STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675371	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Boerne	1102 River Road Boerne, TX 78006

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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 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. Based on observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment with maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 4 units (Unit B), reviewed for physical environment. The facility failed to ensure the door jamb, strike plate, and latch hole of the women's secure unit B shower room was not covered with black duct tape which prevented the door from latching and locking and the push buttons 5, 6, 7, and 9 on the electronic door lock were not missing. The facility failed to ensure the shower floor drain had a drain cover over it. This failure could place residents at risk of being exposed to others while being provided with care and showers, an unsanitary environment, accidents, and could result in embarrassment and being uncomfortable. The findings were: Review of the facility women's secure unit B resident roster on 5/5/25 at 9:45am revealed there were 17 female residents residing on the unit. In an observation on 5/5/26 at 10:35 a.m. the unit B shower room door was pulled to but not fully closed and latched and there was an area of solid black that could be seen between the wall and the door where it would latch. There was an electronic lock with numbered push buttons sticking out and numbered buttons missing were 5, 6, 7, and 9. After knocking and ensuring it was not occupied the door was pushed opened. The door jamb, strike plate, and latch hole were covered with black duct tape approximately 12 inches in length and it was pulling away from the door jamb in an area approximately 6 inches long and in that area was what appeared to be sheetrock or part of the frame that had gotten stuck to the duct tape. There was another piece of duct tape going crossways across this area from the outside of the door frame to the inside of the door frame and wrapping around to the inside wall. Inside the shower room there were two linen carts, a toilet, sink and shower area behind a partial tiled wall. There were no razors or chemicals observed. In the shower area the drain hole in the floor was observed to be open and not covered with what looked to be hair and debris in the drain and a shower chair was inside. The shower chair and floor were damp but not wet and the room smelled of fresh soap. In an observation and interview on 5/5/26 at 10:53 a.m. in the secure women's unit B shower room, MA C stated she was unsure of how long the shower room door jamb had black duct tape on it, or how long the buttons on the lock had been missing and she was unsure of how long the drain cover had been missing on the shower room drain. MA C stated there had been no accidents or issues that she was aware of with residents walking in on other residents or of residents or staff stepping in the drain hole. MA C stated they did not keep shampoo, body washes, razors, or anything the resident could injure themselves with, out in the open in the shower room. The shower room was observed to be exactly as observed at 10:35 a.m In an interview on 5/5/26 at 11:02 a.m. LVN E stated the shower room door and lock had not been like that for long but unable to state how long it had been like that. LVN E stated there had been no issues with the residents wandering into the room while another resident was being showered and provided care as the door was pulled shut and the residents did not try to open closed doors and just walk past them. LVN E stated residents pulled the buttons off of the electronic lock and she was unsure if it had been reported to maintenance. In an interview on 5/5/26 at 11:05 a.m. the DON stated she was unaware of the shower room door in the women's secure unit B having tape on it or the buttons on the lock missing. An (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unknown staff member in the DON's office stated it was being fixed by maintenance already. In an observation and interview on 5/8/26 at 11:30 a.m. in the secure women's unit B shower room, the black duct tape was removed, the electronic lock had been replaced with a new working lock. CNA G demonstrated the lock worked and let the surveyor into the shower room. Observation revealed there was still no drain cover over the shower floor drain and all four of the shower chair wheels would fit into the first upper ring of the drain but only tilted the shower chair slightly and was not enough to tilt the chair significantly. The shower chair was wet as was the shower floor and CNA G stated they had been showering residents and had not had any issues or concerns with the floor drain cover missing. CNA G stated she was unsure of how long the drain cover had been missing or if it had been reported to maintenance but that there had been no issues with the shower chair wheels going into the top of the drain or any staff stepping or tripping on the drain while showering residents. CNA G grabbed the shower chair and pushed it back and forth to demonstrate the drain hole was not near the shower chair wheels and stated there had been no issues or concerns with the drain cover missing. Debris that was dark in color remained in the uncovered drain of the shower floor. In an interview on 5/8/26 at 11:50 a.m. the Maintenance Director stated he was not aware the women's secured