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	04/23/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 3 of 8 residents (Resident #17, Resident #52 and Resident # 58) reviewed for care plans.1. The facility failed to develop and implement Resident # 17 and Resident #52's care plan to reflect Activity Plans and Interventions.2.The facility failed to develop and implement Resident #52's care plan to reflect ADLs and Activity Plans and interventions.3. The facility failed to develop and implement Resident #58 care plan to reflect ADLs.This failure could place residents at risk of not having their needs met to attain their highest practicable well-being.Findings include: 1.Record review of Resident #17's face sheet, dated 04/22/2026, reflected a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included senile degeneration of brain, not elsewhere classified (a progressive decline of memory loss and confusion associated with aging but it is not caused by specific diseases like Alzheimer's- irreversible brain disorder that slowly destroys memory, thinking skill, and eventually the ability to perform daily tasks- or vascular dementia - a decline in thinking, and memory caused by conditions that damage blood vessels in the brain, reducing or blocking blood flow and oxygen), polyneuropathy (chronic disorder causes widespread of numbness, tingling, burning pain, and muscle weakness, typically staring in the hands and feet before potentially affecting other areas), and major depressive disorder (a common but serious mental health condition characterized by a persistent feeling of sadness).Record review of Resident #17's admission MDS Assessment, dated 02/14/2026 reflected Resident #17 had a BIMS score of 6 which indicated her cognition was severely impaired. She was assessed of feeling down, depressed, or hopeless. Resident #17 activity preferences was the following : Have books, newspaper, and magazines to readListening to favorite musicDo things in with groups of peopleDo favorite activitiesGo outside to get fresh air when the weather was goodParticipate in religious services or practices.Record review of Resident #17's Comprehensive Care Plan, dated 02/23/2026, reflected Resident # 17 did not have an activity care plan related to her activity preferences and abilities to participate in activity programming. 2. Record review of Resident #52's face sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), major depressive disorder (a common but serious mental health condition characterized by a persistent feeling of sadness), and anxiety disorder (a group of treatable mental health conditions characterized by excessive , persistent, and uncontrollable fear, worry, or dread that interferes with daily activities).Record review of Resident #52's Annual MDS Assessment, dated 08/09/2025, reflected Resident #52 had a BIMS score of 3 indicating his cognition was severely impaired. The following activities were very important to Resident #52:Keeping up with the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	newsDoing things in groups of peopleDoing favorite activitiesParticipating in religious services or practicesListening to favorite music.Record review of Resident #52's Quarterly MDS Assessment, dated 03/02/2026, reflected Resident #52 had a BIMS score of 4 indicating his cognition was severely impaired. Record review of Resident #52's Comprehensive Care Plan, dated 03/10/2026, reflected Resident #52 did not have an ADL and activity care plan related to his activity preferences and abilities to participate in activity programming3.Record review of Resident #58's face sheet, dated 04/22/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), muscle weakness (a feeling or objective observation that reduced effort, such as attempting to lift or move, fails to produce normal muscle contraction), need for assistance with personal care (requiring hands-on support with activity of daily living due to age, disability, illness, or injury), and lack of coordination (inability to manage precise, smooth, and voluntary muscle movements causing difficulty with daily activities such as : walking, writing, or grasping objects).Record review of Resident #58's Quarterly MDS Assessment, dated 02/11/2026, reflected Resident #58 was rarely/ never understood. She had poor short- and long-term memory recall. Resident #58's decision making ability was severely impaired. She required substantial / maximal assistance (helper does more than half the effort) with showers. Resident #58 was dependent on staff with the following ADLs:Personal HygieneUpper and lower body dressingToileting HygieneRecord review of Resident #58's Comprehensive Care Plan, dated 02/25/2026, reflected Resident #58's ADL's was not documented on the comprehensive care plan.Interview on 04/21/2026 at 11:30 am the Activity Director stated Activity Assistant A planned all activities on the secure unit. She stated all activities programs was expected to be on each resident's care plans. The Activity Director stated it was very important for the residents Activity preferences to be documented on care plan and if they were not capable of doing certain things in activities, they also needed to be care planned. She stated Activity Assistant A was to relate residents activity preferences and her plan for the resident to the MDS Coordinator to enter the information on the care plans. The Activity Director stated she was the Activity Assistant A's supervisor, and she had no explanation of why activity care plans for Resident #12, Resident #52, and Resident #58 were not on their comprehensive care plan. The activity director did not respond to any further questions about the care plan process of how activities were to ensure activity preferences and plan for the next quarter was not on their comprehensive care plan. Interview on 04/23/2026 at 9:15 am the MDS Coordinator LVN stated the Activity Director or Activity Assistant A was expected to discuss the activity plan for each resident with the interdisciplinary team. She stated it was very important for all residents Activity Plans was added to the care plan. She stated the staff would not know what type of interventions to do with a resident if a resident had behaviors, depression or anxiety if there was not an activity care plan. She stated if a resident was required to receive 1:1 activities it was very important for this to be documented on the resident's care plan for staff to know the resident responds more to 1:1 activities instead of group activities. She agreed Resident #17, Resident #52 and Resident #58 did not have an activity care plan. MDS Coordinator LVN stated it was the Activity Department responsibility to ensure they discuss activity plans during care plan meetings and add the activity plan to each resident's plan. She stated if a resident did not have their ADLs documented on the comprehensive care plan it would be difficult for the staff to have the knowledge of what type of care to give the resident. Interview on 04/23/2026 at 9:30 am Activity Assistant A stated she was instructed by the Activity Director to report any activities she planned for the residents to the MDS Coordinator to document on their care plan. Activity Assistant A stated Resident #17, Resident #52, and Resident #58 needed 1:1 activities every day and they needed to do their favorite activities. She stated she did not have a list of the resident's activity preferences. Activity Assistant A stated she knows what they (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were capable of doing and what they liked to do in activity programs. She stated it would be difficult for other staff to know the resident's preferences if it was not documented on the care plan. Activity Assistant A stated she does have her Activity Director Certificate. She stated she had been working at the facility approximately a year as Activity Assistant on the secure unit. Activity Assistant A stated she would need to review the care plan policy prior to answering any further questions about care plans for resident activities. Activity Assistant A did not answer any further questions about activity care plans prior to exit. Interview on 04/23/2026 at 10:14 am the Administrator stated a resident's activity preferences and interventions to meet a resident's quality of life through the activity programming was expected to be care planned. She stated if a resident needed 1:1 activities the other staff needed to know this information to prevent residents from becoming frustrated when staff may invite him to activity programs. The Administrator stated the Activity Director was responsible for discussing activities for each resident in the care plan with the interdisciplinary team and developing an activity care plan for the next quarter for each resident. She stated she was the Activity Director's supervisor and was responsible for monitoring the activity department. She stated all care was to be documented on the care plan including ADLs. She stated the staff refers to the care plans to know what the resident's physical, mental, and emotional needs. Record review of the facility's Care Plans, Comprehensive Person-Centered Policy, dated 2001, reflected A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: Includes measurable objectives and timeframes.Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Includes the resident's stated goals upon admission and desired outcomes.Builds on the resident's strengths; andReflects currently recognized standards of practice for problem areas and conditions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for three of eight residents (Resident # 17, Resident #52 and Resident #58) reviewed for ADL care.1. The facility failed to ensure Resident #17's facial hair was removed on 04/21/2026.2. The facility failed to ensure Resident #52 and Resident #58's nails were cleaned on 04/21/2026. These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included:1. Record review of Resident #17's face sheet, dated 04/22/2026, reflected a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included senile degeneration of brain, not elsewhere classified (a progressive decline of memory loss and confusion associated with aging but it is not caused by specific diseases like Alzheimer's- irreversible brain disorder that slowly destroys memory, thinking skill, and eventually the ability to perform daily tasks- or vascular dementia - a decline in thinking, and memory caused by conditions that damage blood vessels in the brain, reducing or blocking blood flow and oxygen), polyneuropathy (chronic disorder causes widespread of numbness, tingling, burning pain, and muscle weakness, typically staring in the hands and feet before potentially affecting other areas), and polyosteoarthritis, unspecified (a degenerative joint disease characterized by the breakdown of cartilage- a strong, flexible, and resilient connective tissue- in multiple joints, typically affecting three or more joint groups commonly in the hands, knees , and spine simultaneously. Record review of Resident #17's admission MDS Assessment, dated 02/14/2026 reflected Resident #17 had a BIMS score of 6 which indicated her cognition was severely impaired. Resident #17 required supervision or touching assistance with the following ADLS:Personal hygieneToileting hygieneShowersLower and upper body dressingTransfersBed mobility Record review of Resident #17's Comprehensive Care Plan, dated 02/23/2026, reflected Resident # 17 ADL's was not documented on the comprehensive care plan. Observation and interview on 04/21/2026 at 10:29 a.m. revealed Resident #17 was sitting in the dining room on the secured unit with other residents. Resident #17 had facial hair under her chin and on the side of her upper lip. She stated, I do not like hair on my face can you get it off for me. She stated no I did not when she was asked if she knew she had facial hair on her face. She stated if my mother sees it on my face, she will not let me go anywhere. I need to look my best when I go somewhere. 2.Record review of Resident #52's face sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), type 2 diabetes mellitus without complications (a person has the condition characterized by high blood sugar but has not developed related health issues like nerve, eye, or kidney damage), and muscle weakness (a feeling or objective observation that reduced effort, such as attempting to lift or move, fails to produce normal muscle contraction).Record review of Resident #52's Quarterly MDS Assessment, dated 03/02/2026, reflected Resident #52 had a BIMS score of 4 indicating his cognition was severely impaired. Resident #52 required supervision or touching assistance with the following ADLS:Personal hygieneToileting hygieneShowersLower and upper body dressingTransfersBed mobility Record review of Resident #52's Comprehensive Care Plan, dated 03/10/2026, reflected Resident #52's ADL's was not documented on the comprehensive care plan.Observation and interview on 04/21/2026 at 10:19 am revealed Resident # 52 was sitting in the dining room on the secure unit with other residents. Resident #52's fingernails on his left and right hand underneath his middle and ring fingernails had a blackish/brownish substance. Resident #52 did not want to answer any questions. Record review of Resident #58's face sheet, dated 04/22/2026, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), muscle weakness (a feeling or objective observation that reduced effort, such as attempting to lift or move, fails to produce normal muscle contraction), need for assistance with personal care (requiring hands-on support with activity of daily living due to age, disability, illness, or injury), and lack of coordination (inability to manage precise, smooth, and voluntary muscle movements causing difficulty with daily activities such as : walking, writing, or grasping objects).Record review of Resident #58's Quarterly MDS Assessment, dated 02/11/2026, reflected Resident #58 was rarely/ never understood. She had poor short- and long-term memory recall. Resident #58's decision making ability was severely impaired. She required substantial / maximal assistance (helper does more than half the effort) with showers. Resident #58 was dependent on staff with the following ADLs:Personal HygieneUpper and lower body dressingToileting HygieneRecord review of Resident #58's Comprehensive Care Plan, dated 02/25/2026, reflected Resident #58's ADLs was not documented on the comprehensive care plan. Observation on 04/21/2026 at 10:40 am revealed Resident # 58 was sitting in the dining room area with other residents. She was not interacting with other residents. Resident #58's fingernails on her right hand underneath her middle and ring fingernails had a blackish/brownish substance. Resident #58 was not interview able. In an interview on 04/23/2026 at 8:10 am, RN J stated the nurses were responsible for all residents with diagnosis of diabetes nail care such as trimming, cleaning, and filing. She stated the CNAs were responsible for all other residents' nail care. She stated nail care was usually completed on Sundays, as needed and during showers. RN J stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become ill, such as an infection in the stomach. She stated there was a possibility a resident may have nausea and vomiting. RN J stated if a resident refuses showers, nail care or any type of care the nurses document in the nurse's progress notes. She stated if a female had facial hair on their face, there was a possibility the resident may become embarrassed of her appearance and may not want to interact with other residents or leave their room. She stated facial hair on female residents was expected to be removed as needed and during showers. RN J stated she had been in-serviced on ADL care, and all staff was to report any nail issues with the resident to the nurse.In an interview on 04/23/2026 at 8:23 am, CNA D stated the nurses were responsible for diabetic nail care. She stated if a CNA observed any problems with a resident's nails the CNA was to report it to the nurse supervisor with any resident. CNA D stated the CNAs complete all nail care for residents without a diabetes diagnosis. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill, such as nausea and diarrhea. CNA D stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated all female residents' facial hair was checked on shower days and as needed. She stated if a female had facial hair the resident may feel humiliated if other people made comments to them about having facial hair. CNA D stated anytime a resident refused any type of care she reported it to the charge nurse and the charge nurse would document it in the resident's medical record. She stated she was not aware of Resident # 58 or Resident #52 refusing nail care. She stated she had been in-service on nail care; however, she did not recall the date.In an interview on 04/10/2026 at 9:45 am, the Director of Nurses stated the CNAs were responsible to clean and trim all residents' nails except for the residents with diabetes. She stated the nurses were responsible for nail care for diabetic residents. RN B stated the residents' nails were usually cleaned during shower days and on Sundays. She stated if a resident ingested blackish/brownish substance there was a potential the resident may experience vomiting or diarrhea. She stated it depended on the type of bacteria. The Director of Nurses stated she expected (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nail care to be completed as needed and on shower days. She stated anytime there was an issue with nails the staff was to report it to the nurse supervisor. The Director of Nurses stated all female resident was not to have any facial hair unless that was their preference. She stated facial hair on all residents including female residents was to be checked on shower days and as needed. The Director of nurses stated any refusal of care would be documented on the resident's care plan. Record review of the facility's policy on Nail Care, 2001, reflected Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). 