

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Elkhart		STREET ADDRESS, CITY, STATE, ZIP CODE 214 Jones Rd Elkhart, TX 75839	
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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility for 15 out of 15 anonymous residents during a confidential meeting who were reviewed for resident rights. The facility failed to ensure the resident council grievances were promptly resolved. This failure could place residents at risk for a decreased quality of life. The findings included: Record review of Resident council minutes dated 5/21/2026 indicated new business: need the Activity Director back and off the floor because she makes them happy. Staff in attendance was the Activity Director. Record review of Resident council minutes dated 4/16/2026 indicated new business: they run out of tea, having water for all meals, running out of everything; need more money for activities. Residents want meal of the month again. Old business: running out of milk on Mondays, never have juice, no salt, still no alternates. running out of grease and they cannot make fries. Residents said it is not the dietary staff it's the company. Want to know if they can start making meals of the month again. Staff members in attendance were the Activity Director. [sic] During an interview on 6/1/2026 at 2:00 pm, the Activity Director said she was assigned to work as a nurse aide that day for 2 of 5 halls in the facility. She said for the past 2 weeks she had been working on the halls as a nurse aide and had not been able to help with activities. She said if the facility was short a nurse aide when someone called in to work, then they would pull her to work on the floor to cover the shift. During a confidential interview on an undisclosed date and time, there were 15 Anonymous residents who attended the confidential interview. All 15 Anonymous residents indicated they felt their grievances were not being considered and were not given any resolutions. The residents complained about activities and wanted the Activity Director back to assist with activities. They said she had been working on the floor for the past 2 months, but she was not to blame, all fault was on the facility. They said they talked about the meal of the month and were told they did not have the budget for it but were told it would return next month (July 2026). The residents had concerns about having the same menu over and over and were tired of macaroni. They said the facility told them they did not have the funds for the food and were concerned that a new company took over and the facility has gone to shit and things have gotten worse. They voiced concerns about being served meals on paper plates for over a month due to hot water concerns in the kitchen. They said activities such as bingo were called about four times a week, but it was called by the residents currently and some residents choose not to attend because they are not giving out any prizes which does not make it fun anymore. There were not any resolutions to the grievances or concerns when they notified the facility. During a follow up interview on 6/3/2026 at 10:17 am, the Activity Director said she had been the Activity Director for the facility since 2022. She said they had meetings once a month in the facility. She said the residents voiced concerns and she would take notes and put them on the minutes and would get the President of resident council to sign them and then would give 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

FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675217	If continuation sheet Page 1 of 17
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe, clean, and comfortable environment for residents for 4 of 8 residents (Resident #2, Resident #33, Resident #40, and Resident #44) observed for resident environment.1.The facility failed to ensure the room of Resident #2 and Resident #44 did not have a baseboard that was detached from the wall from 6/1/2026 to 6/3/2026. 2. The facility failed to ensure hot water was available in resident bathroom for Resident #33 on 6/1/26 and 6/2/26. 3. The facility failed to ensure the room of Resident #40 did not have a hole in the wall behind the door from 6/1/2026 to 6/3/2026. These failures could place residents at risk for an unsanitary and uncomfortable environment. Findings include:1.Record review of a face sheet for Resident #2 dated 6/3/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of COPD (a group of lung diseases that affect breathing), PVD (a conditions that causes decreased blood flow to the legs and feet), and vascular dementia (a decrease in blood flow in the brain that can lead to damaged brain tissue).Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated he had severe impairment in thinking with a BIMS score of 6. He used a wheelchair for mobility.Record review of a care plan for Resident #2 dated 12/9/2025 indicated he had impaired cognitive function/dementia or impaired thought processes related to prior CVA (stroke) and unaware of safety. Interventions included to encourage resident to ask for help or assistance.Record review of a face sheet for Resident #44 dated 6/3/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Parkinson's disease (a disorder that affects the nervous system that worsen over time that control many parts of the body) and Alzheimer's disease (a progressive disorder that affects memory, thinking, and behavior).Record review of a Quarterly MDS Assessment for Resident #44 dated 3/5/2026 indicated he was rarely/never understood with a BIMS score of 0 indicating severe cognitive impairment. He was dependent on staff for all ADLs.Record review of a care plan for Resident #44 dated 5/5/2026 indicated he was at risk of falls related to confusion. Interventions included to anticipate and meet the resident needs.During an observation on 6/1/2026 at 10:31 am, the room of