unit B shower room floor drain cover was missing and he would fix it right now. The Maintenance Director stated there was an online computer reporting system for all staff to report maintenance issues, anything reported went directly to his notifications, and nothing had been entered in the system for the shower room floor drain cover. In a joint interview on 5/8/26 at 1:35 p.m. with the Administrator and DON, the Administrator stated the door to the women's secure unit B shower room should not have had duct tape on it, the lock should work and have no missing buttons, and the drain cover should be in place. The Administrator stated there could possibly be a dignity issue with the door not being able to be locked and a possible accident with the drain cover missing but there had been no negative occurrences and all of the issues with the door, lock, and drain had already been resolved and the Administrator had a picture of the drain cover in place. Review of the facility policy on maintenance service revised December 2009 indicated Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 4 of 6 carts (the C/D hall treatment cart, the A/B hall treatment cart, the B hall medication cart, and the C hall medication cart) reviewed for medication storage and labeling. The facility failed to ensure all insulins located inside the C/D hall treatment cart and the A/B hall treatment cart were properly labeled with opened dates. The facility failed to ensure all medications located inside the B hall medication cart and the C hall medication cart were stored in labeled containers. These failures could place residents at risk of receiving inadequate treatments or ingesting medications for which they were not prescribed.The findings included:During an observation of the C/D hall treatment cart on [DATE] at 8:45 AM, 3 of 8 insulins in the cart did not contain an opened date indicating when they were removed from refrigeration. During an interview with the ADON on [DATE] at 8:46 AM, the ADON stated insulins should be dated as soon as they were removed from the refrigerator to know if the medication was still potent. The ADON stated if the insulins had lost their potency, residents might not receive the intended effect of their medication.During an observation of the A/B hall treatment cart on [DATE] at 8:54 AM, 1 of 7 insulins in the cart did not contain an opened date indicating when they were removed from refrigeration. During an interview with LVN B on [DATE] at 8:55 AM, LVN B stated it was important to date the insulins when they come out of the refrigerator, so they would know when to dispose of them. LVN B stated if the medications were not dated, they could be past their expiration date. LVN B stated the insulin could be less effective if it was expired, and residents might not get a therapeutic dose of their medication.During an observation of the B hall medication cart on [DATE] at 9:05 AM, 9 loose pills were discovered lying in the bottom of the second drawer of the cart.During an interview with CMA C on [DATE] at 9:06 AM, CMA C stated if there were loose pills in the cart, a resident might not have received their medication. CMA C stated if a resident had a condition like high blood pressure, anxiety, or acid reflux, and they missed a dose of their medication, they could experience an elevation in their blood pressure or an increase in anxiety or discomfort. CMA C stated that when found, loose pills should be discarded, and the nurse should be informed. During an observation of the C hall medication cart on [DATE] at 9:15 AM, 3 loose pills were discovered lying in the bottom of the second drawer of the cart. During an interview with CMA A on [DATE] at 9:16 AM, CMA A stated there should not be loose pills in the cart, because they could be picked up from the drawer and given to a resident causing cross contamination. CMA A stated there could be a delay in therapy if a resident is missing a dose of their medication. During an interview with the DON on [DATE] at 1:33 PM, the DON stated her expectation for insulins was that they be labeled with the date as soon as they came out of the refrigerator so they would know when the medication would expire. The DON stated she expected her staff to clean and inspect their carts for loose pills regularly during any down time. The DON stated if loose pills were administered to residents, they could be expired and less effective, or if given to the incorrect person, the resident could be exposed to an adverse effect like an allergic reaction. Record review of the facility policy titled Medication Labeling and Storage, revised 02/2023, noted Medication Storage 1. Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Medication Labeling 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: d. expiration date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen reviewed for food service safety. 1. A bag of waffles was undated in the refrigerator. 2. A container of orange juice was undated in the refrigerator. 3. A bag of pita bread was in an unsealed plastic bag in the refrigerator. 4. Three boxes of gluten free items were opened and undated in the refrigerator. 5. Two bags of cereal and four prepared bowls of cereals were undated in the pantry. 6. A package of quick oats was in an unsealed and undated bag in the pantry. 7. A package of gravy mix was in an undated bag in the pantry. 8. Scoops were left in the bulk sugar and bulk rice bins in the pantry. 9. A package of corn starch was in an undated bag on the counter. 