

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Avir at Jefferson		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 Martin Luther King Dr Jefferson, TX 75657	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, and serve food in accordance with professional standards for food safety in the facility's only kitchen reviewed for kitchen sanitation. The facility did not ensure: 1. Meat was thawing in the appropriate container and sink under constant flow of cool, running water during the initial tour on 02/26/2024.2. A container which held a thick pink liquid was labeled and dated. 3. A box of frozen biscuits, a box of frozen corn, a plastic bag of cheese, and a plastic bag of chicken nuggets were sealed appropriately in the refrigerator. 4. The potato freezer was free of rust on the bottom shelf inside the freezer. 5. The juice tubing was kept off the ground. These failures could place residents at risk for cross contamination and food-borne illness. The findings included: During an initial tour observation in the kitchen on 12/01/25 beginning at 8:05 AM, revealed the following:1. There was an open box of frozen biscuits and frozen corn in the vegetable freezer.2. There was a container which held a thick pink substance in the milk refrigerator, which was unlabeled and undated.3. There was an open plastic bag of yellow shredded cheese in the salad bar cooler.4. There was an open plastic, resealable bag of frozen chicken nuggets in the potato freezer. The bottom of the potato freezer had large brownish-yellow stains and a small layer of ice.5. There were two long packages of ground hamburger meat that was sitting at the bottom of the third sink on the three-compartment sink. There was no water running.6. The orange juice tubing was located on the ground in front of the juice boxes and was not connected to the box of juice. During an observation on 12/01/25 at 8:37 AM, the 2 long packages of ground hamburger meat were submerged by hot steaming water in the third sink of the three-compartment sink. The packages were not in a container and the water did not run continuously. During an interview on 12/03/25 beginning at 2:43 PM, [NAME] P stated she worked as the cook and as a dietary aide. She said everything was supposed to have been sealed, labeled, and dated. [NAME] P said on 12/01/25 the dietary staff were in the process of serving breakfast. She stated it was hard to ensure everything was sealed, labeled, and dated properly during the busiest times. [NAME] P stated the bottom of potato freezer was cleaned now. She said the potato freezer was cleaned every week according to a cleaning schedule. [NAME] P stated she had not gotten to clean the potato freezer on the morning of 12/01/25 before the surveyor completed the initial tour. She stated meat should have been thawed in a pan with cool water running constantly. [NAME] P stated it was important to ensure everything was properly sealed, dated, labeled, and cleaned to prevent food contamination. She said it was important to ensure meat was thawed appropriately to prevent bacteria growth and contamination of the food. She stated it was unsanitary. During an interview on 12/03/25 beginning at 3:33 PM, the Dietary Manager stated she expected the dietary staff to slow down during the meal services and pay attention to what they were doing. She stated all the dietary staff knew how to label, date, and package the food. She said the juice tubing should not have been on the ground. She said it was important to ensure food was sealed properly, labeled, dated, and tubing was kept off the ground for sanitary reasons. She stated it would have prevented freezer burn and food contamination. The Dietary Manager stated meat should have been thawed in a pan with cool water running continuously. She stated meat should not have been sitting in water. She stated it was (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	important to ensure meat was thawed properly so residents did not become sick. During an interview on 12/03/25 beginning at 3:46 PM, the Interim Administrator stated he expected the dietary staff to ensure proper protocols were in place and followed for food administration. He stated the Dietary Manager was responsible for monitoring to ensure proper food preparation protocols were implemented. He said the Administrator was responsible for monitoring the Dietary Manager. He stated it was important to ensure proper food preparations protocols were implemented to prevent food contamination. Record review of the Food Safety policy, year dated 2012, reflected Food shall be handled in a safe manner.food is to be tightly wrapped or sealed and covered in clean containers.opened food shall be labeled, dated and stored properly. Record review of the Handling of Potentially Hazardous Foods policy, year dated 2012, reflected .never defrost foods of animal origins at room temperature. Record review of the Thawing Foods policy, year dated 2012, reflected All food will be thawed in a safe and sanitary manner.under potable running water temperature of 70 degrees or below, with sufficient velocity to agitate and float off loose food particles into the overflow, in a sealed package.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review, and interview, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 12 residents reviewed for resident rights. (Resident #60) The facility failed to protect and promote the rights of Resident #60 by standing over the resident while feeding her, being on a personal cell phone while feeding the resident and not speaking to the resident during the meal. This failure could place residents at risk for decreased self-esteem, decreased privacy and decreased quality of life. Record review of an undated face sheet revealed Resident #60 was a [AGE] year-old female admitted on [DATE] with the diagnoses of major depressive disorder (depressed mood for at least two weeks or more, and a loss of interest or pleasure in everyday activities), protein calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function) and dementia (a group of symptoms affecting the memory). Record review of a significant change MDS assessment, dated 11/10/2025, revealed Resident #60 had a BIMS of 00 which indicated a severe cognitive impairment. Resident #60 sometimes understood others and sometimes made herself understood. Resident #60 required substantial assistance (extensive) for ADLs such as eating, toileting, transfer, and bathing. Record review of Resident #60's care plan, dated 07/24/2025, revealed Resident #60 had an ADL deficit related to dementia. Resident #60 required one staff assistance with ADL care. During a record review on 12/01/2025 at 10:10 a.m. of the facility Inservice binder from 06/01/2025 to 12/01/2025, no in-service was noted on assisting dependent residents with meals. During an observation on 12/01/2025 from 12:45 p.m. to 12:50 p.m., CNA A stood over Resident #60 while feeding the resident lunch. CNA A was observed looking at and typing on a cellular device the entire observation and failed to speak to Resident #60 while assisting with the meal. During an interview on 12/01/2025 at 1:30 p.m., CNA A stated she was on a personal cellular device for a short time during the lunch meal as she assisted Resident #60. She stated she was standing because there was not a chair in the room to sit in. CNA A stated she had no recollection if she interacted with Resident #60 during lunch. She stated she knew she was supposed to sit down and be on eye level and talk with the resident while feeding her she learned that in CNA class. She stated she also knew the facility had a policy that no cell phone usage should take place in the resident care areas. CNA A stated it could make the residents feel lonesome or ignored with no conversation during mealtime. During an interview on 12/03/2025 at 10:00 a.m., CNA B stated she learned in her training at CNA class to feed residents while sitting at eye level and to engage with the residents while assisting them with all care. She stated it built trust, and you may be the only person that speaks with that resident that day. CNA B stated the facility had a no cell phone in patient care area policy. During an interview on 12/03/2025 at 11:00 a.m., the Regional Nurse stated the expectation for assisting a dependent diner was for the staff to sit and engage with the resident during mealtime to promote comfort and increase the resident's feeling of connection. She was unaware of any training on assisted dining being done at the facility. The Regional Nurse stated mealtimes could be the most important interaction of a dependent resident's day and it was the duty of the staff to help the resident enjoy the experience. She stated cell phone usage was strictly prohibited in resident care areas for HIPAA reasons and resident comfort. During an interview on 12/03/2025 at 1:00 p.m., the Administrator stated that cell phone usage was not acceptable in resident care areas. He stated the staff were trained to take personal calls and messaging outside or in the breakroom during breaktime. The Administrator stated not sitting while assisting the resident to eat could make the resident feel rushed and meals should be enjoyable for the resident. No training had been provided by the facility on proper assisted resident dining, but the CNAs were aware to not have phones in care area. Review of a facility policy titled Dignity, dated 2001, indicated, Each (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident shall be cared 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. When assisting with care, residents are supported in exercising their rights, For example, residents are: . provided with a dignified dining experience.		

