STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675124	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Gonzales	3428 Moulton Rd Gonzales, TX 78629

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 2 of 3 residents (Resident #1 and Resident #4) reviewed for dental services. The facility did not ensure Resident #1's physician was contacted for an order to withhold blood thinners prior to dental extractions on 5/19/26. The facility did not ensure Resident #4's physician was contacted for an order to withhold blood thinners prior to dental extractions on 5/19/26. This failure could place residents at risk of bleeding and diminished quality of life.Findings included: 1. Record review of Resident #1's Face Sheet, dated 6/16/26, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Cerebral Infarction (stroke - disrupted blood flow to the brain). Record review of Resident #1's Dental Treatment Note, dated 5/19/26, revealed: .tooth #4,28,29 extracted. Record review of Resident #1's quarterly MDS assessment, dated 6/8/26, revealed the resident had a BIMS score of 15, suggesting intact cognition. Record review of Resident #1's Order Summary Report, dated 6/16/26 revealed an order for Aspirin 81 MG, 1 tablet by mouth once a day, dated 4/7/25. Record review of Resident #1's May MAR revealed Aspirin 81 MG, 1 tablet by mouth once a day was administered on 5/19/26. During an interview on 6/16/26 at 1:15 pm, Resident #1 nodded yes when asked if he saw the dentist last month (May) and if he had teeth extracted. 2. Record review of Resident #4's Face Sheet, dated 6/16/26, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Cerebral Infarction (stroke - disrupted blood flow to the brain). Record review of Resident #4's quarterly MDS assessment, dated 5/13/26, revealed the resident had a BIMS score of 14, suggesting intact cognition. Record review of Resident #4's Dental Treatment Note, dated 5/19/26, revealed: .tooth #21,22,23,24 extracted. Record review of Resident #4's Order Summary Report, dated 6/16/26 revealed orders for Aspirin 81 MG, 1 tablet by mouth once a day, dated 6/12/25 and Xarelto 10 MG (used to prevent clotting) orally once a day, dated 3/31/25. Record review of Resident #4's May MAR revealed Aspirin 81 MG, 1 tablet by mouth once a day and Xarelto 10 MG orally once a day were administered on 5/19/26. Record review of the mobile dental services communication revealed: .List as of 4/27/2026.Date of Visit: 5/19/26.[Resident #1] Due For: Extraction(s) TX Planned.Begin full mouth extractions.blood thinners to be withheld is requested. [Resident #4] Due For: X-Rays Extractions(s).request physician withhold blood thinners. During an interview on 6/16/26 at 1:39 pm, Resident #4 said he saw the dentist about a month ago. Resident #4 further stated his doctor was supposed to be contacted about stopping his blood thinners. During a telephone interview on 6/16/26 at 1:49 pm, the Dental Services Rep said the mobile dental services did not give orders to hold blood thinners. The Dental Services Rep further stated they sent out a communication informing the facility they were going to be performing dental extractions, and the facility was responsible for contacting the residents' physician to see if he wanted to hold any medications. During an interview on 6/16/26 at 2:07 pm, CNA A confirmed Resident #1 and Resident #4 saw the dentist in May and had teeth extracted. CNA A further stated Resident #4 had continuous bleeding. CNA A said the day following Resident #4's extractions the bleeding had stopped. CNA A said Resident #1 had minimal bleeding after the extractions. Attempt to interview the MD on 6/16/26 at 2:49 pm was unsuccessful. Attempt (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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Avir at Gonzales	3428 Moulton Rd Gonzales, TX 78629

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to interview the NP on 6/16/26 at 2:52 pm was unsuccessful. During an interview on 6/16/26 at 3:01 pm, the ADON said the facility received email communications from the mobile dental services prior to appointments, but she did not pay close attention to them. The ADON further stated that she did not review or respond to emails from the mobile dental services. The ADON said that she did not know if there was a designated person that was responsible for responding to the emails. The ADON said that she remembered Resident #1 and Resident #4 had tooth extractions but did not remember when. During an interview on 6/16/26 at 3:13 pm, the DON said the facility's process, when communication was received from the mobile dental service, was to review the list of residents and confirm the appointments. The DON further stated if medication changes were required, like holding blood thinners, the provider was contacted to decide how to proceed and the nurses were notified of what needed to be done prior to the appointment. The DON said she or the ADON were responsible for contacting the physician and documenting the communication in the residents' progress notes. The DON said Resident #4 saw the dentist on 5/19/26 and had teeth extracted. The DON said Resident #4 bled more than normal on the day of the extractions because he was on blood thinners. The DON said Resident #1 also had teeth extracted on 5/19/26 but he did not have excessive bleeding. The DON said the physician was not contacted for orders to withhold the blood thinners due to a systemic breakdown. Record review of the facility's policy titled Dental Services, revised December 2016, revealed: . Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the current nurse staffing data for 1 of 1 facility, in that: The nurse staffing data upon entrance on 6/16/26 was dated 6/9/26. This deficient practice could place residents at risk by not providing adequate staffing information for the residents, staff, and visitors to ensure that resident care needs are met. Based on observation, interview, and record review, the facilityˆfailed toˆpost the current nurse staffing data for 1 of 1 facility, in that:ˆˆˆ ˆThe nurse staffing data upon entrance on 6/16/26 was dated 6/9/26.ˆ ˆˆThis deficient practice could place residents at risk of not receiving appropriate care by not providing adequate staffing information for the residents, staff, and visitors to ensure that resident care needs are met.ˆ ˆFindings included:ˆ ˆObservation on 6/16/26 at 11:04 am, revealed a posting detailing nurse staffing information for 6/16/26 was not available in the facility lobby. Further observation revealed that the Daily Nurse Staffing Report was dated 6/9/26. ˆDuring an interview on 6/16/26 at 5:28 pm, the DON said staffing should be posted every day. The DON further stated there was no reason why the daily posting was not current. The DON said she should have checked the posting every day, as she was responsible for ensuring the Daily Nurse Staffing Report was current. The DON further stated it was important to ensure the posting was current because the facility needed to ensure they had enough staff to care for the residents and if anyone came in, they could see that the facility had enough staff to care for loved ones. ˆRecord review of the facility's policy titled Posting Direct Care Staffing Numbers, revised August 2022, revealed: .Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents .