STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675101	A. Building B. Wing	11/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Giddings	1400 N Main St Giddings, TX 78942

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 5 residents (Resident #1) reviewed for quality of care. The facility failed to ensure that nursing staff responded to an unwitnessed fall for Resident #1, and when notified by staff member dismissed the fall as a behavior. The fall was not documented by staff, reported to the DON, physician, or resident representative (RP). This failure could place residents at risk for delays in care that could lead to worsening of a serious injury. Findings included: Record review of Resident #1's Facesheet dated 11/25/2025 reflected a [AGE] year-old, male admitted to the facility on [DATE]. Diagnoses included: Repeated falls, Impulse disorder, Cerebral Infarction, muscle weakness, unspecified lack of coordination, bipolar disorder, and chronic kidney disease requiring dialysis. Review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 7 (severe cognitive impairment), He is partial to moderate assist when moving from sitting to standing and for all transfers. Review of Resident #1 care plan dated 11/25/2025 reflected a Problem area stating as follows: Problem Start Date: 11/15/2023 Category: Falls [Resident #1] has impaired balance during transfers, he is at risk for falls. [Resident #1] likes to self transfer and put himself on the floor at times. [Resident #1] likes to sleep on the floor. [Resident #1] will lean forward to pick up items from floor. [Resident #1] states he likes to lie on the floor 1/12/24 on floor----2/19 fall, 11/17/2024 fall, unwitnessed fall 1-11-2025 no injuries. 3/31/2025 unwitnessed fall x3 no injuries. 4/05/25 unwitnessed fall in restroom no injuries.4/20/25 witnessed fall in room with transfer 7/01/25 Edited: 10/15/2025 Edited By: LVN C. Problem Start Date: 04/25/2024 Category: Behavioral Symptoms [Resident #1] has taken himself outside the front door for fresh air, sunshine exposure and to just sit and watch traffic as well as rolls self around building for exercise Edited: 08/18/2025 Edited By: LVN C. Falls noted on Care Plan are dated 1/12/24, 2/19/24, 11/17/24, 1/11/25, 3/31/2025, 4/05/25, 4/20/25, 7/01/25 and 10/14/2025. Further review revealed there are no interventions related to the type or frequency of staff supervision outside during the day. Record review of Resident #1's progress notes from 9/26/2025 to 11/26/2025 revealed no documentation of a fall or reports of delay in care on 11/13/2025. There was no evidence that notifications were made to the physician, RP, or the Administrative staff. Record review of Resident #1's incident reports from 9/25/2025 to 11/25/2025 revealed no documentation of a fall or reports of delay in care on 11/13/2025. There was no evidence that notifications were made to the physician, RP, or the Administrative staff. Review of Resident #1 Fall risk assessment on 11/7/2025 reflected, History of falls (past 3 months): 3 or more falls in past 3 months . Resident is chairbound / incontinent. Systolic blood pressure: No noted drop between lying and standing. Vision status: Adequate (with or without glasses). Predisposing disease: 1-2 present. Resident did not have a change in condition in the last 14 days. Recent hospitalization history in last 30 days: No. Record review of text message from MAINT DIR to SC LVN reflected a text message sent at 10:02PM on 11/13/2025 stated, Hey, I don't know any update but I wanted to let you know that [Resident #1] was on the floor when I walked on [Resident #1's hallway] and the staff took forever to even help him up [Visitor D] walked up to them a second time and snapped on them. The return message from SC LVN on 11/13/2025 at 11:28PM stated, Wow. In an interview with MAINT DIR on 11/25/2025 at 11:10AM, she stated that on 11/13/2025 she observed Resident #1 on the floor in his room. She denied any other witnesses at the scene. She stated that she was unsure how long he had been on the floor. She stated that she informed 2-3 nurses at the nurses station, but they took, too long, about 5 minutes, to respond to the fall. She stated that Resident #1 stated he was on the floor for about an hour, but that she observed him in his wheelchair going down the hallway about ten minutes prior to that. She stated that she informed SC LVN about the fall for Resident #1 and the delay in nursing response. She did not recall which nurses were notified. She stated that was the only phone number that she had for the facility administration. She denied observing any other delays in care or concerning behaviors from nursing before or after this episode. In an interview with the ADON on 11/25/2025 at 10:51AM, she stated that the expectation for resident falls was that nursing assess the resident immediately. She stated that staff should not leave them alone after observing a resident on the floor. She state that nursing should perform vital signs, physical assessment, neurological assessment, and observe for any pain or signs of fracture. She stated that if there was an injury, staff should keep them there and call EMS (emergency medical services). She stated that if nursing was not responding immediately to fall and a resident was injured, they may not receive the medical