10. The bean puree was not held at a temperature of at least 135 degrees Fahrenheit before serving. 11. The corn puree was not held at a temperature of at least 135 degrees Fahrenheit before serving. These failures could place residents who consume meals and snacks from the kitchen at risk for food borne illness.The findings included: During an observation of the facility kitchen on 5/05/2026 at 9:12 AM, a bag of waffles was discovered undated in the refrigerator, a container of orange juice was discovered undated in the refrigerator, a bag of pita bread was discovered in an unsealed plastic bag in the refrigerator, three boxes of gluten free items were discovered opened and undated in the refrigerator, two bags of cereal and four prepared bowls of cereal were discovered undated in the pantry, a package of quick oats was discovered in an unsealed and undated bag in the pantry, a package of gravy mix was discovered in an undated bag in the pantry, scoops were discovered inside the bulk sugar and bulk rice bins in the pantry, and a package of corn starch was discovered in an undated bag on the counter. During an interview with the Dietary Manager on 5/05/2026 at 9:13 AM, the Dietary Manager stated there should not be undated or opened items in the kitchen, and scoops should not be left inside bulk food bins. The Dietary Manager stated if items are opened or undated, or if scoops are left in bulk bins, residents could consume contaminated or expired items. During a second observation of the facility kitchen on 5/05/2026 at 11:37 AM, two items on the warming table were not held at the safe holding temperature of 135 degrees Fahrenheit before serving. The bean puree was measured at 120 degrees Fahrenheit. The corn puree was measured at 132 degrees Fahrenheit. During a second interview with the Dietary Manager on 5/05/2026 at 11:38 AM, the Dietary Manager stated if food is not held at the proper holding temperature of 135 degrees Fahrenheit, it could cause bacteria to grow and illness to residents who consume the items. During an interview with the DON on 5/05/2026 at 2:05 PM, the DON stated it was important to keep bags sealed and dated, and to make sure the food is at the minimum holding temperature before serving to ensure food safety for the residents. Record review of the facility policy titled Refrigerators and Freezers, revised 11/2022, noted This facility will ensure safe refrigerator and freezer maintenance, temperature, and sanitation, and will observe food expiration guidelines. 7. All food is appropriately dated to ensure proper rotation by expiration dates . ?Use by' dates are completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food are observed and ?use by' dates are indicated once a food is opened. 9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past ?use by' or expiration dates. Record review of the facility policy titled Food Receiving and Storage, revised 11/2022, noted Foods shall be received and stored in a manner that complies with safe food handling practices. 2. ?Danger Zone' means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Dry Food Storage 3. Dry foods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. 4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (?use by' date). Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (?use by' date).

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 8 resident rooms (Resident #43) reviewed for physical environment.The facility failed to ensure there were no roaches in Resident #43's room and other areas of the facility.This failure could place residents at risk of unsanitary conditions, feelings of fear, irritation, embarrassment, depression, and an overall decline in quality of life.The findings were:Record review of Resident #43's face sheet dated 5/6/26 revealed the resident was an [AGE] year-old male resident admitted to the facility on [DATE]. Resident #43's diagnoses included encephalopathy unspecified (general, non-specific brain disease or damage where the exact cause is not yet determined), major depressive disorder recurrent and moderate (recurring mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life moderate in severity), and PTSD (mental health condition that's caused by being a part of or witnessing an extremely stressful or terrifying event and symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event).Record review of Resident #43's quarterly MDS assessment dated [DATE] revealed the resident had clear speech, understands and was understood by others. The resident had a BIMS score of 9 out of 15 indicating the resident had moderate cognitive impairment. The resident had rejected care daily and used a walker. The resident was frequently incontinent of urine and bowel.Record review of Resident #43's undated care plan revealed a focus initiated on 11/28/25 with revision on 2/4/26 for a potential behavior problem related to his diagnoses the resident refused care and assistance to include allowing sheets to be placed on mattress, bathing or to receive personal hygiene refusing nursing care, medications, labs, and preferring to eat in his room in the dark at times. This focus had multiple interventions to include psych services, family involvement, and encouragement. Another focus initiated on 9/24/25 with revision on 5/5/26 for verbal aggression towards staff and refusing showers and medications at times. Multiple interventions included on 4/26/26 an off-cycle care conference with family, Administrator, Activities