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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, comfortable and homelike environment for 1 of 1 dining room and 3 of 22 residents reviewed for environment. (Resident #18, Resident #40, and Resident #57) 1. The facility failed to repair wall damage in the rooms of Resident #18, Resident #40, and Resident #57 in a timely manner. 2. The facility failed to repair peeling wallpaper above the bed of Resident #40. 3. The facility failed to repair a leaking skylight, clean two vents, and missing texture in the ceiling of the dining room. These failures could place residents at risk of an uncomfortable environment and a decrease in quality of life and self-worth. During an observation on 12/01/25 at 12:16 p.m., it was raining heavily outside. There was water dripping into a bucket sitting on a table from a skylight in the dining room. There was a puddle of water under the table approximately 8 inches by 11 inches. There was a discolored area around the drip. The discolored area was black and yellow in color. A resident sitting approximately 7 feet away with approximately 3 other residents sitting at the same table. The vent #3 near sky light was covered with a black substance. Texture was missing from ceiling in dining room around vent #1. The sheetrock was exposed. Vent #2 near a second skylight had a gray substance covering it. During an observation on 12/02/2025 at 7:12 a.m., the skylight in the dining room was not dripping. The bucket was on floor under the edge of the table. There was a discolored area around the drip. The discolored area was black and yellow in color. There was a black substance scattered throughout the skylight. Vent #3 near skylight was covered with a black substance. Texture was missing from the ceiling in the dining room around vent #1. The sheetrock was exposed near vent #1. Vent #2, near a second skylight, had a gray substance covering it. 1. Record review of the face sheet, dated 12/02/25, indicated Resident #18 was [AGE] years old and admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease), major depressive disorder (a mental health condition characterized by persistent feelings of sadness and a loss of interest or pleasure in daily activities, affecting an individual's ability to function), shortness of breath and legal blindness. Record review of a quarterly MDS assessment, dated 11/03/25, indicated Resident #18 was understood and understood others. The MDS indicated a BIMS score of 12 indicating Resident #18 was moderately cognitively impaired. The MDS indicated Resident #18 required moderate assistance from staff with ADLs. During an observation on 12/01/25 at 10:36 a.m., Resident #18 was sleeping in his bed. There was an area of exposed sheetrock between the wall and the head of this bed. The area was approximately 12 inches in length and was gaping open vertically and the first layer of paint and sheetrock was peeling away from the area. During an observation on 12/02/25 at 10:52 a.m., Resident #18 was sleeping in his bed. There was an area of exposed sheetrock between the wall and the head of this bed. The area was approximately 12 inches in length and was gaping open vertically and the first layer of paint and sheetrock was peeling away from the area. During an observation and interview on 12/02/25 at 2:05 p.m., there was an area of exposed sheetrock between the wall and the head of this bed. The area was approximately 12 inches in length and was gaping open vertically and the first layer of paint and sheetrock was peeling away from the area. Resident #18 was in bed. He said he was blind, and he became aware of the area when he dropped his electronic device and bent down to pick it up. He said the wall had been that way since he moved into the room. He said he did not know how long his roommate's (Resident #57) wall had been damaged. He said he heard the Maintenance Supervisor tell his roommate he was going to repair the damage to his wall. He said that was approximately 3 - 4 weeks ago. 2. Record review of the face sheet, dated 12/02/25, indicated Resident #40 was [AGE] years old and admitted on [DATE] with diagnoses including generalized anxiety disorder, depression, and chronic pain syndrome. Record review of a quarterly MDS assessment, dated 10/23/25, indicated Resident #40 was understood and understood others. The (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS indicated a BIMS score of 11 indicating Resident #40 had moderately cognitively impairment. The MDS indicated Resident #40 required moderate assistance with most ADLs. During an observation and interview on 12/01/25 at 10:05 a.m., Resident #40 was in bed. There was peeling wallpaper above the bed near the ceiling. There was an area of paint missing beside the bed. The sheetrock was exposed on the wall beside her bed. Resident #40 said the area on the wall and the peeling wallpaper had been that way since she was placed in the room. She said the wallpaper and the paint missing on the wall made her feel like rats could come into her room. During an observation 12/02/25 at 10:50 a.m., Resident #40 was not in her room. There was peeling wallpaper above the bed near the ceiling. There was an area of paint missing beside bed, exposing the sheetrock underneath. 3. Record review of the face sheet, dated 12/02/25, indicated Resident #57 was [AGE] years old and admitted on [DATE] with diagnoses including heart disease (a range of conditions that affect the heart), chronic fatigue, and back pain. Record review of a quarterly MDS assessment, dated 11/08/24, indicated Resident #57 was understood and usually understood others. The MDS indicated a BIMS score of 10 indicating Resident #57 had moderate cognitive impairment. The MDS indicated Resident #72 required a walker to ambulate and supervision for some ADLs. During an observation on 12/01/25 at 10:36 a.m., Resident #57 was sleeping in bed. On the wall beside his bed there was a large area of exposed sheetrock and four smaller areas. There were areas of missing paint, exposing sheetrock underneath. During an observation on 12/02/25 at 2:29 p.m., Resident #57 was in bed. On the wall beside his bed there was a large area of exposed sheetrock and four smaller areas. There were areas of missing paint, exposing sheetrock underneath. He said he did not know how long there was damage to his wall and he did not remember the maintenance man speaking to him about the damage. During an interview on 12/02/25 at 2:22 p.m., the Regional Nurse said there was not a maintenance repair log. She said maintenance request were entered into an electronic system. During an interview on 12/02/25 at 3:26 p.m., Housekeeper N said the skylight in the dining room had been leaking for at least eight months. She said there were no attempts at repairs that she was aware of. During an observation and interview 12/02/25 at 3:30 p.m., the Dietary Manager said approximately one year ago an attempt was made to repair the leaking skylight. She said when it rained hard outside it leaked really bad. She said when it slightly rained it did not leak badly. She said the leak was from something on the roof. She said everyone was aware of the leak. She said when the skylight leaked staff put a bucket under the drip. She said they tried to move residents away from the area when it leaked. She said she did not know how long the sheetrock was exposed around vent #1. She said vent #2 appeared to be dirty. She said it looked dusty. She said vent #3 near the leaking sky light looked moldy. During an interview on 12/03/25 at 8:33 a.m., LVN G said the leak around the skylight had been there as long as she could remember and she was employed at the facility 11 years. She said there were multiple repair attempts. She said she noticed the yellow and black discoloration in the skylight. She said she felt like this area was water damage and mold. She said she had not noticed the wallpaper peeling in Resident #40's room. She said she had not noticed the area by Resident #40's bed. She said staff should notice walls in disrepair when they entered a room and it should be reported to maintenance. She said maintenance issues were reported through an electronic system. She said the areas in Resident #18 and Resident #57's room had been there several months. She said she reported it to maintenance in the past and did not know why it was not repaired. She said walls being in disrepair could lead to dust coming from the area and cause residents to have respiratory issues. During an interview on 12/03/25 at 9:21 a.m., the Wound Care Nurse said the skylight in the dining room only leaked if the rain poured. She said she had been aware of the leak for approximately six months. She said the water was usually caught in the bucket. She said she thought maintenance addressed the leak in the past. She said she had not noticed the discoloration on the skylight. She said the leak could cause a resident to slip and fall. She said if staff did not pull the beds away from the wall it would cause damage exposing the sheetrock. She said she had not noticed the wallpaper in Resident #40's room. She said staff noticing disrepair should put in an electronic work order. She said disrepair (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was unsightly and a pest control issue. During an interview on 12/03/25 at 10:12 a.m., CNA M said maintenance repaired the walls, but moving the beds kept damaging the walls. She said she never noticed the wallpaper peeling in Resident #40's room. She said there used to be a book at the nurse's station for maintenance repair request or you could tell maintenance verbally. She said she noticed the walls in Resident #18's and Resident #57's room approximately a week or two ago. She said she reported it verbally to the Maintenance Supervisor. She said the skylight leaked in the dining room for years. She said there were attempts to repair it in the past. She said it leaked when it rained heavy and a bucket was placed under the leak. During an interview and observation on 12/03/25 at 10:55 a.m., the Maintenance Supervisor said over the last couple of months he had been pulling down vents, sanding them down, and cleaning them. He said he felt vent #2 and #3 in the dining room were missed. He said he was not aware of the texture missing around vent #1 in the dining room. He said it had not been reported to him. He said the skylight had been leaking a while . He said he could not say how long. He said he had been on the roof for repairs. He said he used a compound to repair the leak and then the heat cracked it and then it would dry rot. He said the discoloration on the skylight was approximately 2 feet by 8 inches. He said the discoloration was from water damage. He said vent #3 did have a little bit of black spotting. He said he felt like the black areas near and on the skylight were dust. He said he was on the roof 12/02/25 and there was a huge crack right where you don't want it. He said any staff needing to place a maintenance request should enter work orders into the electronic system. He said they had access on all computers in the facility. He said the wallpaper was put back up in Resident #40's room with glue and it had fallen back down. He said he found out about the wallpaper being back down today (12/03/25). He said Resident #40 reported the damage to her wall to him on 12/01/25. He said he was unaware of the damage in Resident #18's and Resident #57's room until this interview. This surveyor observed the areas with the Maintenance Supervisor. He said the paint and the top layer of the sheetrock had been torn and exposed the sheetrock. He said he expected the issues to be reported to him. He said he would not want his home to look that way. During an interview on 12/03/25 at 11:22 a.m., the ADON said she recently started seeing, over the last month or two, a trash can in the dining room under the skylight catching water. She said they had some guys out doing work on the roof, but she did not know what happened with that. She said she thought they did not come back and had put the Maintenance Supervisor in a bad spot. She said she had not noticed the discolored area or the black substance. She said she noticed dirty vents and the missing texture from the ceiling in the dining room. She said the leaking could cause a resident to fall. She said particles dropping from the ceiling could cause respiratory issues or particles to fall into the resident's food. She said maintenance issues were reported electronically. She said the Maintenance Supervisor was good about getting stuff done. She said she would have expected staff entering residents' room, to report any damage to the walls or wallpaper to the maintenance supervisor. She said she would then expect the damage to be repaired in a timely manner. She said damage in rooms could cause injuries such as skin tears. She said she absolutely would not want her home to look that way. She said it had a major impact on how the residents felt about where they lived. During an interview on 12/03/25 at 1:07 p.m., the Regional Nurse said any staff were to report any damage through an electronic system to the maintenance supervisor. She said it was the responsibility of the maintenance supervisor to make the repairs or get a plan together for repair to be done in a timely manner. She said maintenance was responsible for repairing the leaking skylight. She said she was new to the building and had no idea how long it had been leaking. She said all of the damage not repaired was a failure to provide the residents a comfortable home-like environment. During an interview on 12/03/25 at 1:21 p.m., the Administrator said he expected the walls and wallpaper to have at least been on a list to be repaired. He said any staff entering a resident's room should notice damage in the rooms and use the electronic system to put work orders in . He said repairs not made caused residents to not have a homelike environment. He said he expected for the roof/skylight to be repaired. He said vents should be inspected regularly and kept (continued on next page)		

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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 interview and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 18 residents reviewed for ADL care (Residents #3). The facility did not bathe Resident #3 from 11/19/2025 to 12/02/2025. This failure could place residents at risk of not receiving care and services to meet their needs, feelings of poor self-esteem, and lack of dignity and health. Record review of an undated face sheet revealed Resident #3 was a 77- year-old-male, admitted on [DATE] with the diagnoses of diabetes type II (a chronic condition where the body doesn't use insulin properly, leading to high blood sugar levels, atrial fibrillation (common type of irregular and often rapid heart rhythm where the upper chambers of the heart quiver instead of beating effectively), and insomnia (common type of irregular and often rapid heart rhythm where the upper chambers of the heart quiver instead of beating effectively). Record review of an admission MDS assessment, dated 09/24/2025, for Resident #3 revealed a BIMS of 13, which indicated no memory impairment. The MDS also revealed Resident #3 required substantial assistance with personal hygiene and bathing. Record review of a undated form titled shower schedule revealed Resident #3's designated bath days were every Monday, Wednesday, and Friday on the 2-10 shift. During a record review Resident #3's ADL sheet for bathing for November 1st to November 30th, revealed one documented bath in November 2025 on November 19th. There were no other documented baths for Resident #3 in the month of November 2025. During an interview on 12/03/2025 at 9:20 a.m., CNA B stated Resident #3 was to receive his shower on Monday, Wednesday, and Friday on the 2:00 p.m.- 10:00 p.m. shift. She stated she often worked over on the 2:00 p.m. -10:00 p.m. shift when the facility needed extra staff. She stated she never had a problem giving each resident a bath on any shift. CNA B stated Resident #3 required substantial assistance with all ADLs except eating and brushing his teeth. CNA B stated Resident #3 had never refused care and she had worked with him since he admitted . During an observation and interview on 12/01/2025 at 8:15 a.m., Resident #3 stated he only had one bath in November 2025 around the 20th. Resident #3 stated he was supposed to get a bath every Monday, Wednesday, and Friday on the 2:00 p.m.- 10:00 p.m. shift, but every time he asked the staff had an excuse why they could not assist him that day. Resident #3 stated he was always a clean person that bathed regularly and being dependent on people that were unwilling to assist him with a basic human need made him angry. Resident #3 stated his daughter visited often, but he did not feel comfortable asking his daughter to bathe him. Resident #3 appeared unshaven and had mild body odor. Resident #3 stated he would not name the CNAs he asked for a bath because he did not want to get anyone in trouble. During an interview on 12/03/2025 at 10:20 a.m., CMA H stated she worked as a CNA on the 2:00 p.m.- 10:00 p.m. shift all the time. CMA H stated Resident #3 was not known to refuse care. She stated sometimes on the 2:00 p.m.- 10:00 p.m. after supper there would be less staff and getting to all the showers could be challenging. CMA H stated 6:00 a.m.- 2:00 p.m. CNAs stayed over to help out until 6:00 p.m. During an interview on 12/03/2025 at 11:00 a.m., the Regional Nurse stated it was an expectation for all showers to be given as scheduled. She stated it was an expectation the nurse be notified, and documentation occur if any resident had not received a shower or bath on their scheduled bath day. The Regional Nurse stated it could make the residents feel uncomfortable and uncared for if they missed baths. During an interview on 12/03/2025 at 1:50 p.m., the Administrator stated all baths should be given according to the schedule and when the resident asked for one. He stated it did not matter if the resident requested a shower on a non-bath day it should be given. He stated it could make the residents feel uncared for and that was unacceptable. Record review of an undated policy titled Bathing, indicated .the resident acknowledges that skin feels clean and refreshed, and patient feels relaxed. Sweat, oil, dirt, and microorganisms are removed from resident's skin, and circulation is stimulated. Skin is free of excretions, draining, odor, rashes, irritation, excessive dryness, or breakdown. The resident tolerates procedure without fatigue, shortness of breath, or chilling.		