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. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an ongoing activity 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 3 (Resident #17, Resident #52 and Resident #58) of 8 residents reviewed for activities. The facility failed to provide activities for Resident #17, Resident #52 and Resident #58 to meet their psycho-social and mental needs for the entire month of March and April of 2026. This failure could place residents at risks of boredom, depression, behavior, diminished quality of life and decreased cognitive function. Findings include: Record review of Resident #17's face sheet, dated 04/22/2026, reflected a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included senile degeneration of brain, not elsewhere classified (a progressive decline of memory loss and confusion associated with aging but it is not caused by specific diseases like Alzheimer's- irreversible brain disorder that slowly destroys memory, thinking skill, and eventually the ability to perform daily tasks- or vascular dementia - a decline in thinking, and memory caused by conditions that damage blood vessels in the brain, reducing or blocking blood flow and oxygen), polyneuropathy (chronic disorder causes widespread of numbness, tingling, burning pain, and muscle weakness, typically staring in the hands and feet before potentially affecting other areas), and major depressive disorder (a common but serious mental health condition characterized by a persistent feeling of sadness). Record review of Resident #17's admission MDS Assessment, dated 02/14/2026 reflected Resident #17 had a BIMS score of 6 indicated her cognition was severely impaired. She was assessed of feeling down, depressed, or hopeless. Resident #17 activity preferences was the following : Have books, newspaper, and magazines to readListening to favorite musicDo things in with groups of peopleDo favorite activitiesGo outside to get fresh air when the weather was goodParticipate in religious services or practices.Record review of Resident #17's Comprehensive Care Plan, dated 02/23/2026, reflected Resident # 17 did not have an activity care plan related to her activity preferences and abilities to participate in activity programming.Record Review of Activity Participation records reflected Resident #17 did not receive activities on the following days in March 2026:3/1/20263/7/20263/8/20263/12/20263/14/20263/15/20263/18/2026 thru 3/31/2026Record review of the Activity Participation records reflected Resident #17 did not receive activities on the following days in April 2026:4/1/20264/5/20264/9/20264/11/20264/14/2025 thru 4/20/2026Observation on 04/21/2026 at 10:00 a.m. the Activity Assistant was sitting against the wall away from the residents who were sitting at a long table. She had a card table in front of her and was documenting on March 2026 and first week of April 2026 participation records. She did not move from that area to assist residents with their activities they had in front of them. She did not cue the residents or give them the appropriate activity items to complete the activity tasks.Observation and interview on 04/21/2026 at 10:29 a.m. revealed Resident #17 was sitting in the dining room on the secured unit with other residents. She had a plastic activity item sitting in front of her. The activity item had 3 lines across of small holes. Resident #17 stated what is this and she pointed to the activity item. She stated I don't know what to do. What do you think I am to do with it (she pointed to the activity item. There were not any objects to place in the holes, and she was frustrated with not knowing what to do with the activity item. She crossed her hands and stated, I don't know what to do. Resident #17 would sigh and her jaw was clenched. Observation and interview on 04/21/2026 at 10:35 am the Activity Assistant A continued to sit against the wall away from the residents sitting at the long table. Activity Assistant A stated, I did not know the residents needed assistance and or did not have all the items needed to do an activity. She stated I am the one gave the residents the activity items and thought they knew what to do with them. She stated all the residents does receive 1:1 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visits every day. She stated she does activities with the residents individually every day. Activity Assistant A stated she worked Monday through Friday and was not at the facility on the weekends. She stated she was working on participation records for March and some for April. Activity Assistant A stated she usually knows what all the residents does every day and knew their routines and could remember what each resident did for the month of March 2026. She stated she was expected to document on participation records when the activity occurs, but she did not always do that due to not having enough time. She stated she did not put on the participation records late entry, and she did not know anything about documenting late entries. Activity Assistant A stated only nurses documents late entries. She stated she did not have participation records every day. Activity Assistant A stated she does not have any proof the residents received activities every day in March 2026 and April 2026. Record review of Resident #52's face sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), major depressive disorder (a common but serious mental health condition characterized by a persistent feeling of sadness), and anxiety disorder (a group of treatable mental health conditions characterized by excessive , persistent, and uncontrollable fear, worry, or dread that interferes with daily activities).Record review of Resident #52's Annual MDS Assessment, dated 08/09/2025, reflected Resident #52 had a BIMS score of 3 indicating his cognition was severely impaired. The following activities were very important to Resident #52:Keeping up with the newsDoing things in groups of peopleDoing favorite activitiesParticipating in religious services or practiceListening to favorite music. Record review of Resident #52's Quarterly MDS Assessment, dated 03/02/2026, reflected Resident #52 had a BIMS score of 4 indicating his cognition was severely impaired. Record review of Resident #52's Comprehensive Care Plan, dated 03/10/2026, reflected Resident #52 did not have an activity care plan related to his activity preferences and abilities to participate in activity programming.Record Review of Activity Participation records reflected Resident #52 did not receive activities on the following days in March 2026:3/1/20263/7/20263/8/20263/12/20263/14/20263/15/20263/18/2026 thru 3/31/2026Record review of the Activity Participation records reflected Resident #17 did not receive activities on the following days in April 2026:4/1/20264/5/20264/9/20264/11/20264/14/2025 thru 4/20/2026Observation and interview on 04/21/2026 at 10:19 am revealed Resident # 52 was sitting in the dining room on the secure unit with other residents. He was listening to music. Resident #52 did not answer any questions about his activities. Resident #52 lowered his head looking toward the floor during conversation. He had a sad expression inner eyebrows pulling up and together, and downturned mouth.Record review of Resident #58's face sheet, dated 04/22/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), anxiety disorder (a group of treatable mental health conditions characterized by excessive , persistent, and uncontrollable fear, worry, or dread that interferes with daily activities), and cognitive- mental processes involved in gaining knowledge and comprehensive, including thinking, knowing, remembering, and problem-solving- communication deficit (a communication impairment resulting from underlying cognitive issues such as: memory, attention, or execution function deficits- rather than a primary language or speech problem).Record review of Resident #58's Annual MDS Assessment, dated 05/11/2026, reflected resident was rarely/never understood. She had poor short- and long-term memory recall. Resident #58's decision making ability was severely impaired.Record review of Resident #58's Quarterly MDS Assessment, dated 02/11/2026, reflected Resident #58 was (continued on next page)