Resident #2 and Resident #44 had a baseboard that was not attached to the wall that was approximately about a foot in length that was not attached. Resident #20 was in the room sitting in a wheelchair, but his speech was very difficult to understand. Resident #44 was not in the room.During an observation on 6/2/2026 at 8:40 am, the room of Resident #2 and Resident #44 still had the baseboard that was not attached to the wall. Neither resident was in the room at the time of the observation.During an observation on 6/3/2026 at 8:40 am, the room of Resident #2 and Resident #44 still had the baseboard that was not attached to the wall.2. Record review of a facility face sheet dated 6/2/26 for Resident #33 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of hepatic failure (liver failure).Record review of a quarterly MDS assessment dated [DATE] for Resident #33 indicated a BIMS score of 11, which indicated he had moderately impaired cognition. He was independent with personal and oral hygiene.Record review of a comprehensive care plan for Resident #33 indicated it did not address his ADL status.During an interview on 6/1/26 at 11:30 am Resident #33 said he did not have hot water in his bathroom sink.During an observation on 6/1/26 between 3:12 pm and 3:17 pm the water was turned on at bathroom sink for Resident #33. Hot water was allowed to run for 5 minutes, and water remained cold to touch.During an observation and interview on 6/2/26 between 10:52 am and 10:57 am hot water was turned on and ran in Resident #33's bathroom sink, and after (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	running for 5 minutes, water remained cold to touch. Resident #33 was in his room and said, It's always like that; I don't want to wash my hands in cold water.3. Record review of a face sheet for Resident #40 dated 6/3/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of hemiplegia affective left non dominant side (paralyzed on the left side), dementia (a decline in the mental abilities you need for daily living), and major depressive disorder (persistent sadness or loss of interest in doing things).Record review of a Quarterly MDS Assessment for Resident #40 dated 3/2/2026 indicated he had moderate impairment in thinking with a BIMS score of 12. During an observation and interview on 6/1/2026 at 10:46 am, Resident #40 was in bed awake. He said he had been at the facility for a while. There was a large hole in the wall behind the door.During an observation on 6/2/2026 at 8:44 am, Resident #40 was asleep in bed. The hole was still present on the wall behind his door.During an observation and interview on 6/3/2026 at 8:50 am, Resident #40 was in bed awake. He said he noticed the hole in the wall behind his door a while ago but was not sure how long it had been there. He said no one said anything to him about fixing it. He said it did not bother him one way or another.During an interview on 6/3/2026 at 8:52 am, HSK C said she had been employed at the facility for a year. She was cleaning on the hall of Resident #44, Resident #2 and Resident #40. She said she noticed the hole on the wall behind the door in Resident #40's room but forgot to report it and could not remember how long it had been there. She said she did report the detached baseboard in Resident #44 and Resident #2's room to her supervisor. She said she would not like living in a facility that was not repaired.During an interview on 6/3/2026 at 8:59 am, the HSK Supervisor said the issues in the rooms of Resident #44, Resident #2, and Resident #40 were reported to her by the housekeeping staff of areas that needed repair. She said when maintenance issues were reported to her by the staff she would enter them in TELS and it would go directly to the Maintenance Supervisor.During an interview on 6/3/2026 at 9:02 am, the Maintenance Supervisor said requests for repairs were reported to him verbally and through TELS. He said he was made aware of the baseboard in Resident #44 and Resident #2's room. He said the HSK Supervisor told him about the baseboard last Thursday (5/28/2026). He said he planned to repair the rooms that day (6/3/2026). He said in Resident #40's room he was aware of the hole in the wall that needed repair and he had the sheetrock to repair it. He said those issues were not reported in TELS. He said there could be risk of moisture coming from the wall that had the detached baseboard and could be a slip/trip hazard. He said the hole in the wall would not be pleasing to look at.During an interview on 6/3/26 at 9:40 am the Maintenance Director said sometimes the pilot light would get blown out on the water heater that supplied water to the resident room. He said he would check it. He said he would not want to wash his hands or brush his teeth with cold water.Record review of a TELS work order for the facility undated indicated no work orders for the rooms of Resident #44, Resident #2, and Resident #40.During an interview on 6/3/2026 at 2:10 pm, the Administrator said all staff were responsible for reporting maintenance requests and had access in TELS. She said TELS was a system they had in place to report maintenance issues that were reported to the Maintenance Supervisor. She said each resident in the facility was assigned a staff member that were supposed to check their rooms daily. She said she was not made aware that Resident #33 did not have hot water in his bathroom, nor was she aware the room of Resident #2 and Resident #44 had a baseboard that was detached from the wall; nor was she aware that Resident #40 had a hole in his wall. She said cold water would not feel good to someone's hands and the look in the rooms might feel uncomfortable to the residents if there were holes in the walls or baseboards that were not attached. Record review of a facility policy titled Homelike Environment dated February 2021 read: .Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .		