Director, DON, Social worker, and the Ombudsman to address resident's refusal of showers, clean clothing, and medications. Family member will start coming in at least once a week to get the resident to shower, family will get a hamper for his room so they can keep track of his clothing and will encourage him to take his medications. A nurse will sign off on the shower so day staff will know it has been done. The team agreedto follow up in about three weeks.Record review of an anonymous visitor complaint received by HHSC (Health and Human Services Commission) revealed roaches were seen crawling on the visitor's belongings while in the facility.In an observation on 5/5/26 at 11:10 a.m. Resident #43 was not in his room, a sign on the door indicated there was video surveillance in his room. The resident's bed was stripped and was against the hallway wall, a recliner was across the room, the blinds were open, the room had an odor of cleaner and slight urine and looked to be recently mopped and was sticky. A large approximately 2-inch X 3/4 inch roach was observed on the same wall as the bed near the ceiling facing head down towards the bed. An unknown staff member was notified of the roach and stated he would report it and stated Resident #43 was most likely in the courtyard.In an observation and interview on 5/6/26 at 10:35 a.m. Resident #43 was sitting on the side of his bed, no linens on mattress and his walker next to him. The resident was looking out the window. The resident was dressed in a t-shirt, jogging style pants, and croc style shoes. The resident stated he was irritated and raised his voice slightly while stating no one here at the facility knows what they are doing and that he should not be here and wants the facility to show him one physician's note or piece of paper stating that he belongs here. While interviewing the resident, I was standing at the end of his bed at the door with the door closed and a large roach approximately 1 inch X 1/2 inch ran into my shoe and then went under the resident's bed. The resident asked me what kind of bug it was, and I stated it was a roach and the resident (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, oh yeah, there are thousands of them around here. The resident further stated the roaches get on all his belongings and the roach came out from under the resident's bed and was crossing in front of the resident's feet and he pointed down and stated, there's another one. The resident was calm and was no longer raising his voice. The roach then went across the room and under the resident's recliner. The resident stated someone came and sprayed today but it never helps. The resident stated he was used to the roaches and had served in Vietnam and those bugs were worse. The resident started talking about the bugs in Vietnam and I did not ask any more questions due to his PTSD. The resident was calm and heading outside to smoke.In a resident group meeting on 5/6/26 at 9:19 a.m. two other facility residents reported seeing small roaches in the facility on 5/5/26 at different times and the facility needed to address roach issues. The residents did state the facility does have pest control come.Review of the facility pest control invoices revealed Pest control visits were completed on 11/11/25, 12/5/25, 1/6/26, 2/6/26, 2/13/26, 3/6/26, 3/12/26, 3/20/26, 3/27/26, 4/3/26, 4/10/26, 4/24/26, 5/1/26, and an emergency visit on 5/6/26. At each visit American and or German cockroaches were targeted pests and on each visit different areas throughout the facility were targeted. Pest control time spent treating the facility on each visit varied from 1 hour to 3 hours. On the 5/6/26 visit per the pest control invoice the time in was recorded as 9:51 a.m. and time out was 10:53 a.m. and the only room treated was Resident #43's room and bathroom as that was where the roach was observed on 5/5/26 by surveyor and no other rooms or halls were treated at that time. In a joint interview on 5/8/26 at 1:35 p.m. with the Administrator and DON. The Administrator stated they notify pest control anytime there were reported issues with pests and have pest control come out. The DON stated part of the issue with roaches in Resident #43's room was the resident had a documented history of crumbs on himself and the floor and general uncleanliness but that was addressed in his care plan meeting and was much improved from previously. The Administrator and DON stated the roach problem was much better not only in Resident #43's room but facility wide and pest control continues to address the issues. Review of the facility pest control policy revised May 2008 indicated Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and to protect and promote the rights of the resident for 1 of 8 residents (Resident #59) reviewed for resident rights. The facility staff failed to ensure Resident #59's lunch meal tray was not placed in front of her, uncovered when they were not ready to assist her with eating and after having access to her meal tray that it was not pushed away from her and out of her reach while her tablemate continued eating her lunch. This failure could place residents at risk of feelings of embarrassment, humiliation, depression, and an overall decline in quality of life.The findings were: Record review of Resident #59's face sheet dated 5/6/26 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with readmission on [DATE]. Resident #59's diagnoses included alcohol dependence with alcohol-induced