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NAME OF PROVIDER OR SUPPLIER Avir at Jefferson		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 Martin Luther King Dr Jefferson, TX 75657	
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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that was palatable and attractive for 3 of 5 residents (Resident's #3, #16, and #75) reviewed for palatable food. The facility failed to provide food that was palatable and attractive to Resident #3, #16, and #75 who complained the food was served cool and bland. These failures could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. The findings included: 1. Record review of an undated face sheet revealed Resident #3 was an 77- year-old-male, admitted on [DATE] with the diagnoses of diabetes type II (a chronic condition where the body doesn't use insulin properly, leading to high blood sugar levels, atrial fibrillation (common type of irregular and often rapid heart rhythm where the upper chambers of the heart quiver instead of beating effectively), and insomnia (common type of irregular and often rapid heart rhythm where the upper chambers of the heart quiver instead of beating effectively). Record review of an admission MDS assessment dated [DATE] for Resident #3 revealed a BIMS of 13, which reflected no cognitive impairment. The MDS also revealed Resident #3 required set-up only staff assistance with eating. Record review of the MD orders dated December 2025 revealed an order for a regular consistency, cardiac diet. During an interview on 12/01/25 at 8:15 AM, Resident #3 stated the food was tasteless. He stated the food tasted like air or plain water. Resident #3 stated tasteless food made the food unappetizing to him and he often left half of his food uneaten. During an observation and interview on 12/01/25 at 12:40 PM, Resident #3 consumed less than 50% of the lunch meal. Resident #3 stated the food was bland and not something he wanted to finish. 2. Record review of an undated face sheet revealed Resident #16 was a 74- year-old-female, admitted on [DATE] with the diagnoses of multiple sclerosis (an autoimmune disease that damages the myelin sheath, the protective covering of the nerves in the brain and spinal cord, leading to disrupted communication between the brain and body), seizure (sudden surge of abnormal electrical activity in the brain that can cause a range of symptoms, from brief confusion or a strange sensation to severe convulsions), and morbid obesity (a body mass Index (BMI) of 40 or higher, or a BMI of 35 or higher with at least one obesity-related health condition). Record review of an annual MDS dated [DATE] for Resident #16 revealed a BIMS of 15, which indicated no memory impairment. The MDS also revealed Resident #15 required set up only assistance with eating. Record review of a care plan dated 09/16/25 revealed Resident #16 was receiving a regular diet with no restrictions. During an interview on 12/01/25 at 9:35 AM, Resident #16 stated the food tasted bland and not seasoned at all. Resident #16 stated she ate in her room most days because the environment in the dining room was not appetizing either. Resident #16 stated it was not a particular day, meal, or cook that was worse or better. Resident #16 stated cereal was the most flavorful meal that was served at the facility. During an observation and interview on 12/02/25 at 12:40 PM, Resident #16 stated the mashed potatoes served for lunch tasted exactly like air. She stated she could tell they were instant and had no salt, pepper, butter, garlic powder, or spice at all. Resident #16 consumed less than 50% of the meal. During an interview on 12/03/25 at 11:00 AM, the Regional Nurse stated she was unaware of the complaints about the taste of food. She stated there was no reason that no salt was used to season food, that she was unaware the kitchen was not using pepper. The Regional Nurse stated there was a great number of spices that could be used to flavor food, if dietary restrictions or allergies were the issue for flavorless food. During an interview on 12/03/25 at 1:00 PM, the Administrator stated he was aware the residents complained about the blended vegetables. He understood the problem to be with the consistency of the vegetables and not the flavor. He stated it was discussed in the previous resident council meeting and addressed by the dietary staff. He stated not using salt and pepper according to the recipe for residents with no restrictions was not acceptable practice. He stated flavorless food could lead to weight loss and decline. 3. Record review of the face sheet dated 12/03/25 indicated Resident #75 was a [AGE] (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old male who was re-admitted on [DATE] with diagnosis which included atrial fibrillation (an irregular heart rhythm that originates in the heart's upper chambers) , urinary tract infection (an infection in any part of the urinary system), chronic pain (a persistent pain condition that lasts for more than 3 months affecting the quality of life) and atherosclerotic heart disease of native coronary artery without angina pectoris (a progressive disease where plaque, composed of fat, cholesterol, calcium and other substances, accumulates in the walls of the arteries). Record review of Resident #75's MDS assessment, dated 09/25/25, indicated Resident #75 was usually understood and usually understood by others. The MDS also indicated Resident #75 had a BIM score of 11 indicating moderate cognitive impairment. The MDS indicated Resident #75 was independent with eating, and oral hygiene. Record review of the undated care plan indicated Resident #7 had potential nutritional problems related to chronic pain syndrome (a persistent pain condition that lasts for more than 3 months affecting the quality of life), major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest). Interventions included monitor/document and report signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat or appears concerned during meals. Monitor/record/report to MD as needed signs and symptoms of malnutrition, emaciation (Cachexia) (a complication of severe chronic diseases like cancer and heart failure that causes weight loss), muscle % in 3 months, significant weight loss such as 3 pounds, in 1 week, > % in 1 month, >10 % in 6 months, provide and serve diet as ordered, monitor intake and record each meal, and weigh and record per MD orders. During an interview on 12/01/25 at 2:15 PM Resident #75 said the food was awful. He complained of the food being refrigerator cold. During an observation and interview on 12/02/25 beginning at 12:40 PM, the Dietary Manager stated the lunch meal tray consisted of Swiss steak, broccoli, mashed potatoes, and a dinner roll. The Dietary Manager and five surveyors tasted the meal tray. The Dietary Manager said the broccoli was lukewarm and bland. She stated the mashed potatoes had no flavor and could have been warmer. She stated she had received food complaints from the residents about too much salt. She also stated one of the residents were allergic to pepper, so the dietary cooks did not use pepper in the cooking. During an interview on 12/03/25 beginning at 2:43 PM, [NAME] P stated she had not received any complaints about the taste or temperature of the food. [NAME] P stated the dietary staff usually followed the recipes when cooking. [NAME] P stated the dietary staff did not use pepper because they had a resident allergic to pepper. [NAME] P stated she usually tasted the food to ensure the food tasted well. She said it was important to ensure the food looked good, tasted good and was at the appropriate temperature so the residents ate and did not lose weight. During an interview on 12/03/25 beginning at 3:33 PM, the Dietary Manager stated she had received food complaints regarding vegetables being too hard, so the dietary staff try to cook them a little softer. The Dietary manager said she had gotten food complaints about the seasoning when one particular cook was scheduled for cooking. She stated she used less seasoning than other cooks. The Dietary Manager stated she tried to taste the food daily before it was served but did not have time on 12/02/25. She stated it was important to ensure the food tasted good, looked appetizing, and was served at an appropriate temperature because the facility was their home and it encouraged them to eat. She said the dietary staff needed to cater to the resident's needs. During an interview on 12/03/25 beginning at 3:46 PM, the Interim Administrator stated he expected the dietary staff to follow the recipes. He said most of the food complaints were about the softness of the vegetables. He stated he ate at the facility daily, and some days the food was good and some days it was not as good. The Interim Administrator stated the Dietary Manger was responsible for monitoring the food quality. He said it was important to ensure the food looked good, tasted good, and was served at the appropriate temperature to ensure the residents would eat the food. Record review of the Preparation of Foods policy, year dated 2012, reflected We will establish safe and nutritional preparation of food. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. all food will be prepared by methods that preserve nutritive value, flavor, and (continued on next page)		

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appearance with a variety of color, and will be attractively served at the proper temperature the Dietary Service Manager and cooks will taste and test meals daily.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure complete and accurate documentation for 1 of 18 residents reviewed for medical records. (Resident #52.) 1. The facility did not ensure resident records were free from unauthorized use due to staff not having their own individual login for the (EHR). 2. The facility failed to ensure accurate and complete documentation was entered for Resident #52 related to her diabetes management and wound care. These failures could place residents at risk for inaccuracy of clinical records and the decrease continuity of resident care. Findings included: Record review of Resident #52 face sheet date 12/01/2025 revealed she was an [AGE] year-old female admitted on [DATE] with the primary diagnosis of Acute embolism and thrombosis of popliteal vein (blood clot forms in the popliteal veins located behind the knees, blocking blood flow), being treated postoperatively. Resident #52 has a medical history including type 2 diabetes mellitus (chronic metabolic condition in which the body does not use insulin effectively, leading to elevated blood glucose levels), transient ischemia attack (temporary interruption of blood flow to the brain that causes stroke-like symptoms but does not result in permanent brain damage), hypertension (chronic medical condition of persistently elevated blood pressure level), and chronic obstructive pulmonary disease (progressive lung disease that causes airflow obstruction). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #52 had a BIMS of 11 which indicated a moderate cognitive impairment. Resident #52 was usually understood others and usually made herself understood. Resident #52 required standby and set up assistance for ADLs such as eating, toileting, transfer, and bathing. The MDS assessment indicated she was being treated with antibiotic (treated infection) and hypoglycemic (treat low blood glucose level). Record review of Follow-up appointment case description from 09/22/2025 at 11:09AM indicated Resident #52 had a follow up appointment with MD on 9/22/2025 to remove stitches and would require the removal of the IVC filter on a later date. Record review of physician orders for Resident #52 dated 11/22/25 indicated treatment for bilateral lower extremity cellulitis, however, it was never addressed in the skin assessments nor the skin checks. Record review of the progress note dated 11/24/2025 noted she was taking an antibiotic for redness and warmth of left leg. Record review of the Skin assessments for Resident #52 dated 11/24/2025 at 1:26 PM, completed by LVN G revealed a boil on sacrum. The skin assessment indicated the following issues: Other (specify) Other (specify) and right buttock boil. The skin assessment did not reflect stage II Pressure or residual postoperative stitch. No other documentation or skin issues were provided on the skin assessment. Record review of EHR revealed Resident #52 on 11/28/2025 was identified as having a new identified stage 2 pressure injury to the sacrum when a physician's order was documented in the EHR which was put in by the wound care nurse. Resident #52's EHR failed to have a pressure injury/skin assessment including measurements, drainage, or surrounding tissue condition upon identification. Record review of the skin assessment schedule provided to surveyors by the wound care nurse on 12/02/2025 revealed skin assessments for Resident #52 were due every Monday. Record review of EHR revealed several progress note entries dating for the month of November 2025 for Resident #52 were recorded under the generic login '?Nurse2025', preventing identification of the staff member responsible for the entry. During an observation and interview on 12/01/2025 at 8:43AM Resident #52 was sitting in a chair eating breakfast. Resident #52 stated the surgeon left stitches on the top of her posterior calf. Resident #52 stated she reported these stitches to the nursing staff a few weeks ago, however, she could not recall who she had reported them to or an exact date or time. Resident #52 also stated she had reported pain, redness, and swelling to her anterior legs approximately near her shins where the condition of cellulitis (bacterial infection of the skin and underlying tissue), was being treated. Resident #52 said she was being treated with antibiotics for 10 days. During an interview with the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound care nurse on 12/01/2025 at 4:40 PM revealed the new pressure stage II was identified on Friday 11/28/2025 when the skin check was performed, however, no skin assessment was documented. The Wound care nurse stated she had standing orders from the wound care provider that she began on Friday. She had not seen or identified a postoperative stitch. The wound care nurse used previous wound care orders from treatments that Resident #52 had previously. She stated she put the new orders in; however, the wound care nurse stated she did not document a skin assessment. The wound care nurse stated a skin check was done on Friday before I left. I did it by hand on a notebook. I did not do my due diligence and put it into the computer before leaving my shift. I put the orders in so that she would receive the daily wound care over the weekend. The wound care nurse stated she was responsible for overseeing and ensuring that all skin assessments are completed, accurate and documented in accordance with standards. She stated this placed Resident #52 at risk for the care to be provided more than prescribed. During an interview with LVN L on 12/02/2025 at 9:37 AM, she stated she had not identified a pressure ulcer or postoperative stitch on the skin assessments she had performed; however, she cannot remember when she completed the last skin assessment on Resident #52. She stated that there was a schedule for each resident to have their skin assessment done weekly. 2) Record review and interview on 12/02/2025 at 9:00 AM of physician orders started on 09/03/2025 indicated Resident #52 was treated for type 2 diabetes mellitus with Humulin R insulin (short-acting insulin) inject as per sliding scale: if 150 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units. Give 12 units for levels above 300., and finger stick blood sugar checks 3 times a day. Resident #52 reported her blood sugar had spiked recently. According to records and interviews with resident and LVN L she had started Lantus on 12/1/2025 for hyperglycemia. Record review of the physician orders indicated Resident #52 started Lantus (long-acting insulin) on 12/01/2025. Record review of Resident #52's medication administration record dated November 1, 2025- November 30, 2025, revealed elevated blood sugar levels on: 11/30/2025 at 11:28 a.m., the documented blood sugar level was 569, 11/29/2025 at 11:36 AM, the documented blood sugar level was 470, 11/27/2025 at 7:43 p.m., the documented blood sugar level was 307, 11/26/2025 at 11:33 a.m., the documented blood sugar level was 388, and on 11/21/2025 at 11:30 a.m., the documented blood sugar level was 331. The medication administration record indicated Nurse 2025 documented these blood sugar results and then documented a chart code of 9 indicating see Resident #52's progress notes. Record review of Resident #52's progress notes dated November 21, 2025- November 30, 2025, revealed there were no interventions listed for the elevated blood sugars. Record review on 12/01/2025 for November 1, 2025- November 30, 2025, of the facility EHR system revealed multiple nursing staff using the same login 'Nurse2025' at the same time while on different units. This inhibited the surveyors from being able to differentiate who was charting under each resident at that time. Records reviews revealed blood sugar for Resident #52 was charted under the user 'Nurse2025' seventy times in the month of November 2025 reviewed for documentation of blood sugar monitoring. During an interview with ADON on 12/01/2025 at 3:22 PM, the ADON stated all agency staff used one login and other staff including the weekend supervisor and the wound care nurse. She stated the login being shared was listed as Nurse2025. The ADON could not provide a complete list of staff and agency staff using this login. She voiced she was aware that this could be a potential problem and that it inhibited her from identifying who documented. During an observation on 12/01/2025 at 3:30PM LVN L was noted accessing and documenting in the EHR using a shared, non-individualized login. LVN L was noted to be entering information under the same generic username listed as 'Nurse2025' which was found to be used by LVN Q on different shifts. During an interview on 12/02/2025 9:37 AM, LVN L indicated Resident #52's blood sugar results had been elevated. LVN L stated on 11/30/2025 she contacted the nurse practitioner regarding Resident #52's blood sugar result of 569 at 11:30 AM and received an order for Lantus 10 units every morning. LVN L said the nurse practitioner reviewed Resident #52's blood sugars. LVN L stated nursing notes were used to document communications such as new orders, notification of change, and changes of (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition. LVN L stated she had not yet put a note in as of 12/02/2025 because she had forgotten. She stated she texted the NP and was told to give 12 units Humulin R which was the highest dose ordered at the time. NP ordered to add Lantus to start the following morning and monitor for side effects of Lantus and hyper/hypo glycemia. LVN L stated she started this new medication for the blood sugar on 11/30/2025 at 11:28 AM, the documented blood sugar level was 569. During an interview on 12/02/2025 at 9:36 AM, LVN L reported she did not have her own individualized EHR credentials and routinely used a shared or temporary agency account log in credentials for documentation. LVN L stated the facility had not issued or maintained unique logins for all personnel responsible for charting. LVN L said she was hired on 11/11/2026 and was not provided an unique login for herself. During an interview with LVN L on 12/02/2025 at 9:37 AM, she stated her login was not functioning, so she had to use the generic login 'Nurse2025' which is what agency staff use. LVN L stated it has not been functioning since her start date as of 11/11/2025. She reported the issue to the ADON who instructed her to use the generic login. LVN L stated when she signed into it, it auto populated by signing it. LVN L stated she should have put her name under it so if something happened it does not fall back on her while using that login in. LVN L stated it was important to have individualized logins, so no medication errors or double dosing happened if multiple people were using that login. She stated she would rather use her own login and not share. She stated sharing logins could cause harm to the residents. During an interview with LVN Q on 12/02/2025 at 3:25 PM, he indicated that all agency staff use the same agency login. He stated he could not go back and find his individual note with name attached to it. He stated he did not sign his notes with a signature he just put agency nurse. He stated at passed employers he was provided with an individualized login. LVN Q stated having individual login was a better system and protected the residents from possible errors and harm. During an interview with the DON on 12/03/2025 at 2:10 PM, she stated she expected documentation to be done on any care provided. The DON said a resident was at risk for inadequate/incomplete medical record when documentation was not done and this led to the inability to determine the care provided or not provided. The DON said she expected skin assessments to be done weekly to maintain good skin health and monitor skin barrier issues/breakdown. The DON said the documentation of skin assessments allowed nurses to implement new plan of care if there are any issues. The DON said the nurses complete the skin assessments and treatment wound care nurse oversees the assessments. DON stated all staff should have their own login to the EHR according to the policy and she was unaware of this issue until 12/01/2025 with surveyor intervention. During an interview with the Administrator on 12/03/2025 at 3:38 PM, he said he was not aware of all agency staff and other facility staff were using the same login. He stated that it was against facility policy. The Administrator said he expected all care provided to be documented by the staff providing the care in a timely manner prior to leaving their shift. He stated there was a possibility for harm to the residents, medical errors, and HIPAA violation. Record review of an Electronic Medical Records Policy dated March 2014 indicated Electronic Medical Records: Policy Statement: Electronic medical records may be used in lieu of paper records when approved by the administrator. Policy Interpretation and Implementation. 1. Electronic records are an acceptable form of medical record management. 2. The administrator, in conjunction with the quality assurance and performance improvement committee, shall review requests for and the implementation of our electronic medical records system. 3. Only authorized persons who have been issued a password and user ID code will be permitted access to the electronic medical records system. 4. The facility will make reasonable efforts to limit the use or disclosure of protected health information to only the minimum necessary to accomplish the intended purpose of the use or disclosure. 5. The HIPAA compliance officer, administrator and director of nursing services maintain a listing of each user ID code. Such listing is confidential and secured. 6. When personnel changes occur, or there is reason to believe that unauthorized access to protected information has occurred, the HIPAA compliance officer, administrator and director of nursing services shall review the security of the information and change user ID codes if necessary. Record (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of a Diabetes-Clinical Protocol dated December 2020 indicated: Documentation: The resident's blood glucose result, as ordered; The licensed nurse will initial the Medical Administration Record (MAR). The license nurse will document refuses. Record review of a Wound Care Policy updated July 2024 indicated: The following information should be recorded in the resident's medical record: The date the wound care was given. The initials of the individual performing the wound care. Any change in the resident's condition. Any problems or complaints made by the resident related to the procedure. If the resident refused the treatment and the reason(s) why. The signature and title of the person recording the data. Record review of a Charting and Documentation policy dated July 2017 indicated: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation indicated documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the resident's medical chart as permitted by facility policy. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. Refer all requests for information to the director of nursing services, nurse supervisor/charge nurse or to the business office. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting. Record review of a Skin System Process policy dated October 2025 indicated Skin Assessment (UDA-Skin Assessment V2): Conduct a full head-to-toe assessment every 7 days. New in-house acquired pressure injuries require an incident report and appropriate follow-up. PCC Skin and Wound Total Body Assessment (Skin & Wound Module): (Use Wound Assessment Profile 3.0- V2 until Skin & Wound Module enabled). Complete weekly until all pressure injuries or skin issues (e.g., skin tears, lacerations, abrasions, surgical incisions, diabetic, arterial, stasis, venous ulcers) are resolved. The treatment nurse (if applicable) is responsible for keeping the skin system up to date. However, if the treatment nurse is assigned to work as a charge nurse, it becomes your responsibility to ensure that skin assessments are completed on time. If there is no treatment nurse, charge nurses can conduct skin assessments. You are required to verify the assessments at least once a month to ensure their accuracy.		

