STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675452	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Converse	7700 Mesquite Pass Converse, TX 78109

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review and interview, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) program for residents with newly evident or possible serious mental disorder for 3 of 13 Residents (Resident #67, #48 and #7) whose records were reviewed. The facility failed to refer Resident #67, #48 and #7 for Level I screening when diagnosed with a mental disorder. This deficient practice could affect residents with a mental diagnosis and can result in residents not receiving services as identified by PASRR. The findings were:1.Record review of Resident #67's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included: Bipolar Disorder (is a mental health condition characterized by significant mood swings, including depression), Depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest), and Hyperlipidemia (occurs when there is excessive fat in the bloodstream). Review of Resident #67's admission MDS assessment, dated 6/4/26, revealed he was admitted to the facility on [DATE]. His BIMS score was 15, which indicated intact cognition. Record review of Resident #67's PASRR I screening dated 5/28/2026 revealed no evidence or indicator of mental illness. An interview with the MDS Nurse on 6/4/2026 at 12:12 pm indicated that Resident #67 was diagnosed with bipolar disorder and that the PASRR 1 admission screening was inaccurate. As a result, the screening needed to be redone and submitted to the local health authority. The MDS Nurse explained that Resident #67 risked not receiving state services for his diagnosis, and the facility could lose Medicaid reimbursement for each day Resident #67 remained without a proper PASRR I. She also noted she had not had the opportunity to audit all residents' charts before the state survey to ensure compliance. Interview with Resident #67 on 6/4/2026 at 7:15 AM revealed that he has had a diagnosis of bipolar disorder since being discharged from the military. Interview on 06/4/2026 at 2:30 PM with the ADON revealed that the MDS Nurse was responsible for referring all residents for level I PASRR screening if they had a mental illness. He further stated not referring residents with a mental illness for a Level 1 evaluation could result in Residents not benefiting from resources available. ADON stated he would be monitoring this task at random and ensure a complete audit was done of all Residents in the facility. 2. Review of Resident #48's face sheet, dated 6/4/26, revealed he was admitted to the facility on [DATE] with diagnoses including schizophrenia unspecified (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), bipolar disorder (mental health condition characterized by significant mood swings, including manic (or hypomanic) episodes and depressive episode), borderline personality disorder (is a serious mental health condition characterized by intense emotional instability, impulsive behaviors, and difficulties in interpersonal relationships) and post-traumatic stress disorder (serious mental health condition that can develop after an individual experiences or witnesses a traumatic event). Review of Resident #48's PASRR Level I Screening, dated 12/5/25, revealed there was evidence that he had a mental illness. Review of Resident #48's admission MDS assessment, dated 12/12/25, revealed his BIMS score was 15 of 15 reflective that he did not have cognitive impairment. Further (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review revealed Resident #48 received antipsychotic and antidepressant medications on a regular basis. Observation and interview on 6/01/2026 at 10:54 AM with Resident #48 revealed he was lying in bed. He stated he was not feeling well related to diagnosis of PTSD. Resident #48 stated he usually stayed in his room but knew he should get out more. Interview on 6/4/26 at 5:15 PM with the MDS Coordinator/RN E revealed she had been in charge of processing PASRR applications for about 9 months. She stated Resident #48 was diagnosed with schizophrenia unspecified, bipolar disorder and borderline personality disorder. MDS Coordinator/RN E stated she had inaccurately coded that Resident #48 had a mental illness on the PASRR Level Screening, dated 12/5/25. She stated his primary diagnosis was Dementia. Upon reviewing Resident #48's face sheet she stated his primary diagnosis was Parkinsonism. She stated Resident #48's diagnoses were all in fact qualifying diagnoses and should have referred Resident #48 to the local authority for a PASRR evaluation. MDS Coordinator/RN E stated not following through could result in Resident #48 not receiving services that could improve his quality of life. 3. Review of Resident #7's face sheet, dated 6/4/26, revealed he was admitted to the facility on [DATE] with diagnosis including post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress). Review of Resident #7's PASRR Level I screening, dated 6/2/25 revealed he did not have a mental illness. Review of Resident #7's annual MDS assessment, dated 5/2/26 revealed his BIMS score indicated he was moderately cognitively impaired. Interview on 6/4/26 at 5:15 PM with the MDS Coordinator/RN E revealed Resident #7 had a diagnosis of post-traumatic stress disorder which was reflective of a mental illness. She stated she should have completed another PASRR Level I screening to reflect mental illness and referred Resident #7 to the local authority for a PASRR evaluation. MDS Coordinator/RN E stated not following through could result in Resident #7 not receiving services that could improve his quality of life. Review of facility policy, Policy for PASSR, dated 1/20/2026, reflected When it is determined a PASRR is filled out incorrectly, the MDS coordinator will reach out to the corresponding case worker and ask them to correct the form.