persisting amnestic disorder (associated with chronic ethanol abuse (alcoholism) and nutritional deficiencies characterized by short term memory loss, confabulations, and disturbances of attention), alcohol dependence with alcohol-induced persisting dementia (alcohol-related brain damage), and unspecified lack of coordination (inability to control voluntary movements and manifests as clumsiness, difficulty with fine motor skills, and balance issues). Record review of Resident #59's quarterly MDS assessment dated [DATE] revealed the resident had unclear speech, was rarely or never understood, and usually understands others. The resident was unable to complete the BIMS and staff assessment of mental status indicated the resident was severely impaired cognitively. The resident for eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident) was marked a 3 indicating Partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort and was a risk for malnutrition. Record review of Resident #59's undated care plan revealed a focus initiated on 2/11/26 for risk for potential nutrition problem related to impaired cognition, mechanically altered diet, use of psychotropic medications with interventions that included to provide and serve diet as ordered. Another focus initiated on 2/19/26 for self-care deficit requires assistance related to muscle weakness, lack of coordination muscle weakness, and cognitive impairment/loss with interventions that included partial to moderate assistance with eating. Record review of Resident #59's documentation for the resident's meal intake percentage revealed from 4/9/26 to 5/7/26 the resident ate 25-50 percent of her meal for 10 meals, 51-75 percent of her meal for 19 meals, and 76-100 percent of her meal for 56 meals. In an observation and interview on 5/5/26 at 12:20 p.m. Resident #59 was seated in the tv room in her wheelchair. The resident answered uh huh when asked if she was ready for lunch as it was almost time. The resident was asked if she was hungry and she stated yes and nodded her head. The resident continued to answer all questions with a yes or nodding her head and was not able to answer questions appropriately. In an observation and interview on 5/5/26 at 12:27 p.m. LVN I was checking the meal trays on the cart prior to CNAs's and other staff delivering them to the residents that were in the dining room. Resident #59 was seated at a small table across from an unknown resident who was eating her lunch. Resident #59's lunch tray was delivered and the dome covering removed. The plastic wrap remained over the 3 glasses of fluids on her tray. Resident #59 was observed to pick up her bread and turn it over and set it back down on the plate. The resident then picked up one of her drinking glasses but as she was lifting it her hand was shaking and she set it back down. The resident looked around and continued picking things up off her tray then setting them back down. The last tray was delivered to another resident at a different table and CNA H went over to Resident #59 and pushed her meal tray away from her towards the center of the small table out of the resident's (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reach. The resident looked directly at CNA H's face after she pushed the tray away and CNA H lightly touched the resident's arm and smiled at her. CNA H then started to push the cart out of the dining room and Resident #59 was sitting at the table while her table mate ate her lunch and the resident was looking at her tray. At 12:28 p.m. CNA H stated Resident #59 had to be assisted with her meals when asked why she pushed the resident's tray away from her and out of her reach. CNA H further elaborated the resident spilled and mixed her food unless assisted. CNA H and other unknown staff pushed the cart into the hall to deliver to the resident rooms. LVN I stated he was going to feed the resident her meal and sat down and asked the resident if she was ready to eat and she nodded her head that she was and he moved the tray within reach and began feeding the resident. In an interview on 5/5/26 at 3:05 p.m. LVN I stated Resident #59 ate 100% of her lunch meal without issues. LVN I stated he had always planned to feed the resident and had checked all the trays so they could finish delivering them on the halls but understood the resident's tray being moved away and out of her reach after being provided to her was a problem. In a joint interview on 5/5/26 at 3:30 p.m. with CNA H and CNA G, CNA H stated Resident #59 poured her drinks into her food and spilled it on the front of her and that was why she had pushed the tray away until someone was feeding the resident, so she did not spill her food and that someone else was going to feed the resident but she was not sure who. In a joint interview on 5/8/26 at 1:35 p.m. with the Administrator and the DON, the DON stated a resident's meal tray should never be pushed away or out of their reach once delivered to the resident, and the resident should immediately be assisted with eating when their meal tray was delivered and staff were being re-trained on the issue. The DON stated LVN I did immediately feed the resident when the CNAs were leaving the room. Review of the facility policy on dignity revised February 2021 indicated Each resident will 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. 5. When assisting with care, residents are supported in exercising their rights, for example, residents are:. e. Provided with a dignified dining experience.

