

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2025
NAME OF PROVIDER OR SUPPLIER  Avir at Fredericksburg		STREET ADDRESS, CITY, STATE, ZIP CODE  1117 S Adams St Fredericksburg, TX 78624	
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 0656  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.  (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 3 residents (Resident #1) reviewed for care plans: The facility failed to ensure Resident #1's comprehensive care plan was completed in a timely manner and included pain he experienced, code status, ADL functional status, bladder/bowel incontinence, cognitive loss, skin risk, diet orders, or psychotropic drug use. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included: Record review of Resident #1's admission record, dated 12/04/25, revealed a [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses including secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes (cancer cells that have spread to the lymph nodes located in the abdominal area), secondary malignant neoplasm of bone (bone cancer), chronic obstructive pulmonary disease (lung and airway disease that restrict breathing), drug introduced constipation, nicotine dependence, depression, anxiety disorder, other chronic pain, esophagitis unspecified without bleeding (swelling and irritation of the tissue that line of the esophagus), abnormal weight loss, adverse effect of other opioids, and malignant neoplasm of prostate (prostate cancer). The advance directive section showed he was DNR status. Record review of Resident #1's admission MDS assessment, dated 10/11/25, revealed Resident #1's cognition was severely impaired. Section H revealed he was occasionally incontinent with bladder. Section J revealed the resident received pain medication and used tobacco. Section M revealed the resident was at risk for pressure ulcers. Section N revealed he was taking antianxiety, diuretic, opioid, and anticonvulsant. Section O revealed the resident received hospice services. Section V Care Area Assessment (CAA) summary revealed cognitive loss/dementia, visual function, communication, ADL functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Pressure Ulcer, Psychotropic Drug Use, and Pain were triggered. Record review of Resident #1's Comprehensive Care Plan, initiated on 10/09/25, last revised on 10/12/25, only contained an area for fall risk and functional discharge goals. No other focus areas or interventions were listed on the comprehensive care plan. Record review of Resident #1's physician order summary, dated 12/04/25, revealed orders for: -Code status DNR, start date 9/30/25 -Nasal Cannula 2-5 L as needed, start date 9/29/25, no end date. -buspirone tablet (mild antianxiety medication) 15 mg, start date 9/30/25, and no end date. -clonazepam (antianxiety medication) tablet 1 mg, start date 9/30/25, and no end date. -duloxetine (antidepressant medication) 30 mg tablet, start date 11/27/25, end no end date. -Gabapentin (anticonvulsant, can treat seizures or nerve pain) 300 mg capsule, start date 9/30/25, and no end date. - Ipratropium-Albuterol Inhalation Solution (combination medication used to treat and prevent symptoms of chronic COPD) 0.5-2.5 (3)MG/3ML (Ipratropium-Albuterol) 1 inhalation inhale orally every 4 hours as needed for SHORTNESS OF BREATH, start date 9/29/25, and no end date. -Lasix (diuretic) oral tablet 40 mg, give 1 tablet by mouth in the morning for edema, with start date of 11/26/25, and no end date. -Methadone hcl (pain medication) oral tablet 10 mg, give 10 mg by mouth at bedtime for pain management, start date 10/22/25, and no end date. -Morphine sulfate oral solution (pain medication) 20 mg/5mL give 1 mL by mouth every hour as needed for pain, with a start date of 10/06/25, and no end date. During an interview on 12/04/25 at 12:13 p.m. the DON stated he started at the facility as a floor staff nurse in September and his first day as DON was 12/04/25. The DON stated he was being trained on how to complete care plans by the regional MDS but was not yet trained. The DON stated the previous DON was responsible for the care plans and he was now responsible for the care plans. The DON stated it was important that the resident's comprehensive care plan was completed to manage his care and to implement and meet the resident's goals. Record review of the facility's policy, titled Care Plans, Comprehensive Person-Centered, dated 03/2022, stated Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising</p>		