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 residents with a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 1 of 8 Residents (Resident #53) whose restrooms were observed for safety. The facility failed to ensure Resident #53 sink faucet was functional and did not spray water onto the floor. This deficient practice could prevent residents from using the sink in the restroom and could cause avoidable accidents. The findings were:Review of Resident #53's face sheet, dated 6/2/26, revealed she was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (joint damage), post-traumatic stress disorder (is a mental health condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress) and major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems) recurrent. Review of Resident #53's quarterly MDS assessment, dated 4/14/26, revealed her BIMS score was 15 of 15 reflective of not having cognitive impairment and she was dependent on staff for personal hygiene. Review of Resident #53's Care Plan, dated 4/4/26, revealed she had an ADL self-care performance deficit related to impaired mobility and she required assistance by 1 staff for oral care management and personal hygiene. Observation and interview on 6/1/26 at 11:18 AM with Resident #53 revealed she was lying in bed. Resident #53 stated she had lived at the facility for years. She stated she used her power motorized wheelchair for mobility but had chosen not to get out of bed for some weeks. She stated previously, she would get out of bed and use the sink in the bathroom but the water sprayed out directly from the faucet instead of spraying down. She stated it was an inconvenience for her and commented it was annoying. Resident #53 stated the faucet had not been working for months and had told a few of the CNA's but the faucet had not been fixed. Observation in Resident #53's bathroom revealed the sink faucet sprayed outward instead of downward. When the pressure was turned up the water sprayed onto the floor. Further observation revealed there was a wet towel on the floor in front of the sink. Interview on 6/3/26 at 12:45 PM with CNA D revealed Resident #53 mentioned to her the water from the sink faucet would spray outward onto the floor. She stated she reported it to her charge nurse a few weeks ago. CNA D stated she had also noted it herself when using the sink. Interview on 6/4/26 at 4:50 PM with the MD revealed he had worked for the facility for a few months. He stated he received a work order on 5/8/26 on the facility internal program from one of the nurses who reported the sink faucet in Resident #53's bathroom needed repairs. The MD stated he had not looked at it or repaired it because he had other repairs that were a higher priority. He stated he did not have an assistant, and he was the only one to complete all repairs. Observation and interview on 6/4/26 at 5:00 PM revealed the MD turned on the cold water at the sink in Resident #53's bathroom. The water sprayed straight outwards. He gradually turned the pressure higher, and the water started spraying out of the sink onto the floor. The MD stated it was probably inconvenient for Resident #53 and someone could slip and fall on the wet floor. Review of a facility policy, Resident Rights read in part 1. Federal and state laws guarantee the residents certain basic rights to all residents of this facility. These rights include the resident's right to: a. dignified existence and self-determination.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 Residents (Resident #7) whose records were reviewed. The MDS Coordinator failed to include Resident #7's diagnosis of PTSD in his comprehensive care plan including care and services the facility would provide. This deficient practice could result in residents not receiving the care and services needed. The findings were:Review of Resident #7's face sheet, dated 6/4/26, revealed he was admitted to the facility on [DATE] with diagnosis including PTSD, post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress). Review of Resident #7's annual MDS assessment, dated 5/2/26 revealed his BIMS score indicated he was moderately cognitively impaired and he had a diagnosis of PTSD. Review of Resident #7's, Comprehensive Care Plan, dated 4/10/26 did not reflect that he had a diagnosis of PTSD and it did not address how staff would assist Resident #7 in managing his condition. Observation and attempted interview on 6/03/2026 at 12 PM revealed Resident #7 was sitting at one of the dining rooms tables. Attempted interview with Resident #7 revealed he did not engage in conversation and propelled away. Interview on 6/4/26 at 5:15 PM with the MDS Coordinator revealed she was responsible for completing resident care plans. She stated