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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 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, mental and psychosocial needs that are identified in the comprehensive assessments for 6 of 12 residents reviewed for care plans. (Resident #23, Resident #24, Resident #26, Resident #31, Resident #33, and Resident #53.).1.The facility failed to include in Resident #23's care plan activities of daily living and transfer status. 2. The facility failed to include in Resident #24's care plan activities of daily living and transfer status. 3. The facility failed to include in Resident #26's care plan activities of daily living, urinary and bowel incontinence and his PASRR status. 4. The facility failed to include in Resident #31's care plan activities of daily living and transfer status. 5. The facility failed to include in Resident #33's care plan activities of daily living. 6. The facility failed to include in Resident #53's care plan activities of daily living and her urinary and bowel incontinence. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs.Findings included:1.Record review of a facility face sheet dated 6/2/26 for Resident #23 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right sided weakness and paralysis following a stroke).Record review of a quarterly MDS assessment dated [DATE] for Resident #23 indicated resident was rarely/never understood and had severely impaired cognition. He was dependent with transfers.Record review of a comprehensive care plan for Resident #23 indicated he did not have a care plan for ADLs addressing transfers.2.Record review of a facility face sheet dated 6/2/26 for Resident #24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of Alzheimer's disease.Record review of a comprehensive MDS assessment dated [DATE] for Resident #24 indicated he was rarely/never understood and had severe cognitive impairment. He was dependent for transfers.Record review of a comprehensive care plan for Resident #24 indicated it did not address ADL status or transfers.3.Record review of a Face Sheet for Resident #26 dated 6/3/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of autistic disorder (a condition related to brain development that impacts how a person perceives and socialized with others), hypertension (high blood pressure) and legal blindness (blind in both eyes).Record review of an admission MDS Assessment for Resident #26 dated 4/15/2026 indicated he was rarely/never understood with a BIMS score of 0. He was dependent on staff for personal hygiene and showering/bathing. He was frequently incontinent of urine/bowel.Record review of a care plan for Resident #26 indicated he admitted to the facility on [DATE], his care plan did not reflect his activities of daily living and the assistance he required from staff present; he did not have urinary/bowel incontinence on the care plan with interventions; it did not reflect his PASRR status.Record review of a PL1 screening for Resident #26 dated 4/2/2026 indicated he had an intellectual disability and a developmental disability.Record review of PE for Resident #26 dated 4/10/2026 indicated he was evaluated for his intellectual disability and developmental disability for PASRR services.4.Record review of a facility face sheet dated 6/2/26 for Resident #31 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of epilepsy (seizure disorder).Record review of a quarterly MDS assessment dated [DATE] for Resident #31 indicated a BIMS score of 6, which indicated she had severely impaired cognition. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She was dependent with transfers. Record review of a comprehensive care plan for Resident #31 indicated she did not have an ADL care plan. 5. Record review of a facility face sheet dated 6/2/26 for Resident #33 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of hepatic failure (liver failure). Record review of a quarterly MDS assessment dated [DATE] for Resident #33 indicated a BIMS score of 11, which indicated he had moderately impaired cognition. He was independent with personal and oral hygiene. Record review of a comprehensive care plan for Resident #33 indicated it did not address his ADL status. 6. Record review of a Face Sheet for Resident #53 dated 6/3/2026 indicated she was admitted to the facility on [DATE] and was [AGE] years old with diagnoses of malignant neoplasm of lung (lung cancer), hypertension (high blood pressure) and COPD (a group of breathing diseases that affect breathing). Record review of an admission MDS Assessment for Resident #53 dated 2/5/2026 indicated she had moderate impairment in thinking with a BIMS score of 12. She was dependent on staff for toileting hygiene, and substantial/maximal assistance was needed for showering/bathing. She was always incontinent of urine/bowel. Record review of a care plan for Resident #53 dated 1/31/2026 did not indicate a care plan for her activities of daily to indicate what type of assistance was needed along with urinary and bowel incontinence. During an interview on 6/2/2026 at 11:30 am, the Regional Reimbursement Consultant said that the care plans were triggered from the MDS assessment, but the previous MDS Coordinator was not going into the electronic system correctly to check the care areas that needed to be addressed on the care plan. She said in December 2025 the DON noticed the care plans were not comprehensive and complete and she along