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	04/23/2026

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rarely/ never understood. She had poor short- and long-term memory recall. Resident #58's decision making ability was severely impaired. Resident #58's favorite activities are the following:Listening to music.Being around animals or petsDoing things in groups of people.Participating in favorite activities.Spending time outdoors.Participating in religious activities or practices.Record review of Resident #58's Comprehensive Care Plan, dated 02/25/2026, reflected Resident #58's activity plan , preferences and abilities to participate in activities was not documented on the comprehensive care plan. Resident #58 was at risk for falls related to confusion, impaired mobility and incontinence. Intervention: Encourage Resident #58 to participate in activities to increase strength and mobility. Observation on 04/21/2026 at 10:40 am revealed Resident # 58 was sitting in the dining room area with other residents. She was not interacting with other residents. Resident #58 had a worried expression on her face. She had facial muscle tension especially on her forehead. Resident #58 was not interview able. Interview on 04/21/2026 at 11:30 am the Activity Director stated Activity Assistant A planned all activities on the secure unit. She stated Activity Assistant A was responsible for the participation records for all residents on the secured unit. The Activity Director stated she expected participation records to be completed immediately after each activity program. She stated she was the Activity Assistant A's supervisor. The Activity Director stated if the activities were not documented on the participation records the activity did not occur with the residents. She stated the only proof to show activities was completed with residents was by the participation document. The Activity Director stated back dating participation records was not allowed. She stated if a resident had a diagnosis of depression, anxiety or any type of dementia and was not receiving activities there was a possibility the resident may become more depressed, anxious, develop behaviors and have a decline in their memory. The Activity Director stated she tried to monitor participation records on the secure unit but sometimes she was so busy it was difficult to complete everything she needed to do in a day. She stated all activities programs was expected to be on each resident's care plans. The Activity Director stated it was very important for the residents Activity preferences to be documented on care plan and if they were not capable of doing certain things in activities, they also needed to be care planned. She stated Activity Assistant A was to relate residents activity preferences and her plan for the resident to the MDS Coordinator to enter the information on the care plans. Surveyor requested activity calendars for the secured unit from the Activity Director for the months of February 2026, March 2026, and April 2026. These calendars were not provided prior to exit.Interview on 04/23/2026 at 9:30 am Activity Assistant A stated she was expected to document on participation records when any activity occurs on the secured unit. She stated if a resident had a diagnosis of depression, anxiety, or dementia and the resident was not receiving activities there was a possibility the resident may have an episode of depression, anxiety and their mental status may decline. She stated it did affect their life if they did not have any activities. Activity Assistant A Stated Resident #17, Resident #52, and Resident #58 needed 1:1 activity every day and they needed to do their favorite activities. She stated she did not have a list of the residents activity preferences. Activity Assistant A stated she knows what they were capable of doing and what they liked to do in activity programs. She stated it would be difficult for other staff to know the residents preferences if it was not documented on the care plan. Activity Assistant A stated she does have her Activity Director Certificate. She stated she had been working at the facility approximately a year as Activity Assistant on the secure unit. She stated when residents were doing an activity she needed to sit with them and assist them with activities. Activity Assistant A stated she also needed to ensure the residents had all the activity items they needed to do any type of activity. She stated she did have a job description. Surveyor requested January 2026, February 2026, March 2026, and April 2026 calendars. They were not provided prior to exit.Interview on 04/23/2026 at 10:14 a.m. the Administrator stated she expected a variety of activities to be provided for all residents. She stated each resident's activity preference needed to be assessed, and each resident's activity was expected to be planned according to their activity preferences. She stated activities such as independent, in-room, and/or group (continued on next page)

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	675101	A. Building B. Wing	04/23/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities were to be documented on participation records. The Administrator stated she expected all residents to be interviewed, and their activity preferences updated and all care plans to be revised to reflect each resident's activity preferences. She stated if a resident was not receiving activities there was potential a resident would have a decline in their cognition, mental status, physical status and quality of life. She stated a resident with a history of depression may become depressed and isolate themselves in their rooms. The Administrator stated the Activity Director and Activity Assistant were responsible for the activity programming and documentation of all activities department including participation records. She stated she was the Activity Director's supervisor. Record review of the Activity Director's personnel file reflected Activity Director had completed Directing Activities in Long Term Care Environment. The certificate does not expire.Record review of Activity Assistant A personnel file reflected she had completed activity training and had received her certificate on 04/29/2025. Record review of Activity Participation, group and in- room activities, dated 12/5/2025, reflected Activity Director received this in-service.Record review of the facility policy on Activity Programming, dated 2011, reflected The Activity Director and staff will provide for ongoing activity programs. Programs will be geared to maintain functional ADLS, provide social interaction and, as the same time, protect residents from environmental over stimulation. Those who cannot participate in group settings are provided with individual programming. Inability to participate could include those who refuse to participate in activities, those who are in isolation or physician ordered bed rest. Record review of the facility's policy on Activity Programs, dated 2001, reflected Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. Policy Interpretation and Implementation included:The activities program is provided to support the well-being of residents and to encourage both independence and community interaction.Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.The activities program is ongoing and included facility -organized group activities, independent individual activities and assisted individual activities.Activities are considered any endeavor, other than ADLs, in which the resident participated, that is intended to enhance his or her sense of well-being and to promote physical, cognitive or emotional health.Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs.Activities are scheduled 7 (seven) day a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs.Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity programs include activities that promote:self-esteem;comfort;pleasure;education;creativity;success; andindependence.All activities are documented in resident's medical record.Activities participation for each residents is approved by the attending physician based on information in the resident's comprehensive assessment.Individualized and group activities are provided that:reflect the schedules, choices and rights of the residents;are offered at hours convenient to the residents, including evenings, holidays and weekends;reflect the cultural and religious interests, hobbies, life experiences and personal preferences of the residents;appeal to mean and women, as well as those of various age groups residing in the facility and;incorporate family, visitor and resident ideas of desired appropriate activities.