Resident #7 had a diagnosis of PTSD and his Comprehensive Plan did not reflect this diagnosis, care or services he would receive. She stated the Care Plan did not accurately describe Resident #7's mental status and could result in staff not knowing how to address behaviors associated with PTSD. Review of facility policy, Care Plans, Comprehensive Person-Centered read in part 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. the comprehensive person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, including: (3) which professional services are responsible for each element of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments for 1 (Resident #42) of 8 residents reviewed for care plan revisions. The facility failed to ensure Resident #42's care plan was revised to reflect resident no longer required the use of a foley catheter and resident being occasionally incontinent of urine. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #42's face sheet, dated 06/03/2026 revealed Resident #42 was admitted to the facility on [DATE] with diagnoses which included: local infection of the skin and subcutaneous tissue, unspecified, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, skin transplant status and encounter for fitting and adjustment of urinary device. Record review of Resident #42's Quarterly 5-day MDS assessment, dated 05/04/2026, revealed Resident #42's BIMS score was 15 indicating cognition was intact and Section H-Bladder and Bowel H0100 Appliances was coded as none of the above for use of appliances and H0300 Urinary Continence was coded as 1 for occasionally incontinent (less than 7 episodes of incontinence). Record review of Resident #42's care plan, target date of 07/12/2026, revealed Resident #42 had a focus of [resident name] has an ADL self-care performance deficit r/t impaired mobility and intervention of TOILET USE: The resident requires assistance by (1-2) staff with toileting and managing foley catheter. Record review of Resident #42's care plan, target date of 07/12/2026, revealed Resident #42 had a focus of [resident name] has Indwelling Catheter and goal of The resident will be/remain free from catheter-related trauma. Record review of Resident #42's physician order summary dated 06/03/2026, revealed no orders for foley catheter or the care of a catheter. Record review of Resident #42's physician order recap report dated, 06/03/2026, read, FOLEY CATHETER 16 FRENCH/10 ML BALLOON with a discontinued effective date of 03/15/2026. Observation on 06/01/2026 at 10:42 a.m. revealed Resident #42 in her room and was observed transferring herself to the bed from her wheelchair and adjusting her covers free of difficulty with no Foley catheter present. During an interview and observation on 06/04/2026 at 1:42 p.m. the MDS Coordinator reviewed Resident #42's EMR and stated Resident #42 did not have an active order for a Foley catheter and further stated it was discontinued in March of 2026. The MDS Coordinator stated Foley catheter was still active in Resident #42's care plan, and she had not resolved it in the care plan. The MDS Coordinator stated that care plans were revised when the MDS assessments were due or quarterly. The MDS Coordinator further stated Resident #42's care plan for the catheter should have been revised in April. The MDS Coordinator stated when she was reviewing the care plan for Resident #42, she just did not see it and did not hit resolve the care plan. The MDS Coordinator reviewed Resident #42's Task in the EMR and stated resident was mostly continent according to the task and was 95% continent. The MDS Coordinator stated as she reviewed Resident #42's EMR that she only saw 1 or 2 incontinent episodes in the last 2 weeks. The MDS Coordinator stated the way the care plan was the staff members would assume Resident #42 had catheter care, but Resident #42 did not have a catheter so the staff would check on Resident #42 during their rounds. The MDS Coordinator stated she did not feel it would affect the care of Resident #42. The MDS Coordinator stated Resident #42's care plan should have been revised to show her toileting needs. The MDS Coordinator stated the purpose of the care plan was to inform the staff how to care for the resident and was a type of guidance for caring for residents. During an interview on 06/04/2026 at 2:37 p.m. the Administrator stated the MDS Coordinator was responsible for care plan accuracy. The Administrator stated care plans should be revised during clinical discussions, weekly, and daily as things change with a resident. The Administrator stated the best practice would be as soon as it was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	known that a change had occurred, the care plan should have been revised. The Administrator stated the care plan directed how the care of a resident was to be provided, what the residents' needs were and how the care was to be provided to the resident. Record review of facility's Care Plans, Comprehensive Person-Centered policy, revision date March 2022, read, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents' conditions changes.