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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 establish and 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 of 2 residents (Resident #81 and Resident #83) reviewed for infection control. 1. The facility failed to ensure the LVN L followed the Enhanced Barrier Precautions (EBP) (interventions to prevent spread of infection in high-risk residents) policy of wearing a gown during Resident #81's catheter assessment on 12/1/2025. 2. The facility failed to ensure the ADON followed the Enhanced Barrier Precautions policy of wearing a gown and gloves during an observation of Resident #81's catheter bag on 12/2/2025. 3. The facility failed to ensure CNA J followed the Enhanced Barrier Precautions policy of wearing a gown during Resident #83's catheter care on 12/2/2025. These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: 1. Record review of Resident #81's face sheet dated 12/2/2025 indicated Resident #81 was a [AGE] year-old, male and readmitted on [DATE] with diagnoses including cerebral infarction (a medical condition characterized by the interruption of blood supply to the brain), atherosclerotic heart disease of native coronary artery with other forms of angina pectoris (characterized by the buildup of plaque in the coronary arteries, leading to narrowed or blocked arteries which can cause (angina) chest pain), essential hypertension (characterized by consistently high blood pressure readings,, typically defined as a systolic pressure of 130 mmHG or higher and/or a diastolic pressure on 80 mmHg or higher), and benign prostatic hyperplasia with lower urinary tract symptoms (an enlarged prostate can cause symptoms that can block the flow of urine out of the bladder), and chronic cystitis with hematuria (a long-lasting inflammation of the bladder that can cause symptoms such as pelvic pain, frequent urination and urgency). Record review of Resident #81's care plan initiated 5/1/2024 indicated Resident #81 had an indwelling foley catheter: Atonal bladder (a condition where the bladder muscles cannot contract fully), neurogenic bladder (a condition where nerve damage affects bladder control leading to issues such as urinary incontinence or retention), benign prostatic hypertrophy obstructive uropathy and retention of urine (a common condition that can lead to urinary retention due to the obstruction caused by the enlarge prostate). Intervention included to change catheter every month and PRN for failure to drain, position catheter bag and tubing below the level of the bladder and away from entrance room door, check tubing for kinks and maintain the drainage bag off the floor, enhanced barrier precautions; post EBP sign in room, gown, gloves to be worn during high-contact resident care with indwelling medical device, monitor and document intake and output as per facility policy, monitor/document for pain/discomfort due to catheter, and monitor/record/report to MD for signs and symptoms of UTI such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status and change in behavior, and eating patterns. Record review of a quarterly MDS dated [DATE] indicated Resident #81 had a BIMS score of 6 indicating he had severely cognitive impairment. Resident #81 was able to make self-understood and understood others. The MDS indicated Resident #81 had an indwelling catheter and required assistance for personal hygiene. Record review of Resident #81's care plan initiated on 5/6/2024 indicated Resident #81 had behavioral problems related to fascination with foley catheter tubing and privacy bags. Resident #81 would sit on tubing, remove privacy bag, refused to reposition, wraps tubing around body, thinks privacy bag was a belt, lifts bag above bladder level at times, and empties foley catheter at times. Interventions included: administer medications as ordered. Monitor and document for side effects and effectiveness, anticipate and meet the resident's needs, and evaluate for leg bag if appropriate. During an observation on 12/1/2025 at 8:25 AM, LVN L came in the room to assess Resident #81's catheter. She grabbed gloves from the nurse station and came to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his room. LVN L did not place on PPE while assessing catheter for Resident #81. Resident #81 had a container at the door, a yellow sticker on door and an EBP precaution sign posted. During an observation on 12/2/2025 at 9:18 AM, the ADON was requested to assist Resident #81 who was in the hallway attempting to navigate in his wheelchair. The ADON said Resident #81 had labs ordered yesterday and she was waiting for the results. The ADON assessed the catheter bag without gloves or gown in the hallway. 2. Record review of Resident #83's face sheet dated 12/3/2025 indicated Resident #83 was a [AGE] year-old, male and readmitted on [DATE] with diagnoses including sepsis due to Escherichia coli (can occur when the bacteria enter the bloodstream leading to severe symptoms) , candidal cystitis (a rare urinary tract infection caused by an overgrowth of candida fungus, leading to inflammation and painful urinary symptoms) urethritis (inflammation (swelling and irritation) of the urethra), chronic obstructive pyelonephritis (a long-term kidney infection that occurs when there is an obstruction in the urinary tract, often due to conditions like kidney stones or tumors), neuromuscular dysfunction of bladder (a condition that affects bladder function due to nervous system problems) and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (hemiplegia refers to complete paralysis of one side of the body, while hemiparesis indicates partial weakness. Both conditions are common after a stroke and occur when the brain's motor control areas are damaged). Record review of Resident #83's care plan initiated 5/1/2024 indicated Resident #83 had an indwelling foley catheter related to neurogenic bladder. Interventions included positioning catheter bags and tubing below the level of the bladder and away from entrance room door, check tubing for kinks and maintaining the drainage bag off the floor, enhanced barrier precautions; post EBP sign in room, gown, gloves to be worn during high-contact care with indwelling medical device. Resident #83's care plan indicated staff must wear gowns and gloves during high-contact resident care activities that could result in transferring MDROs to hands and clothing of staff. Interventions include staff washing hands or using alcohol-based gel when entering and exiting the resident room, sign for EBP precautions will be outside residents' room, to alert staff of precautions with direct care procedures and gowns will be available in room for staff to don when performing direct care with resident. During an observation on 12/2/2025 at 3:17 PM, CNA J provided Resident #83 with catheter care. CNA J washed her hands prior to care and did not don (put on) a PPE. Resident #83 was observed with a sign posted on the door indicating Resident # 83 was on EBP precautions and a container at his door with PPE available. During an interview on 12/2/2025 at 3:41 PM, CNA J said stood for Extra Barrier Precautions. She said residents who had foley catheters, feedings, dialysis, and central lines were on EBP. She said the staff were required to wear gloves. CNA J said she got nervous and forgot to put a gown on during care. CNA J said the ADON, and treatment nurse were responsible for ensuring staff were wearing proper PPE. CNA J said the staff had been in-serviced on EBP. She said it was important to wear proper PPE to prevent the spread of infection or cross contamination. During an interview on 12/3/2025 at 9:34 AM CNA K said she knew a resident was on EBP when there was a sign on the door. She said that was when the staff glove and gown up. CNA K said residents who had catheter and infections were on EBP. CNA K said PPE was used to prevent staff from getting an infection or spreading an infection. CNA K said CNA J, ADON and DON were responsible for ensuring staff wore proper PPE. During an interview on 12/3/2025 at 10:53 AM, LVN G said EBP stood for Enhanced Barrier Precautions. She said it was extra precautions for residents who had catheters, PICC lines (peripherally inserted central catheter is a long thin tube that was inserted through a vein in the arm) IV therapy (Intravenous therapy for medication administration), and Peg tubes (gastrostomy tube that allows means to provide nutrition). LVN G said there was a yellow sticker on the resident door indicating the resident was on precautions. LVN G said the staff should be wearing gowns and gloves to prevent infection. She said a resident could get an infection and get sepsis (occurs when your immune system has a dangerous reaction to an infection causing inflammation throughout the body that can lead to tissue damage, organ failure and even death). LVN G said it was the responsibility of ADON, DON to ensure staff were (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wearing proper PPE. LVN G said she had been trained and in-serviced on EBP. She said PPE should be worn while providing catheter care or direct care. During an interview on 12/3/2025 at 11:05 AM, ADON said residents who had peg tubes (gastrostomy tube that allows means to provide nutrition), wounds, feedings, tracheostomy (a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised) and catheters were on EBP. The ADON said the EBP were part of the staff's initial training. She said the facility had yellow stickers on the door and a container outside the resident room. She said it prevents the spread of bacterial or viral infection. The ADON said it was to protect the staff and residents from infection. The ADON said she expected the staff to wear PPE when a resident was on EBP precautions. The ADON said not wearing PPE could cause the residents to get an infection or get worse if they had an infection. She said not wearing proper PPE could also cause cross-contamination among other residents. The ADON said she is responsible for ensuring staff is wearing PPE. The ADON said she was not wearing gloves while looking at Resident #81's catheter in the hallway. The ADON said she should have been wearing it but wanted to take a brief look at the catheter bag. During an interview on 12/3/2025 at 1:20 PM, the DON said she expected the nurses to adhere to the facility policy for infection control and enhanced barrier control measures and wear proper PPE to prevent any organism that could cause infection. The DON said anyone with a wound, medical device such as catheter or PICC line or history of colonized MDRO. The DON said the sign tells them what to put on. She said it puts the resident at risk for infection. The Regional Nurse said she was responsible for ensuring the staff are wearing proper PPE. The Regional Nurse said she had serviced the previous DON on EBP and PPE. During an interview on 12/3/2025 at 1:35 PM, the ADM said he expected the staff to follow infection control policy. He said he saw the staff had in-services previously. The ADM said the facility had work to do on educating staff on infection control and EBP and wearing proper PPE. The ADM said not wearing proper PPE could cause infection. The ADM said the Regional Nurse was responsible for ensuring proper PPE was worn. Record review of a facility policy titled Enhanced Barrier Precautions dated February 2025 indicated .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targets gown and glove during high contact resident care activities. Policy and Interpretation and Implementation. 1. Enhanced barrier precautions (EBPs) were used as an infection prevention and control intervention to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use in addition to standard precautions. 3. High contact resident care activities .dressing, bathing/showering, transferring, providing hygiene, changing lines, changing briefs. 