with the DON worked on them but had not completed them all for the facility. She said the facility had started a PIP in April 2026 and was not sure why they had not been able to get the care plans updated at this time. She said incomplete care plans and care plans that were not comprehensive could cause a delay in resident care. During an interview on 6/3/2026 at 2:00 pm, the DON said the MDS Coordinator was responsible for updating and revising the care plans in the facility. She said the facility had been without a MDS Coordinator for about a month and a new one was hired 6/1/2026. She said care plans should include the residents' diagnoses, wounds if they had them, weights, medications, special considerations, ADLs, etc. and should be individualized for each resident. She said the care plans should be reviewed quarterly and as needed. She said if the care plans were not accurate then the staff would not know how to properly care for the residents. During an interview on 6/3/2026 at 2:10 pm, the Administrator said the nurses and MDS Coordinator were responsible for the care plans. She said the care plan should be implemented initially on admission, quarterly, annually, and any time there after with changes. She said the care plan should include diet orders, activities of daily living, pain, etc. She said if the care plan were not accurately reflected, the residents might not get the care needed. She said she expected to have more accurate care plans in the facility for the residents. Record review of a facility policy titled Comprehensive Assessments dated March 2022, .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 2. any specialized services to be provided as a result of PASRR recommendations .		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the residents' status for 1 of 6 residents reviewed for assessments. (Resident #15) The facility failed to ensure Resident #15's quarterly MDS assessment, dated 3/03/2026, was coded correctly. This failure could place residents at risk of not having individual needs met. Findings include: Record review of Resident #15's facility face sheet dated 6/02/2026, indicated Resident #15 was a [AGE] year-old male that admitted on [DATE] with a diagnosis of traumatic brain injury. Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated Resident #15 had a wound, wound infection and insulin. Record review of Resident #15's order summary report dated 6/02/2026 indicated Resident #15 did not have a current nor a discontinued order in the last 6 months for a wound, infection or insulin. During an interview on 6/02/2026 at 11:30 am the Regional Reimbursement Consultant said that the previous MDS nurse was not accurately completing the MDS assessments and was no longer in that position as of a month ago. She said the facility had a new MDS nurse that started yesterday and she would be training the new MDS nurse on proper completion of MDS assessments. She said she was responsible for the oversight of the MDS assessments and was not aware that Resident #15's was inaccurate. She said that when the facility changed electronic charting systems the MDS assessments began to be incorrect, but it wasn't until a few months ago they realized it. She said that inaccurate MDS assessments affect the resident care areas and could result in incomplete care of the resident. During an interview on 6/03/2026 at 1:00 pm the DON said that she was not sure how Resident #15's MDS was coded incorrectly and where the MDS nurse at the time got her information. She said that Resident #15 had never had a wound, wound infection or used insulin that she was ever aware of. She said that miscoded assessments could cause inaccuracy of the care plans and inaccurate resident care. During an interview on 6/03/2026 at 1:34 pm the Administrator said that the previous MDS nurse was not completing the MDS assessments accurately and was no longer in that position. She said the Regional Reimbursement Consultant was monitoring the MDS assessments monthly and had not realized that Resident #15's assessment was inaccurate. She said the facility had hired a new MDS nurse and she was currently being trained and audits would occur weekly to ensure accuracy of assessments. She said inaccurate assessments could result in a delay of resident care. Record review of a facility policy titled Resident assessment dated 2001 indicated, . A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. 8. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information .		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new pressure ulcers from developing for 1 of 6 residents (Resident #6) reviewed for pressure ulcers. The facility failed to provide wound care for a pressure ulcer to his left heel for Resident #6 for 10 of 31 days in May of 2026 which could have caused pressure ulcers to deteriorate. The facility failed to ensure a wound care treatment order was in place for Resident #6 for 10 days between the dates of 5/25/26 and 6/3/26. This failure could place residents with pressure ulcers at risk for wound deterioration and decline in existing pressure ulcers. Findings included: Record review of a facility face sheet dated 6/3/26 for Resident #6 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness following a stroke), and hypertension (high blood pressure). Record review of an MDS assessment dated [DATE] for Resident #6 indicated a BIMS score of 10, which indicated he had moderately impaired cognition. He was