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide food that accommodated resident preferences for 1 of 8 Residents (Resident #53) whose records were reviewed. The facility failed to provide Resident #53 the option to receive a regular diet (non-mechanically altered food) per her preference. This deficient practice could result in residents not having the freedom of making their own food choices. The findings were:Review of Resident #53's face sheet, dated 6/2/26, revealed she was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (joint damage), post-traumatic stress disorder (is a mental health condition triggered by experiencing or witnessing a traumatic event, leading to severe anxiety, flashbacks, and emotional distress) and major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems) recurrent. Review of Resident #53's quarterly MDS assessment, dated 4/14/26, revealed her BIMS score was 15 of 15 reflective of not having cognitive impairment. Further review revealed Resident #53 received a mechanically altered diet and it did not reflect she had a swallowing problem. Review of Resident #53's Care Plan, dated 2/13/26, revealed she was at risk of increased depression and one of the interventions included for staff to encourage and allow resident to verbalize needs and concerns; she was at nutritional risk. On a regular diet, mechanical soft (consists of foods that are chopped, mashed, pureed, or blended to make chewing and swallowing easier), thin liquids. Interventions included honor residents' meal choices and observe meal intake, record and offer alternative if eats less than 50 % of meal. Review of Resident #53's Multidisciplinary Care Conference, dated 4/22/26, revealed she C/O (complained) of DIET TEXTURE. WILL F/U (follow up). Observation and interview on 6/1/26 at 11:18 AM with Resident #53 revealed she was lying in bed. Resident #53 stated she had lived at the facility for years. Observation revealed Resident #53 did not have any teeth. Resident #53 stated she could not stand the food because staff insisted on serving her a mechanical blended diet. She stated she ordered her own food and would have the CNAs prepare instant oatmeal for breakfast, pasta, and other items. Resident #53 stated she had asked over and over for a regular food but staff basically ignored her. She stated staff acted like she could not chew. She commented she had been eating a regular diet for years without any problems. Observation and interview on 6/3/26 at 12:45 PM revealed CNA D was passing out lunch trays. She stated Resident #53's tray was the last one and CNA D presented Resident #53's lunch tray including beef Tator tot casserole, mixed vegetables and a smoothie. The beef Tator tot casserole was blended. CNA D stated she would present the meal tray to Resident #53 and the resident would let her know whether she wanted the tray or not. CNA D stated Resident #53 never accepted her meal trays. She stated Resident #53 would sometimes accept some of the drinks. Observation revealed CNA D delivered the tray to Resident #53 and then returned with the tray with all food items except the smoothie. CNA D stated Resident #53 accepted the smoothie served with the meal tray. CNA D stated she had worked at the facility for a couple of months and initially she let the charge nurse know Resident #53 was not accepting the food. CNA D stated Resident #53 would have her prepare some macaroni and cheese or other easy to prep foods and she would eat that instead of what was served. Interview on 6/3/26 at 1PM with LVN E revealed she had worked at the facility for about 11 years and stated Resident #53 was already living in the facility. She stated Resident #53 had always bought her own food and did not eat the facility food. LVN E stated she had never personally talked to Resident #53 about why she did not eat the food and again stated Resident #53 had always eaten whatever she wanted. Interview on 6/4/26 at 11:30 AM with the ADON and DOR revealed Resident #53 was not on caseload with rehabilitation services at this time. The DOR stated at one point the ST worked with Resident #53 and the primary concerns was that Resident #53 did not want to sit up during meals including having the head of her bed upright (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while she ate. In addition, Resident #53 would scoop the food from the plate into her mouth while lying down in bed. The DOR stated Resident #53 did not want staff to feed her. The ADON and DOR expressed concern that she could possibly choke, although they stated she had eaten whatever she wanted for as long as they had known Resident #53. The DOR and the ADON stated they were not aware Resident #53 having any choking incidents. Both the DOR and ADON stated Resident #53 had the right to choose her diet plan even if she was at risk for aspiration. They stated the facility had a waiver staff could have Resident #53 sign in order to release the facility of any liability. They stated they had not offered it to Resident #53. The DOR stated she had not contact with Resident #53 because she had not been on caseload for several months. The ADON stated he was not aware that Resident #53 wanted a diet upgrade. He stated he talked to Resident #53 often, was aware that she refused to eat the facility food but had never had a discussion with Resident #53 about her preferences. The ADON stated he could imagine Resident #53 might be frustrated about the situation. Interview on 6/4/26 at 5:15 PM with the MDS Coordinator revealed she remembered the Care