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	675101	A. Building B. Wing	04/23/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to ensure drugs used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (Resident #36) out of 8 residents reviewed for medications. The facility failed to update Resident #36's medication label for hydrocodone-acetaminophen 5-325 mg tablet to reflect a change in the frequency of the administration of the medication. This failure could have placed residents at risk for a medication error such as not receiving adequate pain medication as ordered by the physician.Findings include: Review of Resident #36's face sheet dated 04/23/2026 revealed an [AGE] year-old male initially admitted to the facility on [DATE]. He was readmitted to the facility on [DATE] with the following diagnoses: encephalopathy (brain dysfunction, damage, or disease); cerebellar stroke syndrome (a serious neurological condition caused by interrupted blood flow or bleeding in the cerebellum, which is located at the back of the brain); pain; localized swelling, mass and lump, lower limb, bilateral; and cognitive communication deficit. Review of Resident #36's quarterly MDS dated [DATE] revealed Resident #36 had a BIMS score of 12 which indicated moderate cognitive impairment. Review of Resident #36's comprehensive care plan with an initiation date of 11/19/2025 revealed Resident #36 had acute/chronic pain with the following interventions: administer pain medications per order. Review of physician orders printed on 4/23/2026 revealed an order for HYDROcodone-Acetaminophen Oral Tablet 5-325 mg (Hydrocodone-acetaminophen) *Controlled Drug* Give 1 tablet by mouth three times a day with a start date of 03/29/2026 at 7 pm. Review of discontinued medication orders dated revealed HYDROcodone-Acetaminophen Oral Tablet 5-325 mg Give 1 tablet by mouth every 6 hours as needed for pain was started on 01/20/2026 at 6:15 pm and discontinued on 02/19/2026 at 7:32 pm. Review of the medication administration record dated 02/2026 revealed Hydrocodone-Acetaminophen 5-325 mg Give 1 tablet by mouth three times a day for pain with a start date of 02/20/2026 at 7 am and a discontinue date of 03/29/2026 at 4:43 pm. Observation and interview on 4/21/2026 at 10:18 am reflected Resident #36 was lying in bed and stated, this morning I ordered two pain pills at 7 am and didn't get them until just before you came. My left knee was hurting. Resident #36 rated his pain level at 10 which indicated severe pain on a scale of 1-10. In an interview on 4/23/2026 at 12:50 pm with ADON, she reported when the frequency of administration for a medication had changed, the medication aide and nurse can place a change of direction label on a medication. She stated, ultimately it would be the nurse's responsibility. She reported, the nurses give all prn [as needed] meds. She reported Resident #36 had an order for hydrocodone-acetaminophen 5-325 mg 1 tablet by mouth three times a day. She stated Resident #36 did not have a prn (as needed) order for hydrocodone-acetaminophen 5-325 mg. She reported a change of direction label should have been put on the medication card. She reported the prn order was discontinued. She denied that Resident #36 requests hydrocodone-acetaminophen 5-325 mg pain medication more often than it was ordered. She stated, [Resident #36] hasn't requested [as needed medication] from me since March. In an interview on 04/23/2026 at 12:47 pm with MA/CNA K, she reported ADON told her to put a change of direction label on Resident #36's hydrocodone-acetaminophen 5-325 mg medication which was in MA/CNA K's medication cart. She reported she told ADON to be honest that they were using the tablets from the hydrocodone-acetaminophen 5-325 mg prn medication card to administer Resident #36's scheduled hydrocodone-acetaminophen 5-325 mg medication. She reported she was aware Resident #36 received the medication three times a day, but someone who was not familiar with his medications could make a medication error if a change of direction was not on the label. In an interview on 04/23/2026 at 2:40 pm, RN J reported prn medications were given by the nurses. She (continued on next page)

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	675101	A. Building B. Wing	04/23/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported the medication aides give scheduled medications, but the nurses give the initial doses of the medications. She stated, there should be a card for scheduled and prn medications. She reported when the frequency of the medication is changed, and staff fails to place a change of direction label on the medication, then a medication error could occur. She reported staff may check the medication administration record or look at the computer screen to make sure it is the most current medication order. She stated, they can also go back to the orders and can see if the order had changed. She reported the nurse who received the order to change the frequency of administration for the medication would be responsible for placing a change of direction label is on the medication card. In an interview on 04/23/2026 at 6:20 pm with the DON, she reported the nurse who gets the order was responsible for putting a change of direction label on the medication card. She stated, it will flag the med aides in the electronic medical record.

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	675101	A. Building B. Wing	04/23/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation. The facility failed to ensure the Dietary Manager and Dietary Aide G used proper hand hygiene during food preparation. These failures could place residents who ate food from the kitchen at risk for foodborne illness.Findings included: Observation on 04/22/2026 at 8:15 am the Dietary Manager was wearing gloves in the kitchen. She was serving breakfast from the steam table. She picked up a red crate (used all fingers on both hands) stored near the steam table and moved it to a different area in the kitchen. The Dietary Manager returned to the steam table and did not change her gloves. Her thumb and forefinger on her right hand touched inside a divided plate and placed food on the area where she had touched inside the plate. She exited the steam table area of the kitchen and entered the back of the kitchen to obtain a pitcher. When she placed her hands on the pitcher from the shelf behind the kitchen her forefinger, middle finger and ring finger touched the shelf. The Dietary Manager returned to the steam table and did not change her gloves. She continued to serve food and placed oatmeal in a bowl. When she placed the oatmeal in a bowl her forefinger and middle finger on her right hand touched the oatmeal. The Dietary Manager continued to serve several more plates. She did remove her gloves and washed her hands and placed new gloves on her hands at the end of meal service. Interview on 04/22/2026 at 8:35 am the Dietary Manager stated she did not change her gloves when she was placing food on residents plates and bowls. She stated she did touch the crate, but she did not consider the crate contaminated. The Dietary Manger stated she did not recall if she touched the shelf when she grabbed the pitcher. She stated when she walked away from the steam table to another part of the kitchen to obtain pitcher this was not considered changing tasks in the kitchen. She stated the dietary staff did not sanitize the crates and she did not know how many people had touched the crates without washing their hands. The Dietary Manager stated her gloves were not contaminated and she was not required to change her gloves if she touched a shelf or a crate in the kitchen. She later stated after thinking about what she touched, she was expected to change her gloves and wash her hands prior to continuing serving breakfast. The Dietary Manager stated she did not change her gloves when she touched the crate or the shelf. She stated she had given and received in-services on hand hygiene. She stated she did not remember the date. Interview on 04/23/2026 at 10:14 am the Administrator stated she expected the dietary staff to change their gloves and wash hands in between tasks or whenever they touched any contaminated items. She stated if dietary staff did not change their gloves after touching anything considered contaminated, there was a potential a resident may become ill with an upset stomach such as nausea if a resident ingested any type of bacteria in their food. The Administrator stated the Dietary Manager was responsible to monitor the kitchen. She stated she was the Dietary Managers supervisor. Observation on 04/23/2026 at 10:47 am Dietary Aide G was cutting cheesecake and placing them on dessert plates on the food prep table located to the side of the steam table. She was wearing gloves. Dietary Aide G exited the food prep area and as she was walking to another area of the kitchen she touched her shirt in the left shoulder area with her right hand. Dietary Aide G returned to the food prep area and continued to cut the cheesecake and place the cake on dessert plates. She touched the side of two pieces of cheesecake with her right hand. She also touched inside 4 dessert plates and placed the cheesecake slices on these dessert plates. Interview on 04/23/2026 at 10:55 am Dietary Aide G stated if she touched her clothes it was a habit and did not realize she touched her top. She stated anytime she touched her clothes she was expected to change her gloves, wash her hands and place new gloves on her hands. She stated there was a possibility germs may have been on her gloves. Dietary Aide G stated there was a possibility germs may have transferred from her gloves to the cheesecake or plate. She stated if a resident ate the cheesecake and it had germs on the cheesecake (continued on next page)

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	675101	A. Building B. Wing	04/23/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident may become sick with upset stomach. Dietary Aide G stated she had been in-service on hand hygiene and changing her gloves. She stated she did not remember the date or time of the in-service. Record review of in-service on Hand Hygiene, dated 04/08/2026 reflected Dietary manager signed hand hygiene in-service record. Record review of in-service on hand washing and hand hygiene, dated 03/16/2026, reflected Dietary Aide G signed in-service record. The in-service was given by the Dietary Manager. Record review of the facility's Handwashing/ Hand Hygiene policy for nursing infection control, dated 01/2023, reflected The facility considers hand hygiene primary means to prevent the spread of infections. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.