dependent with most ADLs. He had 2 stage 3 pressure ulcers and was receiving pressure ulcer/injury care. Record review of Medication and Treatment Administration Records dated May 1-31, 2026 indicated he had the following treatment order: Cleanse wound to left heel with wound cleanser, pat dry and apply calcium alginate, cover with gauze island dressing, may change prn for soiling or dislodgement every day shift related to pressure ulcer of left heel, stage 3. Order had a start date of 4/18/26 and a discontinued date of 5/25/26. There was no documentation of treatment being administered from 5/25/26 until 5/31/26. Record review of an electronic medical record on 6/3/26 for Resident #6 indicated there was no wound care order for pressure ulcer to left heel. Record review of a Physicians Order Summary Report dated 6/3/26 for Resident #6 indicated the following order dated 6/3/26: .Cleanse left heel with normal saline, pat dry, apply calcium alginate and Medi honey prn if saturated, soiled, or dislodged secure island dressing daily every day shift . which was obtained after surveyor intervention. Record review of a Braden Scale for Predicting Pressure Ulcer Risk dated 5/13/26 for Resident #6 indicated a score of 12, which indicated he was at high risk for developing pressure ulcers. Record review of a wound care physician evaluation dated 5/22/26 for Resident #6 indicated a stage 3 pressure injury to left heel with the following measurements: 1 x 0.6 x 0.1 cm. Record review of a wound care physician evaluation dated 5/29/26 for Resident #6 indicated a stage 3 pressure injury to left heel with the following measurements: 0.8 x 0.6 x 0.1 cm. Wound progress showed improvement as evidenced by decreased necrotic tissue and decreased surface area and wound showed no signs of infection. During an observation on 06/02/2026 at 1:45 pm DON was observed to perform wound care to Resident #6's pressure ulcer to his left heel with no infection control issues observed. Wound was pink in appearance with no drainage observed, there was no odor detected. No visible signs and symptoms of infection were observed. During an interview on 6/3/26 at 2:20 pm DON said if wound care orders were not put in the system appropriately, the orders would not show up on the Medication Administration Record or Treatment Administration Record for the nurses to know to perform the wound care and the wounds could possibly get worse. She said she was the one most of the time doing the wound care and she had been performing it because she knew to do it, and she was unsure how she missed noticing the order was not on the TAR the last week. She said it was possible the order was obtained when the old one was discontinued and that she possibly may have been interrupted because they have been short staffed, and maybe forgot to go back and the put (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the order in. During an interview on 6/3/26 at 2:35 pm Administrator said she expected her staff to put orders in when received or changed so that residents would receive the ordered care. She said if treatments were not provided as ordered, wounds could get worse. Record review of a facility policy titled Physician Orders dated February 2025 read: .Physician orders are essential for the comprehensive care of the residents. Record review of a facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 2001 read: .The physician/physician extender will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 3 of 10 residents reviewed for quality of care. (Resident #23, Resident #24, and Resident #31)The facility failed to remove worn and damaged mechanical lift slings from service for Resident's #23, #24, and #31.This failure could result in a loss of quality of life due to injuries.Findings include:Record review of a facility face sheet dated 6/2/26 for Resident #23 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right sided weakness and paralysis following a stroke).Record review of a quarterly MDS assessment dated [DATE] for Resident #23 indicated resident was rarely/never understood and had severely impaired cognition. He was dependent with transfers. Record review of a comprehensive care plan for Resident #23 indicated he did not have an ADL care plan addressing transfer status.Record review of a facility face sheet dated 6/2/26 for Resident #24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of Alzheimer's disease.Record review of a comprehensive MDS assessment dated [DATE] for Resident #24 indicated he was rarely/never understood and had severe cognitive impairment. He was dependent with transfers. Record review of a comprehensive care plan for Resident #24 indicated he did not have an ADL care plan addressing transfer status.Record review of a facility face sheet dated 6/2/26 for Resident #31 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of epilepsy (seizure disorder). Record review of a quarterly MDS assessment dated [DATE] for Resident #31 indicated a BIMS score of 6, which indicated she had severely impaired cognition. She was dependent with transfers. Record review of a comprehensive care plan for Resident #31 indicated she did not have an ADL care plan addressing transfer status.During an observation on 6/1/26 at 11:20 am Resident #24 was observed in common area in a geri-chair with a blue mesh mechanical lift sling observed underneath him. There was no tag on the sling, it appeared to have been ripped off, and the loops on