Conference meeting held on 4/22/26 and Resident #53 wanted her diet upgraded to a regular diet. The MDS Coordinator stated Resident #53 reported she had a swallow study and was able to eat regular food. The MDS Coordinator stated the DOR was not present for the Care Conference meeting and let Resident #53 know they would get back with her. She stated this was discussed during the morning meeting on 4/23/26 and her request for a diet upgrade was denied without further discussion. The MDS Coordinator stated she had not met with Resident #53 about the outcome. She stated Resident #53 probably felt like nobody was listening to her and that what she wanted did not matter. Review of a facility policy, Resident Rights read in part 1. Federal and state laws guarantee the residents certain basic rights to all residents of this facility. These rights include the resident's right to: a. dignified existence and self-determination.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 service safety for 1 of 1 kitchen observed for food and nutrition services. The facility failed to ensure dietary staff used facial hair restraints properly during meal preparation and dish washing. The facility failed to ensure the dietary staff used proper hand hygiene during plate preparation. These failures could place residents at risk for food borne illness. The findings included:During an observation on 06/02/2026 at 11:57 a.m. Dietary Aide A was observed assisting [NAME] B by preparing a cheese burger, placing cheese on the burger, placing the cheese burger on bun and giving the plate to [NAME] B while he was wearing a beard restraint only covering his beard hair to his chin and side of face with the restraint not pulled over his mustache. During an observation on 06/02/2026 at 12:04 p.m. [NAME] B was observed leaving the serving line to go to the pantry while wearing gloves, opening the pantry door, returning to the line with bag of chips, opening the bag of chips, reaching into the bag of chips with a gloved hand, placing chips on a plate, covering the plate, and putting it on a tray. [NAME] B did not change gloves or wash hands when she returned to the serving line. [NAME] B continued to serve plates for the lunch service. During an observation on 06/02/2026 at 12:15 p.m. Dietary Aide A was observed in the dish washing room putting the following items through the dish washing machine: meal trays, steam table pans, and cooking utensils with mustache exposed and beard restraint only covering his chin. During an interview on 06/02/2026 at 12:19 p.m. Dietary Aide A stated he had taken a drink and forgot to pull the beard restraint back over his mustache. Dietary Aide A stated the beard restraint should have been covering his mustache. Dietary Aide A further stated the beard restraint was supposed to keep hair from falling in the food and could cause cross contamination. Dietary Aide A stated if the hair was to fall in food it could possibly cause someone to get sick and could possibly cause vomiting. Dietary Aide A stated he should have the beard restraint over his facial hair when he was working in the kitchen. During an interview on 06/02/2026 at 12:22 p.m. [NAME] B stated she should have changed her gloves and washed her hands when she returned to the kitchen with the bag of chips and put new gloves on to continue serving. [NAME] B stated by not removing the gloves and washing her hands it could cause cross contamination and people could get sick. During an interview on 06/02/2026 at 12:25 p.m. the Dietary Manager stated hair restraints should be put on prior to entering the kitchen. The Dietary Manager further stated beard restraints should be worn to cover all facial hair. The Dietary Manager stated that by not wearing hair restraint properly hair could fall and contaminate food or dishes causing cross contamination. The Dietary Manager stated hair could get lodged in a resident's throat, and bacteria could be on the facial hair which could cause or make someone sick. The Dietary Manager stated [NAME] B should have removed her gloves when leaving the line, washed her hands and put on new gloves when returning to the line. The Dietary Manager further stated that by not doing this it could cause cross-contamination and could put residents at risk of becoming sick from contamination. During an interview on 06/03/2026 at 3:44 p.m. the Administrator stated hair restraints/beard restraints should be always worn when in the kitchen. The Administrator stated not wearing hair/beard restraints could cause cross contamination during meal prep or kitchen duties. The Administrator stated cross contamination could cause food borne illness. The Administrator stated kitchen staff should change gloves and wash hands when they walk into the kitchen, touch their face/clothing, when eating, toileting, or touching unclean surfaces to prevent contamination of food or causing food borne illnesses. Review of facility's policy, Food Safety and Sanitation, dated 2023, read Policy: All local, state, and federal standards and regulations will be followed to assure a safe and sanitary food and nutrition services department. Procedure: 2. Employees: c. Employees are required to. [NAME] nets are required when facial hair is visible. d. Employees will wash their hands just before they start to work in the kitchen and after smoking, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675452	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Converse	7700 Mesquite Pass Converse, TX 78109