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	675101	A. Building B. Wing	04/23/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for 2 residents (Resident #10, and Resident #24) of 8 residents observed for infection control practices. The facility failed to ensure RN J followed the hand hygiene policy procedures during wound care on 04/22/2026 for Resident #10 and Resident #24. This failure could place residents at risk for healthcare-associated cross-contamination and infections.Findings included: Review of Resident #10's face sheet dated 04/21/2026 revealed he is a [AGE] year-old male initially admitted to the facility on [DATE]. He was readmitted to the facility on [DATE] with the following diagnoses: Type 2 diabetes mellitus (a chronic condition where the body develops insulin resistance, which is a condition where body cells fail to respond effectively to insulin eventually leading to high blood sugar or type 2 diabetes); Stage 3 pressure ulcer of sacral region (a full thickness skin loss over the tailbone area where subcutaneous fat is visible, but muscle, tendon, or bone is not exposed); end stage renal disease (permanent kidney failure where function falls below 10-15%, requiring dialysis or transplant for survival); and dependence on renal dialysis (chronic, ongoing dependence on dialysis [life-sustaining treatment for kidney failure, filtering water and excess fluid from the blood when kidneys can no longer function]). Review of Resident #10's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 5 which indicated severe cognitive impairment. Review of Resident #10's care plan with an initiation date of 12/18/2025 revealed he is on enhanced barrier precautions. Enhanced barrier precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds). An intervention with a revision date of 01/05/2026 revealed 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. An intervention with an initiation date of 12/18/2025 revealed staff are to wash hands or use alcohol-based gel when entering and exiting the resident room. Observation on 04/22/2026 at 9:41 am reflected RN J failed to clean Resident #10's bedside table prior to placing the wound care supplies onto it. She began wound care on Resident #10's left lateral great toe wound. When she was done, she removed her gloves and gown. She failed to perform hand hygiene. She left the room to get more wound care supplies. When she returned, she failed to perform hand hygiene prior to putting on a new gown and a new pair of gloves. She performed wound care to Resident #10's right medial foot. She changed her gloves and failed to perform hand hygiene. Further observations were made of the complete wound care process for Resident #10, and no other concerns were identified. Review of Resident #24's face sheet dated 4/23/2026 revealed he is a [AGE] year-old male initially admitted to the facility on [DATE]. He was readmitted to the facility on [DATE] with the following diagnoses: peripheral vascular disease (a slow, progressive circulation disorder involving blood vessel blockage or narrowing outside the heart/brain, often causing reduced blood flow to legs, arms, or organs); open wound to his right foot; and non-pressure chronic ulcer (long-lasting skin breaks caused by underlying conditions like poor circulation, diabetes (a chronic condition causing high blood sugar due to insufficient insulin production or ineffective use of insulin), or infection rather than pressure) of other part of left foot [excluding heel/midfoot). Review of Resident #24's annual MDS assessment dated [DATE] revealed he had a BIMS score of 3 which indicated severe cognitive impairment. Review of Resident #24's care plan with an initiation date of 12/18/2025 revealed he is on enhanced barrier precautions. Enhanced barrier precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with wounds). An intervention revealed 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. An intervention with an initiation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date of 12/18/2025 revealed staff are to wash hands or use alcohol-based gel when entering and exiting the resident room. Observation on 04/22/2026 at 10:16 am reflected RN J failed to perform hand hygiene after doing wound care on Resident #24s left heel wound and beginning wound care on his right lateral ankle. She failed to perform hand hygiene or change gloves after cleaning Resident #24's right lateral ankle wound. She proceeded to dress Resident #24's right lateral ankle wound. Once wound care was completed for Resident #24, she washed her hands in the sink with soap and water for less than 10 seconds. Further observations were made of the complete wound care process for Resident #10, and no other concerns were identified. In an interview on 04/23/2026 at 2:40 pm, RN J reported she has worked at the facility for about a month. She reported she cleaned the bedside table prior to performing wound care for Resident #10. She stated, once I remove the old dressing, I change dirty gloves to clean gloves, do the wound care, and put the patient back the way they were. She stated, if the old [gloves were contaminated, I would put on new clean gloves. She stated, I try to wash my hands rather than using sanitizer. My hands don't tolerate it. It tears up my skin really bad, and it gets sticky. She agreed that she should perform hand hygiene after removing her gloves prior to moving from cleaning a dirty area to working on a clean area on the resident. She reported residents could get an infection. She reported she received orientation training. She stated, I still have [trainings] due. I don't think I did any. She stated, I followed a nurse for a couple of days.as we ran into things I would ask how they do things around here. She stated, I know what should be there and what should be done. I am learning how the facility does things. In an interview on 04/23/2026 at 6:20 pm, DON reported she was the infection control preventionist. She reported that she was responsible for monitoring infection control. She reported the nurse's and ADONs also monitor it. She reported staff need to take their gloves off and wash their hands or use hand sanitizer prior to putting on new gloves. She stated, cross contamination is possible if they fail to perform hand hygiene between glove changes. Review of infection control and control committee policy with a revision date of 07/2016 revealed the infection prevention and control committee will oversee the infection prevention and control program and report to the infection prevention and control committee. The administrator will be responsible for oversight of the infection prevention and control program. The infection prevention and control committee assist in monitoring and assessing facility-wide environmental infection prevention and control practices. The infection control committee shall oversee training programs for all employees who may have the potential for exposure to blood, or to body fluids containing visible blood, during the course of their workday. Instructions will focus on identifying and using procedures related to the prevention of bloodborne illnesses, including but are not limited to: 1. disease transmission and prevention.3. standard and transmission-based precautions.5. types of personal protective equipment (i.e., gowns, gloves, masks) that are necessary when performing tasks that may involve exposure to blood/ body fluids,8. Procedures to follow when personal protective equipment is used.9. how personal protective equipment in the facility is to be used, decontaminated, and disposed of. Review of the handwashing/hand hygiene policy with a revision update of 01/2025 revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. The following are administrative practices to promote hand hygiene: 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol-based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility. 4. Personnel are educated regarding ways to prevent contact dermatitis and other skin irritation and provided with supplies that support healthy hand skin. A. Facility-supplied lotions are compatible with antiseptics and gloves. B. ABHRs, soaps and lotions are free of allergenic surfactants, preservatives, fragrances and dyes. Indications for hand hygiene: 1. Hand hygiene is indicated a. immediately before touching a resident; b. before performing an aseptic (techniques and environments free from disease-causing (continued on next page)