the sling were faded in color. During an observation on 6/1/26 at 11:42 am Resident #31 was observed up in dining room with a solid blue mechanical lift sling observed underneath her. There was a tag observed on the back of the sling, it was torn and illegible.During an observation on 6/2/26 at 11:50 am Resident #23 was observed up in the dining room with a blue mesh mechanical lift sling underneath him and there was no tag observed on the sling, it appeared to have been ripped off.During an interview on 6/2/26 at 11:52 am DON said she did not know why the tags were getting messed up on the slings unless it was because of the dryer. During an interview on 6/3/36 at 10:45 am Laundry Aide said she might use bleach on the slings, but she was unsure and could not remember which setting they were washed on. She said she did dry them in the dryer. She said she did not know they were supposed to be air dried. During an interview on 6/3/26 at 1:10 pm Housekeeping/Laundry Supervisor said slings were dried in the dryer. She said she did not know they should be air dried and they did not have an appropriate place to hang them to dry. She said she would talk to administration to find a solution.During an interview on 6/3/26 at 2:20 pm DON said if slings were laundered inappropriately, it could weaken them and they could break, causing accidents. She said she would be ordering new slings and ensure they were air dried going forward.During an interview on 6/3/26 at 2:35 pm Administrator said if the slings were weakened, they could break down and cause accidents. She said they would be putting a system in place to air dry the slings so they would not be dried in (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the dryer going forward. Record review of a facility policy titled Safe Lifting and Movement of Residents dated July 2017 read: .staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order .Record review of a manufacturer guideline for use obtained at www.medline.com on 6/3/26 indicated: .Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that it was not possible or the resident preferences indicated otherwise for 1 of 6 residents (Resident #7) reviewed for nutrition status. The facility failed to follow facility policy and dietary recommendations for Resident #7. Resident # 7 lost 29 lbs. from 3/26/2026 to 05/05/2026 which was a significant weight loss of 20.7%. These failures could place residents at risk for loss of weight and inadequate nutrition. Findings include: Record review of Resident #7's face sheet, dated 06/02/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included Type 2 Diabetes Mellitus (a problem in the way the body regulates and uses sugar as a fuel), hypertension, (high blood pressure), cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), and cerebral aneurysm (a localized dilation or ballooning of a blood vessel in the brain due to a weakness in the vessel wall). Record review of Resident #7's admission comprehensive MDS, dated [DATE], revealed BIMS score of 99, which indicated severe cognitive impairment. Section K: Nutritional Approaches revealed resident receives 51% or more of calories from tube feeding. Resident recorded height 68 inches and weight 163 lbs. Record review of Resident #7's vital sign flowsheet indicated weights obtained on 3/26/2026- 163.0 lbs; 4/7/2026- 163.0 lbs; 4/8/2026- 130.8 lbs; 5/5/2026 134.0 lbs. Body Mass Index at 134.0 lbs. equals 20.4 with healthy range of 18.5 - 25.0 for Resident #7 age and height. Record review of Resident #7's Nutrition/Dietary note dated 05/5/2026 at 1:36 p.m. by the Registered Dietician, revealed resident weight 143.4 lbs with a mechanical lift. no visible signs of 13% weight loss. recommendation of weekly weights, continue current enteral feeding order, and registered dietician to evaluate monthly. Record review of Resident #7's hospital after care visit summary dated 3/16/2026 indicated that discharge recommendations for enteral nutrition via tube feeding was Osmolite 1.2 at 65 ml/hr. Record review of Resident #7's clinical notes indicated resident was assessed by primary care physician on 4/21/2026 and 5/19/2026 with no new orders. Record review of Resident #7's physician orders for March, April, May, and June 2026 has a diet order of nothing by mouth diet, Osmolite 1.2 at 65 cc/hr via gastronomy tube (g-tube) stationary pump. Record review of Resident #7's care plan initiated 3/30/2026 of impaired nutrition related to g-tube feeding. Intervention included consult dietician. During an observation on 6/02/2026 at 9:20 AM, Resident #7 was lying in bed with head of bed elevated 30 degrees. Resident was clean and well groomed. Observation of personal care by staff revealed resident well nourished in appearance and without any skin alterations. Resident with tube feeding running on feeding pump of Osmolite 1.2 at a rate of 65 cc/hr. During an interview with the Director of Nurses on 6/3/2026 at 9:30 AM, she stated she was responsible for reviewing residents' weights and making sure residents who required weekly weights were done every week. She stated she was aware of the weight discrepancy with Resident #7. She said she believed the weight that the resident was currently at was an accurate weight and that weekly weights should have been obtained upon admission to establish a baseline for the resident due to the initial weight of 163.0 lb not being an accurate weight. She stated a resident is re-weighed if a