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	675371	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Boerne	1102 River Road Boerne, TX 78006

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the environment was free from accidents and hazards for 3 of 17 residents (R# 23, # 38 and # 12) in the Men's Secure Unit, in that: Resident # 23 had 3 unsecured bottles (shampoo/conditioner, moisturizer, and hand cream) in his room. Resident # 38 had an unsecured disposable razor and an unsecured electric shaving razor in his bathroom. Resident # 12 was wandering in and out of rooms. This failure could result in residents in the Men's secure unit experiencing accidents, injuries and/or a diminished quality of life.The findings were: Record review of R #23 's face sheet, dated 5/7/26, reflected a -[AGE] year-old male who was admitted to the facility on [DATE]. Resident #23 had diagnoses which included: metabolic encephalopathy (brain dysfunction), dementia (a decline in mental ability), bi-polar disorder (mental illness) and schizoaffective disorder bi-polar type (hallucination/delusions and mood disorder) The RP was listed as: a Guardian.Record review of R#23's quarterly MDS, dated [DATE], reflected a BIMS score of 6, indicative of moderate impairment in cognition. In Section GG, the ADLs were documented as: resident needing supervision with bowel and bladder, transfer, and mobility. The resident had no impairments to range of motion. Record review of R#23's CP, undated, reflected the resident had the behavior of removing personal items and bringing them back to his room. An intervention included: removing items and storing items in safe storage. Record review of R #38 's face sheet, dated 5/7/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. R#38 had diagnoses which included: myocardial infarction (blood blockage in the heart), lack of coordination, dementia (decline in cognition), anxiety, and Alzheimer's disease (irreversible brain disorder). The RP was listed as: a family member.Record review of R#38's quarterly MDS, dated [DATE], reflected a BIMS score of 5, indicative of severe impairment in cognition. Section GG revealed the ADLs were documented as: resident required supervision for bowel and bladder. R#38 was independent in ambulation but required some partial to moderated assistance in mobility and transfer. R#38 required partial/moderate assistance in toilet hygiene. The resident had no impairments in ROM and had no assistive devices. Record review of R#38's CP, undated, reflected the resident lack safety awareness and had confusion. An intervention listed in the CP was to Keep environment free from possible hazards. Record review of R#12's face sheet dated 5/7/26, revealed the resident was admitted on [DATE] with diagnoses that included dementia (decline in cognition), schizoaffective disorder (mental illness), anxiety, and Alzheimer's disease (irreversible brain disorder). The RP was listed as the resident. Record review of R#12's quarterly MDS dated [DATE] revealed (Section C), the resident's BIMS score was 5 indicative of severe impairment in cognition. The resident was ambulatory and only required supervision in mobility and transfer (Section GG). Record review of R#12's CP, undated, reflected the resident was a wanderer and at risk for elopement. Intervention included close monitoring of the resident and re-direction. Observation on 5/6/26 at 10:46 a.m. of room [ROOM NUMBER] in the secure Men's Unit revealed on the overhead shelf near R#]23's bed were 3 unsecured bottles (1 bottle of shampoo/conditioner, 1 bottle of moisturizer, and one bottle of hand cream). Further observation and interview on 5/6/26 at 11:25 a.m. of room [ROOM NUMBER]'s bathroom, in the secure Men's Unit, revealed a disposable razor and an electric shaving razor in the resident's bathroom. R#38 stated the items belong to him. Further observation revealed R#12 wandering in an out of room [ROOM NUMBER]. During an attempted interview on 5/6/26 at 10:25 a.m., R #23 refused the interview and did not want to answer any questions about the 3 unsecured bottles of personal items in his room. During an interview on 5/6/26 at 10:30 a.m., LVN A stated it was not okay for R#23 to have lotions and shampoos because: the resident or wanderers could swallow the shampoo or lotions and lead to stomach issues. LVN A stated the family brought the bottles into the secure unit. LVN A stated the staff should have been aware of the bottles and stored (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them in the locked shower room in the cabinet. During an interview on 5/6/26 at 10:36 a.m., CNA C stated he worked at the Men's Unit 2 days per week. CNA C stated R#23 tended to hide the 3 unsecured bottles. CNA C stated he did not see the 3 unsecured bottles on 5/5/26 and 5/6/26. CNA C stated the resident