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	675101	A. Building B. Wing	04/23/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	microorganisms); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after the glove removal. 5. The use of gloves does not replace handwashing/hand hygiene. Washing hands: 1. Wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure each resident was treated with respect, dignity and care for 1 of 4 residents (Resident #10) observed for resident rights. RN J failed to ensure Resident # 10's privacy curtain was used or the door to his room was closed when RN J was repositioning Resident #10 in bed and did not ensure his buttocks was not exposed. This failure could place residents at risk of feeling embarrassed and diminish the resident's quality of life. Findings included:Record review of Resident #10's face sheet, dated 04/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of depression (a common but serious mental health condition characterized by a persistent feeling of sadness), anxiety disorder (a group of treatable mental health conditions characterized by excessive , persistent, and uncontrollable fear, worry, or dread that interferes with daily activities), and pressure ulcer of sacral region (a damaged area of skin and underlying tissue, ranging from red skin to a deep crater, located on the triangular bone at the base of the spine - sacrum).Record review of Resident #10's Quarterly MDS Assessment, dated 03/03/2026, reflected Resident #10 had a BIMS score of 5 indicating his cognition was severely impaired. He was assessed to have a pressure ulcer. Resident #10 was dependent on staff for the following ADLs:Upper and lower body dressing.Eating.Toileting hygiene.Personal hygieneResident #10 required substantial/maximal assistance (helper does more than half the effort) with the following:Rolling left and right when in bedSit to lying when in bedLying to sitting on side of bed Record review of Resident #10's Comprehensive Care Plan, revised on 03/25/2026, reflected Resident # 10 had a Stage 3 coccyx pressure ulcer. Interventions: follow orders for prevention/treatment of skin breakdown. Notify MD/RP of any worsening of wound. Observation on 04/21/2026 at 10:55 am revealed Resident #10's door was opened, and privacy curtain was not pulled when he was in bed and being repositioned by RN J while he was receiving x-ray. RN J moved Resident #10 toward the window and was holding him while his buttocks was exposed and could see an open area to his sacrum. Interview and observation on 04/21/2026 at 10:57 am CNA E stated Resident #10 was exposed and could see his buttocks and the pressure wound to his buttocks. CNA E stated anytime a resident was receiving care the privacy curtain was expected to be pulled and the door to the resident room to be closed. He stated this was a dignity issue and may humiliate a resident for their buttocks to be shown to anyone passing in the hallway. He stated he had been in-service on resident rights and dignity. He stated he did not remember the date of the in-service. CNA E did not enter the room to ask RN J to pull privacy curtain and did not close the door. CNA E walked toward the end of the hallway (100 hall) where Resident #10 resided. Observation on 04/21/2026 at 11:04 am RN J asked the person from the x-ray company to pull the privacy curtain the surveyor was in the hall. The lady from the x-ray company pulled Resident #10's privacy curtain.Interview on 04/21/2026 at 11:30 am RN J stated anytime care was given to a resident the privacy curtain was expected to be pulled and the door closed to the hallway. She stated Resident #10's buttocks was exposed and anyone passing in the hall would be able to view his buttocks. RN J stated this was a dignity issue and may cause embarrassment or humiliation to Resident #10. She stated she did not know if she would have told the lady from the X-ray department to close the privacy curtain if she had not seen surveyor in the hallway. She stated she did not think about pulling the privacy curtain until she saw the surveyor. RN J stated she had been in-serviced on resident rights and knew this was a resident right to provide privacy during any type of care to a resident. She did not recall the date when she received resident rights in-service or dignity in-services. Interview on 04/21/2026 at 12:05 pm Resident #10 stated he did not want his bottom to be where other people could see it (referring from the hallway). He stated it wasn't nice for people to see him naked in the hall. Resident #10 stated he did not want to talk anymore.Interview with the Administrator on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/23/2026 at 1:40 p.m., she stated in-services had been given to all staff regarding dignity and resident rights. She stated she did not recall the date of the last in-service. The Administrator stated it was a resident right to preserve the resident's dignity. She stated RN J was expected to pull the privacy curtain and close the door to Resident #10's room prior to repositioning him. The Administrator stated all staff was responsible to ensure Resident Rights are being followed including dignity. She stated if a resident was exposed there was a possibility the resident may become embarrassed, feel humiliated or can become upset by other people in the hall observing their private area. Record Review of the Facility's Policy on Dignity, dated February 2021, reflected Each resident shall be care for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Policy Interpretation and Implementation include the following:Residents are treated with dignity and respect at all times.The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay.Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record reviews the facility failed to ensure the resident environment remained as free of accident hazards as is possible for one of two housekeeping carts (Housekeeping Cart #1) reviewed for hazards.The facility failed to ensure Housekeeping Cart #1, with chemicals inside the compartments, was locked when unsupervised. This failure could place residents at risk for injuries, illness, and hospitalization. Findings included:Observation on 04/21/2026 at 9:30 am revealed Housekeeping Cart #1 was located in the dining room. The compartment where chemicals were stored was not locked. The compartment had glass cleaner, disinfectant cleaner, tub and tile cleaner, and bio waste degrader. Housekeeper H was not standing near the housekeeping cart, and no other staff was near the unlocked housekeeping cart. Housekeeper H was behind the wall in the dining room and was unable to view the housekeeping cart.During an interview on 04/21/2026 at 9:35 a.m., Housekeeper H stated the housekeeping cart was expected to be locked anytime housekeeper walked away from the cart. Housekeeper H stated she could not see Housekeeping Cart #1 from where she was standing behind the wall in the dining room. She stated there was a possibility that if a resident drank some of the chemicals the resident may become sick with stomach issues or have an allergic reaction. She stated it was possible a resident may need to be evaluated at the hospital. She stated she did have a key to the housekeeping cart, but it was difficult to lock the cart.Interview on 4/23/2026 at 10:14 a.m., the Administrator stated he expected the housekeeping cart to be locked at all times when the housekeeper was not obtaining an item from the housekeeping cart. The Administrator stated all housekeeping staff had been in-serviced on locking the housekeeping carts. The Administrator stated if a resident drank a chemical there was a possibility a resident may become ill with nausea and vomiting. She stated there was a possibility a resident may need to be transported to the emergency room for further evaluation. Interview on 04/23/2026 at 1:30 p.m., the Housekeeping Supervisor stated if a resident swallowed the chemical the nurse would not know what type of care to give the resident without knowing the name of the chemical. She stated all housekeeping carts were expected to be locked anytime the housekeeper was not standing in front of the cart. The Housekeeping Supervisor stated if a resident ingested some chemicals there was a potential for an allergic reaction, such as burning their throat, stomach and may need to be assessed at the hospital. She stated all housekeeping staff were in-serviced on locking housekeeping carts. She stated there was a possibility if a resident spilled chemical on their skin it may cause irritation to the skin. Review of the Facility's Safety and Supervision of Residents dated 2001, Our facility strives to make the environment as free from accident and hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Facility Oriented Approach to Safety:Our facility -oriented approach to safety addresses risks for groups of residents.Safety risks and environmental hazards are identified on an ongoing basis.Our individualized, resident -centered approach to safety addresses safety and accident hazards for individual needs.Resident Risks and Environmental Hazards1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These are risk factors and environmental hazards include the following: a. poison control.Record request via email on 04/22/2026 at 9:49 am and on 04/23/2026 at 11:29 am of storage of chemicals on housekeeping carts related to accidents and hazards was requested and not provided prior to exit.