significant difference is noted during monthly weights. She said Resident #7 should have been re-weighed and that weekly weights should have been done upon admission, but it was overlooked. She said she also failed to put Resident #7 on the weekly weights list in May after the dietician recommended weekly weights. The DON stated staffing has been challenging, and she (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overlooked placing resident on weekly weights and obtaining a reweight. She stated she tracks all residents' weights, monthly and weekly weights using a spreadsheet and that she will print off a list of residents needing to be weighed weekly. She stated orders for weekly weights are not put into the current system due to if recorded in electronic medical record it will alter monthly, 3 month and 6 month weight loss calculations. She stated she keeps weekly weights in a separate binder. The DON said moving forward she will review weights weekly and obtain any reweighs within 24-48 hours. She stated she will ensure that all new admissions are weighed weekly to establish a baseline weight. She said that if weights are not rechecked or if weekly weights are not done, weight gains and/or losses are not identified promptly. During an interview with the Administrator on 6/3/2026 at 10:00 AM she said the Director of Nurses is responsible for the weight program. She stated all nursing staff are responsible for obtaining accurate weights on residents in the building. She stated moving forward, all new admissions and dietary recommendations would be reviewed during the morning meeting. She said a standard of care meeting occurs every Thursday and that follow ups to dietary recommendations and weight loss/gain concerns would be discussed in detail at that time. She stated not weighing residents per recommendations or policy could result in a delay in identifying resident weight loss or weight gain. Record review of the facility's policy titled, Weight Assessment and Intervention revised March 2022, revealed the following: 1. Residents are weighed upon admission or readmission and weekly for four weeks, as determined by the Interdisciplinary Team (IDT) and monthly thereafter .3. Any weight change of 5 pounds or more since the last weight assessment will be reweighed for confirmation.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to ensure all medications 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 of 2 medication carts (Nurse Cart) reviewed for medication storage. The facility failed to ensure injectable medications were labeled with an open and use by date on 6/3/26. This failure could put residents at risk for adverse reactions to medications and decreased quality of life. Findings included: During an observation on 6/3/26 at 7:40 am an opened multi-dose injector pen of Ozempic for Resident # 22 was observed on the nurse medication cart without an opened date or use by date; and an opened multi-dose Novolog Flex Pen for Resident # 4 was observed with no opened date or use by date. Label indicated Ozempic had been filled on 2/20/26, and Novolog had been filled on 5/5/26. During an interview on 6/3/26 at 7:45 LVN B said she normally always dated medications when she opened them, she said she was unsure why those medications were not dated, she said another nurse must have opened them. She said residents should not be given medications that may be old or outdated, it could make them sick. During an interview on 6/3/26 at 2:20 pm DON said if medications were not labeled with an open date, they could go bad. She said you should not give medications that are old because they may not work as well. She said she would provide more education to nurses to ensure medications were appropriately dated when opened and orders were put in as ordered. During an interview on 6/3/26 at 2:35 pm Administrator said she expected her nursing staff to date medications once they were opened. She said if medications were used past the date the efficacy could be compromised. She said going forward, the facility would provide further education to the nurses and audit the medication carts periodically. Record review of a facility policy titled Medication Labeling and Storage dated February 2023 read: .multi-dose vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial .Record review of safety information for Ozempic retrieved from www.ozempic.com on 6/3/26 indicated medication should be stored at room temperature for 56 days once opened and then discarded. Record review of safety information for Novolog Flex Pen retrieved from https://diabeteseducation.novocare.com/ on 6/3/26 indicated medication should be stored at room temperature or refrigerated for up to 28 days and should be discarded after 28 days even if there was insulin left in the pen.