4. for residents infected or colonized with a CDC targeted or epidemiologically important MDRO, including. pan-resistant organisms. has a wound or indwelling medical device, secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized. 5. EBP were indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBP remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device. 7. The use of EBPs does not impose limitations on group activities. 8. The facility may use EBP at its discretion for resident who do not have a chronic wound, indwelling medical device. 10. Staff were trained prior to caring for residents on EBP. 11 Signs are posted. 12. PPE for EBP's is available outside or inside the resident room. 13. Residents, families, and visitors are notified of implementation. Record review of a facility policy titled Infection Control System dated October 2025 indicated .Designated Infection Preventionist. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) must complete an approved Infection Preventionist Course. The ADON will serve as the designated Infection Preventionist for the facility. Antibiotic Stewardship Program. the facility maintains an Antibiotic Stewardship Program in accordance with CMS and CDC standards. Infection Tracking and Surveillance. Care planning. Competencies and Education. Facility assessment.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the option he or she prefers for 1 of 6 residents reviewed for the right to be informed. (Resident #11) 1. The facility failed to ensure Resident #11 had a signed psychotropic consent form for Haldol and Zyprexa (antipsychotic medications). 2. The facility did not ensure the need for, and benefits of, the proposed treatment with antipsychotic or neuroleptic medication was filled out on the HHSC Form 1012 Consent for Antipsychotic or Neuroleptic Medication. These failures could place residents at risk for treatment or services provided without their informed consent Record review of an undated face sheet dated revealed Resident #11 was an [AGE] year-old male admitted on [DATE] with diagnoses of schizophreniform disorder (a psychotic disorder characterized by symptoms similar to schizophrenia, such as delusions, hallucinations, and disorganized speech, but its duration is shorter, lasting from one to six months) psychotic disorder (a severe mental health condition characterized by a loss of contact with reality, resulting in symptoms like hallucinations, delusions, and disorganized thinking and speech) and chronic atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat). Record review of the quarterly MDS assessment, dated 09/12/2025, revealed Resident #11 had a BIMS of 13, which indicated cognitively intact. The MDS revealed Resident #11 used antipsychotic medications and required partial to moderate assistance with ADL care. Record review of the comprehensive care plan, dated 09/16/2025, revealed Resident #11 used antipsychotic medications for the treatment of schizophreniform disorder. Record review of the order summary report, dated 12/03/2025, revealed Resident #11 had an order, which started on 11/21/2025, for Haldol 1mg three times daily and Zyprexa 5mg twice daily. Record review of the MAR, dated 12/03/2025, revealed Resident #11 received Haldol 1 mg and Zyprexa 5mg as ordered by the physician. Record review of the electronic medical record for Resident #11, accessed on 12/03/2025 at 10:00 a.m., revealed no consent forms for Haldol or Zyprexa. During an observation and interview on 12/03/2025 at 9:34 a.m., Resident #11 was sitting in his wheelchair in his room, clothing appeared neat and clean. Resident #11 was pleasant during interview but was not able to remember the medications he was taking. He stated he was unaware he was on antipsychotic medications and was unaware of the side effects. He stated he had no behavior issues that he was aware of. During an interview on 12/03/2025 at 11:10 a.m., Resident # 11's family member stated they never signed consent or gave permission for the medication because Resident #11 usually took care of his own business. During an interview on 12/03/2025 at 11:16 a.m., LVN G stated she was responsible for completing the psychotropic consent forms for Resident #11 because she received the order changes, but she got busy and forgot to have the consent signed. LVN G stated an informed consent form should have been obtained for an antipsychotic medication prior to the medication being administered. LVN G stated it was important to ensure psychotropic medication consent forms were obtained prior to administering the medications so the resident and family knew the risks and benefits of the medication. LVN G stated the failure of not getting a consent prior to administration of the medication could cause unwanted side effects to the resident and was against the resident's right. During an interview on 12/03/2025 at 11:20 a.m., the DON stated the nurses were responsible for ensuring psychotropic consent forms were obtained prior to administering the medications. The DON stated consent form should have been obtained for Resident #11's Haldol and Zyprexa. The DON stated it was important to ensure consent forms were completed prior to administering medications so that residents and their family were aware of the medication, side effects, risks, and benefits. The DON stated the failure was the resident may not get the medication they need. The DON stated she would monitor by medication review. During an interview on 12/03/2025 at 1:52 p.m., the Administrator (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he expected psychotropic consent forms to be obtained prior to administering psychotropic medications. The Administrator stated nursing management was responsible for monitoring psychotropic consent forms. The Administrator stated it was important to ensure psychotropic consent forms were obtained prior to administering the medications to ensure the residents were informed of the risks and benefits and provided informed consent. The Administrator stated the failure was unnecessary medication may be given. Record review of the Psychotropic Medication Review policy, dated May 2025, did not address psychotropic consent forms.		

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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 an accurate MDS was completed for 1 of 18 residents reviewed for accuracy of assessments. (Resident #8) The facility failed to accurately document restraint usage for Resident #8. This failure could place residents at risk of not receiving needed care and services. Record review of an undated face sheet revealed Resident #8 was a 100-year-old- female, admitted on [DATE] with the diagnoses of Alzheimer's disease (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anemia (a condition in which the body does not have enough healthy red blood cells), and malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). Record review of a quarterly MDS, dated [DATE], for Resident #8 revealed a BIMS of 05, which indicated a severe cognitive impairment. The MDS also revealed Resident #8 required substantial assistance with bed mobility, eating, transferring, and toileting. The MDS revealed Resident #8 required a restraint less than daily. Record review of December 2025 consolidated physician orders revealed no order for a restraint for Resident #8. During an interview on 12/02/2025 at 10:00 a.m., MDS Nurse E revealed Resident #8 should not have been coded as having a restraint less than daily on the MDS. MDS Nurse E stated there were no restraints in the facility and this was a miscoding. MDS Nurse E stated miscoding the MDS could lead to wrong information reported on the Quality Measures and potentially wrong information care planned for the resident, which could confuse the staff caring for the resident. During an interview on 12/03/2025 at 11:15 a.m., the Regional Nurse stated it was the responsibility of the MDS nurse to ensure accurate MDS's were produced and transmitted to CMS. The DON stated there was currently no system check in place to audit the MDS accuracy but ultimately the DON or Regional Nurse signed the MDS for completion and the MDS nurses signed it for accuracy. During an interview on 12/03/2025 at 2:00 p.m., the Administrator stated it was the responsibility of the MDS Nurse to produce accurate MDSS and care plans. The Administrator stated accuracy was important for revenue as well as to ensure the facility was reporting the correct information to CMS on the quality measures. During a record review of the facility's undated policy titled Minimum Data Set Policy for MDS assessment Data Accuracy, revealed the purpose of the MDS policy was to ensure each resident received an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. The assessment should accurately reflect the resident's status.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop the baseline care plan within 48 hours of admission for 1 of 22 residents (Resident #55) reviewed for baseline care plans. The facility failed to ensure Resident #55's baseline care plan was completed within 48 hours of admission. This failure could affect residents by not addressing their physical, mental, and psychosocial needs for each resident to attain or maintain their highest practicable physical, mental, and psychosocial outcome. The findings included: Record review of the face sheet, dated 12/03/25, reflected Resident #55 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of extradural and subdural abscess (buildup of pus from an infection located in the brain), acute on chronic heart failure (chronic, progressive disease in which the heart muscle is unable to pump enough blood to oxygenate the body), and COPD (chronic lung condition in which the lungs are damaged). Record review of the admission MDS assessment, dated 11/25/25, reflected Resident #55 had unclear speech, was sometimes understood by others, and was able to understand others. Resident #55 had a BIMS score of 9, which indicated moderately impaired cognition. Resident #55 had no behaviors or refusal of care. Record review of Resident #55's baseline care plan, completed on 11/17/25. The baseline care plan should have been completed by 11/16/25. During an interview on 12/03/25 beginning at 3:12 PM, LVN O stated the admitting nurses were responsible for completing the baseline care plan. LVN O said she was unsure of the timeframes for completing the baseline care plans. LVN O said Resident #55 was admitted to the facility on her shift, but she was unsure why his baseline care plan was not completed until 11/17/25. LVN O stated the baseline care plan reflected the care and services needed by the residents when they were admitted to the facility. She said it was important to ensure the baseline care plan was completed within the required timeframes to ensure communication of the care and services needed by the residents from the facility staff. During an interview on 12/03/25 beginning at 3:20 PM, the Regional Nurse stated she was the acting DON until a new one was hired. The Regional Nurse stated baseline care plans should have been completed within 48 hours of admission. She stated the DON was responsible for ensuring the baseline care plans were completed. The Regional Nurse stated she was unsure why Resident #55's care plan was completed late. She said it was important to ensure baseline care plans were completed within the required timeframes to capture the care each resident needs. During an interview on 12/03/25 beginning at 3:46 PM, the Interim Administrator stated he expected the baseline care plans to have been completed within 48 hours of admitting to the facility or as quickly as possible after 48 hours. The Interim Administrator stated the nursing management was responsible for monitoring to ensure baseline care plans were completed timely. He said it was important to ensure baseline care plans were completed within the required timeframes because it was used to deliver care to the residents. Record review of the Care Plans - Baseline policy, revised March 2022, reflected, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who had a urinary