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure a resident with dementia received the necessary care and services to support the highest practicable level of physical, mental, and psychosocial well-being for 1 of 3 residents (Resident #2) reviewed for dementia care. The facility did not identify, document, or implement individualized person-centered interventions that were cognitively appropriate for Resident #2. There was no evidence that care planning addressed the resident's specific preferences, abilities, or need for engagement. This failure resulted in lack of dementia-focused care and placed the resident with dementia at risk for increased behavioral symptoms, boredom, and a decreased quality of life.Review of Resident #2's Face Sheet dated 04/21/2026 indicated Resident #2 was a [AGE] year-old female was admitted to the facility initially on 07/17/2025 and last admitted to facility on 03/06/2026 with multiple diagnosis to include hyperosmolality and hypernatremia (large quantity of body fluids are elevated and high sodium levels were in the blood),unspecified dementia(decline in memory and thinking skills), major depressive disorder(sadness loss of interest) anxiety(feelings of panic, fear, irritability) and hypothyroidism(thyroid gland does not produce enough thyroid hormone).Review of Resident #2s Quarterly MDS assessment dated [DATE] revealed that Resident #2 did not a have recorded BIMS score as it noted resident was unable to complete interview as resident was rarely/never understood. Staff Assessment for Mental Status indicated Resident #2 c ognitive skills were severely impaired. Review of Resident #2's comprehensive care plan dated 4/21/2026 included only two focus areas: Resident #2 had a DNR in place and she was at risk for falls related to balance problems.Review of Resident #2's psychiatric evaluation visit note dated 01/12/26, revealed Resident #2 was seen for moderate dementia with behavioral disturbances, delusional disorders, generalized anxiety disorder, major depressive disorder, moderate and primary insomnia. The evaluation further stated, Care Plan Recommendations: The plan of care was discussed with the DON and medication management reviewed.Utilize behavioral interventions to manage episodic behaviors(agitation/aggression), redirect as needed.Provide supportive encouragement to increase interaction to improve socialization.Staff will notify psychiatry services if resident begins to exhibit and signs of worsening mood, anxiety, confusion, or behaviors between visits.Observation and interview conducted 4/21/2026 at 1:09 PM, revealed Resident #2 yelling Oh God while in bed. She was unable to answer questions regarding whether she needed assistance or was she in pain.In an interview conducted 04/23/2026 at 2:10 PM with DON and RNC. They stated the correct care plans were in the miscellaneous section of the electronic health records. It was explained that the facility had been converting documents since October 2025 from their previous system to the current system. RNC provided a printed copy of Resident #2 comprehensive care plan. Resident #2 current care plan was reviewed by the surveyor, and it failed to include dementia as an area of focus and absence of individualized interventions to address resident's cognitive needs.In an interview conducted 04/23/2026 at 4:45 PM, the MDS Coordinator stated she was responsible for care plan entries and reported that the DON inputs information related to wounds. The MDS Coordinator stated she was unsure why dementia was not included on Resident #2's care plan and acknowledged that it should have been care planned, as the resident was followed by psychiatric services. The MDS Coordinator further stated that the potential effect of not including dementia on the care plan was that the resident may not receive appropriate care and services for dementia. She stated the care plan would be updated on the day of the interview.In an interview conducted 04/23/2026 at 4:53 PM, the RNC stated that dementia should be included on a resident's care plan when a diagnosis is present. She stated that it was important for staff to have this information care planned so they can understand how to appropriately care for the resident. The RNC further stated that failure to include dementia on (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care plan could result in staff not understanding the residents' needs and abilities. She indicated that this could lead to the resident not receiving appropriate care.In an interview conducted 04/23/2026 at 4:59 PM, the DON stated that care plans were discussed and reviewed during morning meetings and are updated through the MDS process on a quarterly basis. She stated that nursing staff complete a baseline care plan upon admission, and the MDS Coordinator updates the care plan with input from the Interdisciplinary Team. The DON stated that dementia was required to be included on the care plan when a resident has a diagnosis. She reported that the facility provides dementia-related training and in-service education, and that CNAs were trained in dementia care. The DON further stated she did not know why dementia was not included on Resident #2's care plan. She emphasized that it was important for dementia to be reflected on the care plan so staff are aware of appropriate interventions and can provide individualized care. The DON stated that failure to include dementia on the care plan could result in the resident not receiving the best possible individualized care. She further indicated that potential harm could occur if a resident was experiencing pain but was unable to effectively communicate their needs, and staff may not recognize or properly respond due to dementia-specific interventions not placed on the care plan.In an interview conducted 04/23/2026 at 5:22 PM, the Administrator stated that the MDS Coordinator was responsible for updating residents' care plans. She stated that dementia should be included on the care plan when a resident has a diagnosis. The Administrator reported that staff receive training on dementia care. She further stated that failure to include dementia on the care plan could negatively impact the resident's overall care. The Administrator stated her expectation was that the care plan be updated to accurately reflect the resident's diagnosis and care needs.Record review of the facility's policy titled; Dementia -clinical Protocol dated 2001 revised date November 2018 Treatment/Management1. For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life.2. Nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. Additionally, performance reviews will be conducted annually, and in-service education will be based on the results of the reviews.5. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise.a. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools).Monitoring and Follow-Up1. The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician/physician extender.2. The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors.Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered Policy, dated 2001, revision date March 2022 reflected: A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan:b.^^Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.