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relayed the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities for 2 of 12 residents (Residents #3 and #33) reviewed for call lights. The facility failed to ensure Resident #3 had a call light in the bathroom that was functional on 06/01/2026 and 06/02/2026. The facility failed to ensure Resident #33's bathroom had a call light pull cord on 6/1/26. This failure could place residents at risk of injury, pain, hospitalization, and a diminished quality of life. Findings included: 1. Record review of facility face sheet dated 6/2/2026 for Resident #3 indicated he was a [AGE] year-old male admitted to facility on 4/29/2025. Diagnosis included chronic obstructive pulmonary disease (a condition that limits airflow into and out of the lungs), schizoaffective disorder (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), polyneuropathy (a nerve damage condition), and acquired absence of right leg below the knee (surgical removal of portion of leg below the knee). Record review of a quarterly MDS dated [DATE] for Resident #3 indicated a BIMSscore of 11, indicating moderate cognitive impairment. He was always continent of bowel and bladder. He was independent with toileting transfers. Record review of Resident #3's comprehensive care plan initiated 2/3/2026 indicated resident was at risk for falls with interventions that included .ensure call light is available to resident . During observations on 6/1/2026 at 10:00 AM and 6/2/2026 at 8:00 am revealed the emergency call light located in Resident #3's bathroom without a cover and a black and red plastic-coated wire protruding from the uncovered area of the call light. During an interview on 6/2/2026 at 8:00 AM, Resident #3 stated he used his bathroom daily and was able to transfer himself from his wheelchair to the toilet without assistance. He stated he was unsure how long the cover to the emergency call light in his bathroom had been missing. He denied having a need to utilize the call light while in the bathroom. He stated he has not experienced any delay of care or assistance related to not having a call light available in the bathroom. He said he had not told any staff about the missing call light cover in his bathroom 2. Record review of a facility face sheet dated 6/2/26 for Resident #33 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of hepatic failure (liver failure). Record review of a quarterly MDS assessment dated [DATE] for Resident #33 indicated a BIMS score of 11, which indicated he had moderately impaired cognition. He was independent with personal and oral hygiene. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a comprehensive care plan for Resident #33 indicated it did not address his ADL status. During an observation on 06/01/2026 at 11:05 am Resident #33's bathroom call light was observed with no call light cord connected to the call light box. During an interview on 6/2/26 at 8:45 am Maintenance Director said he had been out sick yesterday, but he was putting a new string on the call light now. He said residents needed to be able to call for help in the event of a fall. During an interview on 6/2/26 at 10:52 am Resident #33 said He (maintenance director) put a string on my call light for me. Thank you. Resident #33 denied having suffered any falls. During an interview on 6/3/26 at 2:20 pm DON said she expected call lights to be available to all residents in their bathrooms. She said they should be available in the event of a fall. She said residents might not be able to call for help if call lights were not available. During an interview on 6/3/26 at 2:35 pm Administrator said she expected all bathrooms to have a functioning call light for residents to use in the event of an emergency. She said a resident might not be able to call for help if strings were not attached to the call lights. Record review of a facility policy titled Call System, Residents dated January 2025 read: .Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, interview, and record review, the facility failed to follow their own established smoking policy for 1 of 2 smoking areas. The facility failed to keep paper and plastic trash out of the designated ashtrays and fire can on 6/02/2026. This failure could place residents at risk for injury, burns, and an unsafe smoking environment. Findings include: During an observation on 6/02/2026 at 11:48 am the smoking area located off the secured unit had 2 ashtrays and 1 red fire can. 1 ashtray had 3 empty cigarette boxes in it and the red fire can had 4 plastic cups and 1 plastic bottle in it. During an interview on 6/02/2026 at 12:03 pm CNA A said that the staff assist the residents to smoke and only take the lighter and cigarette outside. She said the trash was probably put there by staff. She said maintenance or housekeeping were responsible for cleaning out the ashtrays and fire can, but if she saw the trash she would remove it herself. She said they had been told not to place trash in the ashtrays or red fire can because it could cause a fire. During an interview on 6/02/2026 at 12:55 pm Housekeeping/Laundry Supervisor said she and the Maintenance Director had to clean the smoking areas daily because staff often put trash in the ashtrays and fire can. She said the staff had been educated on fire risk, but some still did not listen. During an interview on 6/03/2026 at 1:34 pm the Administrator said that the smoking area was to be monitored with each smoke break and cleaned daily by the Housekeeper or Maintenance Director. She said there should not be any paper or plastic trash in the ashtrays or fire can because of the risk of fire. She said the staff had been told the ashtrays and fire can were for cigarette butts only and she would provide further education to them regarding fire safety in the smoking areas. Record review of a facility policy titled Smoking Policy dated October 2022 indicated, This facility shall establish and maintain safe resident smoking practices. Metal containers, with self-closing cover devices, are available in smoking areas. Ashtrays are emptied only into designated receptacles .		