catheter received appropriate treatment and services to prevent urinary tract infections to the extent possible for 1 of 2 residents reviewed for catheter care. (Resident #81).The facility failed to ensure Resident # 81's securement device was in place to reduce friction and movement at the insertion site on 12/1/2025.This failure could place residents at risk of not receiving care and services needed to address catheter care.Findings included: Record review of Resident #81's face sheet dated 12/2/2025 indicated Resident #81 was a [AGE] year-old, male and readmitted on [DATE] with diagnoses including cerebral infarction (a medical condition characterized by the interruption of blood supply to the brain), atherosclerotic heart disease of native coronary artery with other forms of angina pectoris (characterized by the buildup of plaque in the coronary arteries, leading to narrowed or blocked arteries which can cause (angina) chest pain), essential hypertension (characterized by consistently high blood pressure readings,, typically defined as a systolic pressure of 130 mmHG or higher and/or a diastolic pressure on 80 mmHg or higher), and benign prostatic hyperplasia with lower urinary tract symptoms (an enlarged prostate can cause symptoms that can block the flow of urine out of the bladder), and chronic cystitis with hematuria (a long-lasting inflammation of the bladder that can cause symptoms such as pelvic pain, frequent urination and urgency). Record review of Resident #81's care plan initiated 5/1/2024 indicated Resident #81 had an indwelling foley catheter: Atonal bladder (a condition where the bladder muscles cannot contract fully), neurogenic bladder (a condition where nerve damage affects bladder control leading to issues such as urinary incontinence or retention), benign prostatic hypertrophy obstructive uropathy and retention of urine (a common condition that can lead to urinary retention due to the obstruction caused by the enlarge prostate). Intervention included to change catheter every month and PRN for failure to drain, position catheter bag and tubing below the level of the bladder and away from entrance room door, check tubing for kinks and maintain the drainage bag off the floor, enhanced barrier precautions; post EBP sign in room, gown, gloves to be worn during high-contact resident care with indwelling medical device, monitor and document intake and output as per facility policy, monitor/document for pain/discomfort due to catheter, and monitor/record/report to MD for signs and symptoms of UTI such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status and change in behavior, and eating patterns. Record review of Resident #81's care plan initiated on 5/6/2024 indicated Resident #81 had behavioral problems related to fascination with foley catheter tubing and privacy bags. Resident #81 would sit on tubing, remove privacy bag, and refuses to reposition, wraps tubing around body, thinks privacy bag was a belt, lifts bag above bladder level at times, and empties foley catheter at times. Interventions included: administer medications as ordered. Monitor and document for side effects and effectiveness, anticipate and meet the resident's needs, and evaluate for leg bag if appropriate.Record review of a quarterly MDS dated [DATE] indicated Resident #81 had a BIMS score of 6 indicating he had severely cognitive impairment. Resident #81 was able to make self-understood and understood others. The MDS indicated Resident #81 had an indwelling catheter and required assistance for personal hygiene. During an observation on 12/1/2025 at 8:18 AM, Resident #81 was observed lying in bed with wheelchair at bedside. Observed Resident #81 wearing brief with blood located near the insertion site and 700 cc of red blood in urine bag located on the floor without a privacy bag and no securement device anchoring the catheter tubing. Resident was withdrawn and did not communicate during observation. During an interview and observation on 12/1/2025 at 8:25 AM, LVN L said Resident #81's catheter was changed on Saturday. She said he had blood in his catheter this morning. LVN L said Resident #81 pulls on his catheter. LVN L said Resident (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Jefferson		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 Martin Luther King Dr Jefferson, TX 75657	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#81 had an appointment today with a Urologist. Resident #81 had an appointment on 12/1/2025 with Nephrologist (a Physician who diagnose and manage various kidney-related conditions). During an interview on 12/1/2025 at 3:15 PM, LVN L said Resident #81's catheter was irrigated, and Resident #81 was referred to a Urologist in another town. She said the facility was waiting for a return call to schedule. During an interview on 12/1/2025 at 3:22 PM, the ADON said Resident #81 was seen by his Nephrologist today and he wanted the facility to continue to monitor. The ADON scanned the note into the computer system. During an observation and interview on 12/2/2025 at 9:18 AM, Resident #81 was attempting to wheel himself down the hall and needed assistance. He was observed to have yellow urine in part of the tubing and blood-tinged urine in the catheter bag attached to the wheelchair and covered with a privacy bag. Unable to determine if a securement device was anchored and secured. The ADON came to assist Resident #81 and said she the Physician had ordered labs yesterday and she was waiting for the results. During an interview on 12/3/2025 at 9:34 AM, CNA K said she provided catheter care for residents with catheters. CNA K said she was not familiar with securement devices on catheter tubing. She said she had seen them. CNA K said she did not mess with the securement devices, and the nurses were responsible for the catheters. CNA K said it could cause infection if a securement device was on the catheter. During an interview on 12/3/2025 at 10:53 AM, LVN G said residents with catheters should have a securement device on the catheter. She said it was important, so the catheter does not pull, or the resident does not pull it out. LVN G said the securement device was changed monthly and as needed. She said it could cause the resident pain and infection if the catheter slides back and forth. LVN G said the nurse was responsible for ensuring the securement device was on the resident. LVN G said she assessed it when she makes her rounds. LVN G said Resident #81 does not like the securement device or privacy bag. LVN G said it would be care planned if he refused the securement device. During an interview on 12/3/2025 at 11:05 AM, the ADON said residents with catheters should have a securement device on the catheter. She said the securement device was to prevent the catheter from being pulled out and potentially causing injury. The ADON said Resident #81 should have a securement device. The ADON said she was going to get with the MDS nurse and have her care plan for his refusal and messing with the catheter. The ADON said the nurses were responsible for ensuring privacy cover and securement device was on the catheter. During an interview on 12/3/2025 at 1:20 PM, the Regional Nurse said she expected the staff to make sure the resident had a securement device and privacy bag on the foley catheter. The Regional Nurse said the charge nurses were responsible for ensuring the catheter was secure and the catheter bag was off the floor. The Regional Nurse said it should be care planned for noncompliance. The Regional Nurse said Resident #81 could get an infection due to the catheter not being secure and it could cause trauma related to urethra trauma. During an interview on 12/3/2025 at 1:35 PM, the ADM said the securement device should be on a resident with a catheter bag and the privacy bag should be covering the catheter bag. The ADM said the nurse was responsible for ensuring the privacy bag and securement device were in place. He said not having the securement device in place could cause infection of the bladder. Record review of the facility's policy dated July 2024 titled Catheter Care, Urinary, indicated .purpose of this procedure is to prevent catheter-associated urinary tract infections. Changing catheters.Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. Catheter tubing should be strapped to the resident's inner thigh. Complications.Observe resident for complications associated with urinary catheters.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the PICC line site was maintained consistent with professional standards of practice for 1 of 1 residents (Resident #83) reviewed for central venous lines (a thin, flexible tube that's inserted into a large vein to provide access to the circulatory system). The facility failed to change a PICC line (a type of central venous line) dressing, consistent with physician's orders for Resident #83. This failure could place residents at risk of a systemic infection that could lead to serious illness and/or death. Record review of a face sheet dated 12/02/25 revealed Resident #83 was a [AGE] year-old male and was re-admitted on [DATE] with diagnoses including sepsis due to Escherichia Coli (a life-threatening condition caused by the body's extreme response to an E. coli (a type of bacteria) infection), muscle wasting, and lack of coordination. Record review of a progress note dated 11/21/25 at 10:11 p.m. indicated Resident #83 had returned to the facility from the hospital. Record review of a progress note indicated Resident #83 had new orders for intravenous antibiotics. Record review of a physician's order for Resident #83 dated 11/23/25 indicated an order for a dressing change to PICC (a type of central venous line) site every 7 days and as needed. The order type was listed as a wound (WAR - wound administration record). The order was entered by LVN G. Record review of an annual MDS dated [DATE] revealed Resident #83's speech was unclear. The MDS revealed a BIMS score of 12, indicating moderate cognitive impairment. The MDS indicated Resident #83 was dependent on staff for ADLs. Record review of a care plan last revised on 11/21/25 revealed Resident #83 had received antibiotic therapy through a PICC line in 07/2025. The care plan did not indicate the resident had a PICC line or had received IV (intravenous) antibiotics beginning 11/21/25. Record review of Resident #83's electronic medical record from 11/21/25 - 12/02/25 did not indicate documentation of a central venous line dressing change. The Medication Administration Record, Treatment Administration Record, Nurse Medication Record, and the Wound Administration Record were all reviewed. During an observation on 12/02/25 at 11:45 a.m., Resident #83 was in bed. There was a PICC Line with a transparent dressing to his left upper arm. The dressing was clean, dry and intact. The dressing was dated 11/21/25. There were no signs of infection. During an interview on 12/03/25 at 8:33 a.m., LVN G said Resident #83 was re-admitted to the facility on [DATE]. She said she was off that day. She said when he was re-admitted he did have the PICC line in place. She said she did remember putting the order in for a PICC line dressing change for every 7 days for his PICC line. She said she tried to follow up on PICC lines and catheters on newly admitted or re-admitted residents. She said the policy was for PICC line dressings to be changed every 7 days. She said she did not know why the order did not pull over for documentation. She said maybe she selected the wrong category. She said she did administer his medications while he was getting them. She said she did assess the date on the dressing. She said she did not know why the dressing had not been changed on 11/28/25. She said the wound care nurse usually did the PICC line dressing changes. She said when she entered the order, she selected wound care documentation and maybe the order should have been placed under the treatment administration record. She said then the order would have populated for the