should not have the unsecured bottles because it posed a poisoning danger to residents. During an interview on 5/6/26 at 10:39 a.m., CNA D stated she worked in the Men's Unit about 4-5 days per week. CNA D stated that she had not seen the 3 unsecured bottles belonging to R#23 on 5/5/26 and 5/6/26. CNA D stated she removed the 3 bottles after being directed by LVN A because the bottles posed a danger to the residents. CNA D stated the family gave the bottles to the resident, but she was not certain when the bottles were given to the resident. During an interview on 5/6/26 at 10:53 a.m., LVN B stated she worked in the Men's Unit 2 days per week. LVN B stated, part of working in the secure unit was to check for accidents and hazards and unsecured items. LVN B stated she did not notice the 3 of liquids in R#23 on 5/5/26 or 5/6/26. LVN B stated that it was not safe for residents in the secure unit to have lotions or moistening cream in the room because of the hazard of poisoning. During an interview on 5/6/26 at 11:03 a.m., the DON stated residents in a secure unit were not allowed to have unsecured bottles of shampoo/conditioner, moisturizer, and/or lotions in their room because it could present a poisoning hazard to residents. The DON stated that family members did not know that items brought into the secure unit had to be checked and locked. The DON stated that the staff working the secure unit may have failed to see the products that should have been secured in a locked cabinet. During an interview on 5/6/26 at 11:26 a.m., R #38 stated he had a disposable razor in his room to shave with, and an electric razor and the staff were not aware of the items. stated he kept the disposable razor and electric razor in the bathroom. The resident stated he did not know how or where the disposable razor and shaving electric razor where [NAME] into his bathroom. The resident stated he did not know the razor and the electric razor had to be stored in a secure cabinet outside of his room. During an interview on 5/6/26 at 11:41 a.m., CNA D confirmed the existence of the disposable razor blade and electric shaving razor in R#38's bathroom. CNA D stated the said items were not permitted in the Men's Unit. CNA D stated she did not know how the resident got the disposable razor blade and electric shaver; and would request approval from LVN A to remove the items and stored them in a secure cabinet. During a joint interview on 5/6/26 at 11:46 a.m., CNA C stated and LVN A confirmed the existence of the disposable razor blade and an electric razor in R#38's bathroom. Both stated it was unsafe for R#38 to have an unsecured disposable razor and electric shaver because it posed a danger to the resident and other residents that could wander into R#38's bathrrom. LVN A and CNA D stated they had not seen the razor or shaving electric razor on 5/5/26 and 5/6/26. During an interview on 5/6/26 at 11:50 a.m., LVN B stated she did not see the disposable razor blade or the electric razor on 5/5/26 during her shift. LVN B stated that housekeeping and CNAs needed to be aware of the environmental hazards and inform her. LVN B stated that she constantly educated staff in the secure unit on maintaining environmental visibility for potential accidents and hazards. Attempted interview on 5/6/26 at 11:55 a.m., R #12 had severe cognition issues and could not answer any direct questions. [Also, R#12 was observed wandering throughout the Men's Unit.] During an interview on 5/6/26 at 12:05 p.m., the ADON stated a resident in the secure unit with t a disposable razor and electric shaver needed for the items to be secured in a locked cabinet when not in use. The ADON stated the unsecured razor, or electric razor could present harm. The ADON stated she did not know how R#38 got the disposable razor and electric shaver in the room. The ADON stated every staff member in the Men's Unit should have checked the room for safety hazards. During an interview on 5/8/26 at 10:15 a.m., the Administrator stated the items in room [ROOM NUMBER] and room [ROOM NUMBER] should not have been present because the items posed potential harm to residents in the secure unit. The Administrator stated that the staff (nursing, housekeeping, maintenance, and laundry) entering and exiting Rooms #4 and #8 should have seen the prohibited items and should have secured the items in a locked cabinet. The Administrator stated she had no explanation why the staff did not see the prohibited items and had them locked in a cabinet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Facility's Non-Allowable Items policy dated 4/2025, revealed: For the safety of yourself and others the following is not allowed to be brought in or kept at the facility.7. Razors.Sharp Objects [electric razor] . [checklist did not include shampoos/conditioner, moisturizers, and/or body creams].