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that resident environment remained as free from accident hazards as is possible, by not providing adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for falls. The facility failed to provide adequate supervision to Resident #1, who has frequent falls and severe cognitive impairment, and was allowed to wander outside with no supervision near a busy highway with a speed limit of 45 mph and through restricted construction areas with uneven pavement.This failure resulted in an Immediate Jeopardy (IJ) situation on 11/26/2025. While the IJ was removed on 11/27/2025, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm with an isolated scope and severity. 2. The facility failed to ensure that nursing staff responded to an unwitnessed fall for Resident #1, and when notified by staff member dismissed the fall as a behavior. The fall was not documented by staff, reported to the DON, physician, or resident representative (RP). This failure could place residents at risk for serious injury, fracture, or death. Findings included: Record review of Resident #1's Facesheet dated 11/25/2025 reflected a [AGE] year-old, male admitted to the facility on [DATE]. Diagnoses included: Repeated falls, Impulse disorder, Cerebral Infarction, muscle weakness, unspecified lack of coordination, bipolar disorder, and chronic kidney disease requiring dialysis. Review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 7 (severe cognitive impairment), He is partial to moderate assist when moving from sitting to standing and for all transfers. Review of Resident #1 care plan dated 11/25/2025 reflected a Problem area stating as follows: Problem Start Date: 11/15/2023 Category: Falls [Resident #1] has impaired balance during transfers, he is at risk for falls. [Resident #1] likes to self transfer and put himself on the floor at times. [Resident #1] likes to sleep on the floor. [Resident #1] will lean forward to pick up items from floor. [Resident #1] states he likes to lie on the floor 1/12/24 on floor----2/19 fall, 11/17/2024 fall, unwitnessed fall 1-11-2025 no injuries. 3/31/2025 unwitnessed fall x3 no injuries. 4/05/25 unwitnessed fall in restroom no injuries.4/20/25 witnessed fall in room with transfer 7/01/25 Edited: 10/15/2025 Edited By: LVN C. Problem Start Date: 04/25/2024 Category: Behavioral Symptoms [Resident #1] has taken himself outside the front door for fresh air, sunshine exposure and to just sit and watch traffic as well as rolls self around building for exercise Edited: 08/18/2025 Edited By: LVN C. Falls noted on Care Plan are dated 1/12/24, 2/19/24, 11/17/24, 1/11/25, 3/31/2025, 4/05/25, 4/20/25, 7/01/25 and 10/14/2025. Further review revealed there are no interventions related to the type or frequency of staff supervision outside during the day. Record review of Resident #1's progress notes from 9/26/2025 to 11/26/2025 revealed no documentation of a fall or reports of delay in care on 11/13/2025. There was no evidence that notifications were made to the physician, RP, or the Administrative staff. Record review of Resident #1's incident reports from 9/25/2025 to 11/25/2025 revealed no documentation of a fall or reports of delay in care on 11/13/2025. There was no evidence that notifications were made to the physician, RP, or the Administrative staff. Review of Resident #1 Fall risk assessment on 11/7/2025 reflected, History of falls (past 3 months): 3 or more falls in past 3 months . Resident is chairbound / incontinent. Systolic blood pressure: No noted drop between lying and standing. Vision status: Adequate (with or without glasses). Predisposing disease: 1-2 present. Resident did not have a change in condition in the last 14 days. Recent hospitalization history in last 30 days: No. 1. In an interview with CNA A on 11/25/2025 at 4:10PM she stated that Resident #1 was outside the facility doing laps around the building on his own. She stated that he would let himself out of the building. She stated that when he pushed the doors open it would set off the alarm and the staff would know that he was going outside. She led surveyor to the resident and stated that he was allowed to self-propel outside around the building without supervision or assistance. She left the surveyor and resident outside after observing him in that area. Observation of Resident #1 on 11/25/2025 at 4:15PM revealed he was alone outside the facility on the left side of the building, self-propelling in his wheelchair passed a section of broken caution tape. There was a strip of pavement approximately a foot wide, missing with exposed dirt and rocks that was below the level of the pavement. The broken, yellow caution tape was in front of the first strip of missing pavement. In front of Resident #1 was another strip of missing pavement that was below the level of the pavement. He was observed pushing himself over the second area without assistance or supervision from staff. There was caution tape on one side of the breaks in pavement only. The facility was directly adjacent to a busy, 4 lane highway with a paved, uneven driveway leading to the road. In an interview with Resident #1 on 11/25/2025