wound care nurse. She said a PICC line dressing not being changed could lead to infection or sepsis. During an interview on 12/03/25 at 9:21 a.m., the Wound Care Nurse said on 12/02/25 there was an order placed to pull the PICC line from Resident #83's left upper arm. She said she removed the PICC line on 12/02/25. She said pressure was held and there were no signs of infection. She said when she pulled the PICC line she did notice the date on the dressing was 11/21/25. She said any RN could do the dressing changes on a PICC line. She said the dressings should be changed every week. She said the order never crossed over to her treatment administration record. She said she never knew that the dressing change needed to be done. She said she never administered any medications through the PICC line. She said any nurse giving a medication through the PICC line should have assessed the line and dressing. She said she (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would have expected it to have been changed within the 7 days of 11/21/25. She said a dressing not being changed timely could lead to infection. She said dressings can become old and pull up from the skin. During an interview on 12/03/25 at 11:22 a.m., the ADON said Resident #83 was re-admitted on [DATE] with the PICC line in place. She said a PICC line dressing should be changed every 7 days and as needed. She said the order was put in and it was put into a medication administration record that was being phased out, and it did not populate on the treatment administration record for the Wound Care Nurse. She said she would have expected nurses administering medications to have checked the date on the dressing and changed it as needed. She said a PICC line not being changed could lead to infection and possible sepsis. During an interview on 12/03/25 at 1:07 p.m., Regional Nurse said PICC line dressings should be changed every 7 days. She said the order went onto the wrong treatment administration record and it did not trigger to the Wound Care Nurse's treatment administration record. She said the doctor did order to have it pulled yesterday (12/02/25). She said she would have expected nurses to have assessed the PICC line dress when administering medications and someone should have caught that the dressing had not been changed. She said a PICC line dressing not being changed at least every 7 days increased the risk of infection. During an interview on 12/03/25 at 1:21 p.m., the Administrator said staff should follow the doctor's orders for PICC line dressing changes. He said a PICC line dressing not being changed could lead to infection. During an interview on 12/03/25 at 4:35 p.m., the Regional Nurse said she had been unable to find a facility policy for PICC line dressing changes. A policy was not received prior to exit. The website https://medlineplus.gov/ency/patientinstructions/000156.htm accessed on 12/04/25 indicated, . Central venous catheter - dressing change. Dressings are special bandages that block germs and keep your catheter site dry and clean. You'll need to change your dressing often, so that germs don't get into your catheter and make you sick. You should change the dressing about once a week. You will need to change it sooner if it becomes loose or gets wet or dirty.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 22 residents reviewed for respiratory care. (Resident #10) The facility failed to properly store Resident #10's oxygen mask while not in use by the resident. This failure could place residents at risk of respiratory complications or respiratory infection. 1. Record review of a face sheet dated 12/04/25 indicated Resident #10 was [AGE] years old and admitted on [DATE] with diagnoses including acute respiratory failure (a life-threatening condition where the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide from the blood), tracheostomy status (an opening in the neck to the windpipe, or trachea, through which a tube is inserted to provide an airway), and history of cardiac arrest (is when the heart suddenly stops beating effectively due to electrical problems, cutting off blood flow to the body). Record review of the MDS dated [DATE] indicated Resident #10 had no speech. The MDS indicated Resident #10 was usually understood and understood others. The MDS indicated a BIMS was not conducted due to the resident being rarely/never understood. The MDS indicated Resident #10 received tracheostomy care and used a ventilator while a resident in the facility. Record review of a care plan last revised on 11/04/25 indicated Resident #10 had altered respiratory status related to tracheostomy status and was at risk for complications related to his trach. The care plan indicated Resident #10 was at an increased risk for secretions, congestion, respiratory infections and infections to the tracheostomy site. There was an intervention to administer nebulizer as ordered. The care plan did not indicate that Resident #10 would take his oxygen nebulizer mask off and lay it on the nightstand. During an observation on 12/01/25 at 12:08 p.m., revealed a trach oxygen nebulizer mask laying directly on the nightstand of Resident #10. The mask was not stored in a bag. A storage bag was not present on the nightstand. During an observation on 12/02/25 at 7:15 a.m., revealed a trach oxygen nebulizer mask laying directly on the nightstand of Resident #10. The mask was not stored in a bag. A storage bag was not present on the nightstand. During an interview on 12/03/25 at 8:33 a.m., LVN G said oxygen mask and equipment when not in use should be stored in a bag. She said Resident #10 did take his mask off and just lay it around. She said she did believe that a storage bag was not present. She said an oxygen mask not being stored in a bag could get bacteria on it and go straight to a resident's lungs. During an interview on 12/03/25 at 9:21 a.m., the Wound Care Nurse said all oxygen supplies were supposed to be bagged when not in use. She said she would have expected Resident #10's mask to have been stored in a bag. She said a mask not being stored in a bag is an infection control issue. During an interview on 12/03/25 at 11:22 a.m., the ADON said oxygen equipment was supposed to be stored at bedside in a respiratory bag and hung on the concentrator or placed in a drawer at bedside. She said she would not have expected Resident #10's mask to have not been left directly on the bedside table. She said if it was contaminated, he could get a respiratory infection. She said it could be lost, and he might be unable to locate the mask if needed. During an interview on 12/03/25 at 1:07 p.m., the Regional Nurse said oxygen supplies not in use should be bagged. If the resident took off the equipment themselves, it should care planned and the resident should be educated on the equipment being bagged. She said oxygen equipment not being bagged was a risk for infection. During an interview on 12/03/25 at 1:21 p.m., the Administrator said oxygen supplies not being used should be bagged. He said equipment not being bagged was not being kept clean. Record review of an Oxygen Administration facility policy last revised 10/2010 did not indicate proper storage of equipment while not in use by a resident.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and reviews, the facility failed to act upon the recommendations of the pharmacist report of irregularities for 1 of 6 residents (Resident #11) reviewed for (DRR) Drug Regimen Review. The facility failed to complete a psychotropic consent form for Resident #11 after the pharmacist recommended the form was needed on 11/10/2025 for Haldol (antipsychotic medication) and Zyprexa (antipsychotic medication). This failure could place residents at risk residents of not having a drug regiment that is appropriate for their needs. Record review of an undated face sheet dated revealed Resident #11 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of schizophreniform disorder (a psychotic disorder characterized by symptoms similar to schizophrenia, such as delusions, hallucinations, and disorganized speech, but its duration is shorter, lasting from one to six months) psychotic disorder (a severe mental health condition characterized by a loss of contact with reality, resulting in symptoms like hallucinations, delusions, and disorganized thinking and speech) and chronic atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat). Record review of the order summary report on 12/3/2025 at 9:00 a.m., dated 12/01/2025, indicated Resident #11 was prescribed Haldol 1 mg three times daily and Zyprexa 5mg twice daily since 11/21/2025. Record review of the quarterly MDS assessment on 12/3/2025 at 9:15 a.m., dated 09/12/2025, revealed Resident #11 had a BIMS of 13, which indicated minimal cognitive impairment. The MDS revealed Resident #11 used antipsychotic medications and required partial to moderate assistance with ADL care. Record review of the MARs dated November 2025 and December 2025, indicated Resident #11 received Haldol three times daily from 11/21/2025 to 12/02/2025. The MARs also indicated, Resident #11 received Zyprexa 5mg twice daily from 11/21/2025 to 12/02/2025. Record review of the comprehensive care plan, revised on 09/16/2025, revealed Resident #11 used antipsychotic medications for the treatment of schizophreniform disorder. Record review of the Pharmacist Consultant Medication Regimen Review dated 11/10/2025 revealed the licensed pharmacist recommended consents should be obtained and added to chart for the following medications: Haldol and Zyprexa for Resident #11. The pharmacist also recommended adding side effect monitoring and behavior monitoring for Resident #11's antipsychotic medication usage. During an interview on 12/03/2025 at 11:50 a.m., the DON stated the Pharmacy Consultant recommendations for Resident #11 should have been reviewed but it was not, if it had been reviewed, she would initial on the report when recommendations had been followed up. The DON stated the nurse who received the order was responsible for ensuring the consents are signed and completed prior to the first dose of medication administration. The DON stated she monitors by reviewing the orders to ensure consents were obtained in a timely manner during her daily clinical meeting with the ADON, Administrator, and the 6a-2p charge nurses. The DON was unable to give an explanation why the pharmacy recommendation was not completed. The DON stated not reviewing pharmacy consultations and documenting they had been reviewed and completed could lead to something the patient needed being missed. During an interview on 12/03/2025 at 1:52 p.m., the Administrator stated he expected all pharmacist recommendations to be reviewed with the physician and followed. He stated he expected psychotropic consent forms to be obtained prior to administering psychotropic medications, side effect and behavior monitoring to be done per pharmacist recommendation. The Administrator stated nursing management was responsible for monitoring psychotropic consent forms and that side effects and behaviors were monitored. The Administrator stated it was important to ensure psychotropic consent forms were obtained prior to administering the medications to ensure the residents were informed of the risks and benefits and provided informed consent. The Administrator stated the failure was unnecessary medication maybe given. Record review of the facility's Psychotropic/Psychoactive Medication Management policy revised 10/2022 revealed . psychotropic (continued on next page)		

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications are used only when appropriate and at the lowest possible dose to enhance the residents' quality of life, maximize functional ability or promote overall well-being. Record review of the facility's Pharmacy Services Overview policy revised 04/2025 revealed . 2. The facility shall contract with a licensed consultant pharmacist to help obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements.		