information gathered will include: (i) stop date. (j) total days of therapy.		

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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 and prevention control program that included, at a minimum, a system for preventing and controlling infections for 3 of 6 residents reviewed for infection control (Resident #39, Resident #42, and Resident #57). 1) MA failed to clean the electronic blood pressure cuff after use on Resident #57 and prior to use on Resident #39 in an observation of medication pass at 8:45 a.m. on 12/4/25. 2) LVN A did not wear PPE for enhanced barrier precautions while performing wound care and wash/clean her hands when removing soiled gloves, prior to applying clean gloves on 12/04/2025 at 10:17 a.m. for Resident #42's wound care observation. This deficient practice could place residents at risk for cross contamination and the spread of infection. Findings included: 1. Record review of Resident #39's undated face sheet reflected an admission date of 10/01/2025 with diagnoses of Atrial Fibrillation (an irregular heartbeat), Hypothyroidism (a lack of thyroid hormone), heart disease, and Hypertension (elevated blood pressure). Record review of Resident #39's care plan, dated 10/01/2025, reflected, (Resident #39) have hypertension and is at risk for blurred vision, vertigo (dizziness), headache and nosebleeds. Receives antihypertensive medication and is at risk for side effects. Interventions included, Check blood pressure before administering medication and record on medication administration record. Record review of Resident #39's admission MDS, dated [DATE], reflected a BIMS score of 15 indicating she was cognitively intact. Resident #39 had lower body impairment and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard) assistance with her activities of daily living such as dressing, bathing, and personal hygiene. 2. Record review of Resident #57's undated face sheet reflected an admission date of 08/25/2025 with diagnoses of Alzheimer's disease (an impairment in memory), anemia (a lack of red blood cells), hypertensive chronic kidney disease (elevated blood pressure that had caused kidney disease), and age-related physical debility. Record review of Resident #57's care plan, dated 09/01/2025, reflected, (Resident #57) am at risk for circulatory impairment, chest pain, irregular pulse, impaired skin integrity, skin desensitized to pain, or pressure related to history of heart disease. Interventions included, Administer meds per order, monitor labs, report abnormalities to medical doctor. In an observation at 8:45AM on 12/4/25, the MA checked Resident #57's blood pressure prior to administration of medications. She did not clean cuff after use on Resident #57 and proceeded to use the blood pressure cuff on Resident #39. In an interview on 12/4/25 at 8:57 a.m., the MA stated she was aware she was supposed to clean the blood pressure cuff between residents. She stated she was nervous and forgot. She stated she was educated by the DON and the pharmacist on policy and procedures for medication pass that included cleaning the blood pressure cuff between residents. The MA stated failing to clean the blood pressure cuff between residents could lead to the spreading of germs causing infections. 3. Record review of Resident #42's undated face sheet reflected an admission date of 11/22/2021 with diagnoses of Atherosclerosis of Native Arteries of Extremities (a narrowing of the arteries in the legs), Type 2 Diabetes Mellitus (elevated blood sugar), Unstable Angina (chest pain), and weakness. Record review of Resident #42's care plan, dated 08/13/2025, reflected, Enhanced Barrier Precautions: Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of multiple drug-resistant organisms to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a multiple drug-resistant organism as well as those who are not confirmed to have a multiple drug-resistant organism (e.g., residents with wounds or indwelling medical devices). Interventions included, Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a multiple drug-resistant organism as well as those who are not confirmed to have a multiple drug-resistant (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2025
NAME OF PROVIDER OR SUPPLIER Avir at Hillsboro		STREET ADDRESS, CITY, STATE, ZIP CODE 411 Old Brandon Rd Hillsboro, TX 76645	
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	organism. Record review of Resident #42's quarterly MDS, dated [DATE], reflected a BIMS score of 11 indicating moderate cognitive impairment. Resident #42 was independent with dressing and grooming and was indicated to have a diabetic foot ulcer. Record review of Resident #42's active physicians order summary, dated 12/04/2025, reflected an order for enhanced barrier precautions dated 08/13/2025. In an observation of wound care on 12/04/2025 at 10:17 a.m. for Resident #42, LVN A washed her hands and proceeded to glove and remove soiled dressing. LVN A disposed of the soiled dressing and gloves, not washing hands or cleaning with alcohol-based hand sanitizer, she applied clean gloves and proceeded with completion of wound care. LVN A nurse did not don PPE for enhanced barrier precautions prior to start of wound care. In an interview on 12/04/2025 at 10:47 a.m., LVN A stated she was nervous and forgot to wash/clean her hands in-between changing her gloves. She stated she laid her gown on top of her treatment cart for enhanced barrier precautions and forgot to put it on. She stated the risk to residents for not using PPE and cleaning her hands between gloving was infection due to bacteria spreading from open wound beds from resident to resident. In an interview on 12/06/2025 at 1:03 p.m., the DON stated the nurses and medication assistants were responsible for making sure they used proper hand hygiene, cleaning equipment, and ensured personal protection equipment was worn during care. The DON stated the nursing staff was educated on infection control and were checked off annually in their competency evaluations. She stated risk to the residents would be the spread on infection, Record review of facility policy titled Standard Precautions, dated 2021 and revised September 2022, reflected, Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Hand hygiene a) Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or the use of alcohol-based hand rub (ABHR), which does not require access to water. b.) Hand hygiene is performed with ABHR or soap and water: before and after contact with the resident, before performing an aseptic task, before moving from work on a soiled body site to a clean body site on the same resident, after removing gloves. Gowns are worn for direct resident contact if the resident has uncontained secretions or excretions. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. Record review of facility policy titled Handwashing/Hand Hygiene, dated 2001 and revised October 2023, reflected hand hygiene was indicated before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. Record review of facility policy titled Enhanced Barrier Precautions, dated March 2024 and revised February 2025 reflected, 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. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: (h.) wound care (any skin opening requiring a dressing).		