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 2 of 6 carts (D hall medication cart and C hall medication cart) reviewed for pharmacy services. The facility failed to ensure the controlled substance reconciliation logs were signed for accuracy of medication quantities during shift change. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain and anxiety, and a decreased quality of life.The findings included: During an observation of the D hall medication cart on 5/07/2026 at 8:32 AM, one signature was discovered missing from the controlled medication reconciliation log used to audit the inventory of the cart during shift change on 5/07/2026. During an interview with CMA A on 5/07/2026 at 8:33 AM, CMA A stated it was important to sign the controlled medication reconciliation log at the time of cart exchange, because they need to realize if there was a missing medication as soon as possible. CMA A stated it was important for the log to be accurate to make sure all medications were accounted for. CMA A stated residents might not get the therapeutic benefit of their medications if their pills were missing. During an observation of the C hall medication cart on 5/07/2026 at 9:15 AM, the controlled medication reconciliation log had one signature signed in advance of the next cart exchange audit on 5/07/2026. During an interview with CMA A on 5/07/2026 at 9:16 AM, CMA A stated the controlled medication reconciliation log should not be signed in advance of the cart exchange. CMA A stated to ensure accuracy of the inventory, the log should be signed at the time of the audit conducted with the staff member taking control of the cart. CMA A stated a medication error could occur if the log was signed in advance. During an interview with the DON on 5/07/2026 at 1:33 PM, the DON stated her expectation for the controlled medication reconciliation logs was that medications should be counted at shift change, and the logs should be signed at the time of the audit. The DON stated if the logs are signed in advance, the count of the controlled medications could be off causing residents to miss a dose of medication or increase the risk of drug diversion. Review of the facility policy titled Controlled Substances, revised 11/2022, noted Dispensing and Reconciling Controlled Substances. 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse [NAME] off duty make the count together and document and report any discrepancies to the director of nursing services.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 trash disposal areas that was reviewed for disposal of garbage. The doors on the left and right sides of the dumpster were open, and trash was on the ground outside of the dumpster. These failures could place residents at risk for exposure to germs and diseases carried by vermin and rodents.The findings included: During an observation of the trash disposal area on 5/05/2026 at 9:12 AM, both the left and right dumpster doors were open, and two disposable gloves were lying on the ground outside of the dumpster. During an interview with the Dietary Manager on 5/05/2026 at 9:13 AM, the Dietary Manager stated the dumpster doors should be closed, and no trash should be left on the ground. The Dietary Manager further stated if the dumpster doors were open or trash was left on the ground, rodents could come to the facility and expose residents to contamination or other illness. During an interview with the DON on 5/05/2026 at 2:05 PM, the DON stated her expectation for the trash disposal area, was that the dumpster should be closed and the grounds should be free of litter, so residents were not exposed to rodents or contaminated trash. During an interview with the Maintenance Director on 5/08/2026 at 11:43 AM, the Maintenance Director stated it was the responsibility of management to educate staff on proper garbage disposal and use of the dumpster. The Maintenance Director stated his expectation for staff was to pick up any debris and throw it in the dumpster and to make sure the dumpster doors were closed. The Maintenance Director stated residents could get an illness from exposure to trash left on the floor, and that the dumpster doors should be closed so that trash could not get out. Record review of the facility policy titled Grounds, revised 5/2008, noted Facility grounds shall be maintained in a safe and attractive manner. 1. Maintenance shall be responsible for keeping the grounds free of litter.