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sneezing, using the restroom.and touching face, hair, other people or surfaces or items with potential for contamination. Review of facility's policy, Employee Hygiene for Food Safety, dated 2023, read Policy: All food and nutrition services employees will practice good personal hygiene and safe food handling procedures. Procedure: All employees will: 1. Wear hair restraints (hair, hat, and/or beard restraint) to prevent hair from contacting exposed food.6. Use utensils to handle food, avoiding bare hand contact with food. Disposable gloves are a single use item and should be discarded after each use. Hands must be washed prior to using gloves and after removing gloves. Review of facility's policy, Personal Hygiene and Health Reporting, dated 2023, read Policy: All food and nutrition services employee will be trained in appropriate personal hygiene and health reporting. Procedure: 2. Personal hygiene criteria to follow include the following: c. Beards and mustaches should be closely cropped and neatly trimmed. When near exposed foods, beards must be restrained using beard covers. Review of facility's policy, Hand Washing, dated 2023, read Policy: Employees will wash their hands as frequently as needed throughout the day using proper hand washing procedures.Procedure: Hands and exposed portions of arms (or surrogate prosthetic devices) should be washed immediately before engaging in food preparation. 1. When to wash hands: f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil or contamination and prevent cross contamination when changing tasks. j. After engaging in other activities that contaminate the hands. Review of facility's policy, Bare Hands Contact with Food and Use of Plastic Gloves, dated 2023, read Policy: Single use gloves or other barriers will used when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited. Procedure: 6. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched the gloves must be changed and hands must be washed. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-402 Hair Restraints, 2-402.11, Effectiveness., (A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-301.14, When to Wash, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTNESILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675452	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Converse	7700 Mesquite Pass Converse, TX 78109

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, that medical records were accurately maintained for each resident, as documented for 1 of 4 residents (Resident #28) whose medical records were reviewed for accuracy. The facility failed to ensure that documentation on Resident #28's face sheet ccurately reflected the diagnosis of pain. This failure could place residents at risk of receiving improper care. Findings included: Record review of Resident #28's face sheet, dated 2/17/2026, revealed a [AGE] year old male admitted to the facility on [DATE] and remitted on 7/23/2025 with diagnoses that included: Bipolar Disorder (is a mental disorder characterized by periods of depression and abnormally elevated mood), Dementia (a loss of memory, thinking, reasoning, and other mental abilities), and Diabetes (disease in which the body can not properrtly control the amount in sugar in your blood). Record review of face sheet for Resident #28, dated 6/3/26, revealed no diagnosis for pain. Record review of Resident #28's BIMS assessment, completed 5/13/26, revealed a BIM score of 14, which indicated intact cognition. Record review of Resident #28's history and physical, dated 4/23/2025, revealed a diagnosis of pain. Record review of Resident #28's care plan, updated 12/20/2022, revealed a care plan with a focus on Pain. Record review of Resident #28's June 2026 monthly physician orders revealed an order for Morphine Sulfate (pain medication) 30 mg, to be administered as one tablet twice a day. Interview with Resident # 28 on 6/2/2026 at 9:44 am revealed that he has had pain for years due to an old military back injury. Interview with the MDS nurse on 6/3/2026 at 9:15 AM revealed that she was responsible for entering diagnoses on face sheets and that resident #28's pain diagnosis was not entered on the face sheet. The MDS Nurse said omitting this diagnosis may have affected staff awareness of the Resident's condition and the provision of appropriate care and services. She also said she had not yet audited the residents' diagnoses against the corresponding histories and physicals, which was why the information was not correlating. During an interview on 6/3/2026 at 10:25 a.m., the ADON stated he had been in his role for two months and had not yet audited all prior admissions for face sheet accuracy. He noted that omitting a pain diagnosis from the face sheet could cause confusion for providers and may result in Resident #28 not receiving appropriate care. He explained that the MDS Nurse is responsible for this task, while he conducts random monitoring. Record review of the facility's policy charting and documentation, dated 2001, revealed: Documentation in the medical record will be objective, complete, and accurate.